# HOOPER LUNDY & BOOKMAN, INC.

HEALTH LAW PERSPECTIVES

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## OIG Rejects Hospital Management Arrangement

The Health and Human Services Office of Inspector General (OIG) has issued an advisory opinion which calls into question many common hospital program management arrangements.

In Advisory Opinion No. 03-8, the OIG declined to protect an arrangement by which a company would manage "distinct part" inpatient rehabilitation units located within general acute care hospitals. Under the proposal, the requester and each hospital would enter into a three-year agreement pursuant to which the requester would develop and operate the unit, including provision of all patient care personnel other than nurses (who would be provided by the hospital).

The requester would provide a leadership team, consisting of a program director, community outreach coordinator, and medical director. The medical director might have a separate medical practice, and might refer his or her patients to the unit. The requester represented that each medical director agreement would be protected under the safe harbor for personal services and management contracts, and would qualify under the Stark law's personal services exemption.

Members of the leadership team would interact with physicians, hospital discharge planning personnel, and third party payor utilization review personnel who might have the ability to make or influence referrals to the managed units. These interactions would consist primarily of one-on-one meetings, educational presentations and workshops for physicians and medical personnel, as well as the distribution of correspondence, brochures and other literature. The requester would not directly solicit Medicare or Medicaid beneficiaries or other patients, either in person, by telephone, or by mail. The requester would be paid a monthly management fee, which it represented to be at fair market value, that would be calculated on a per patient day basis.

Approximately 70 percent of the patients in the units would be Medicare beneficiaries. Medicare would pay for the services rendered to such patients under its PPS systems applicable to rehabilitation and general acute care hospitals.

The arrangement could not qualify for safe harbor protection because the per day fees resulted in compensation which was not fixed in advance in its aggregate amount. The OIG observed that per patient, per click, per order and similar payment arrangements involving parties in a position to, directly or indirectly, refer or recommend items or services covered by Medicare are disfavored under the anti-kickback statute.

The OIG explained its decision to decline to extend protection to the arrangement before it based upon the following specific concerns:

(1) The PPS payment methodology would not reduce the risk of overutilization since the parties would have an incentive to fill all beds;

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(2) The OIG was not in a position to determine how malleable the criteria were for admission for the principal diagnoses that would be involved in the program;

(3) The hospital's nurses working in the unit would share the goal of making the program a success;

(4) The medical director would be in a position to generate patients for the unit;

(5) The requester would perform community outreach services, including marketing; and

(6) The per patient day fee, while potentially reflective of costs actually incurred, could also "simply cloak a success fee."

***Analysis***

The type of arrangement described by the requester is typical of hospital program management arrangements that were developed in the early 1980s, and which have continued to be implemented to this day. It is not unusual for program managers to have marketing programs which are more extensive than the one that was described in the request.

Over the course of the last 10 years, experienced health care counsel have guided their clients towards structuring these arrangements to involve fixed fees which can be protected by the safe harbor regulations. However, it is not clear that such arrangements will satisfy the safe harbor's requirement that services be performed on a full-time basis, and, in some instances, it has been advisable for all marketing personnel to be employed directly by the hospital, instead of by the program manager.

Parties are, however, often reluctant to seek safe harbor protection since, depending upon the census level reached by the program, a fixed fee will often result in the either the hospital feeling it has overpaid or the program manager feeling it has been underpaid. This may lead the parties to renegotiate the fee (either mid-term or after the expiration of the safe harbor's minimally required one year term) to reflect actual program results. Such renegotiations can be problematic.

This advisory opinion confirms that health-care counsel have been on the right track in trying to restructure these types of management arrangements.

*If you have any questions relating to this opinion, please call Brad Tully at (310) 551-8160 (wtully@health-law.com); or David Henninger at (310) 551-8177 (dhenninger@health-law.com).*

# DOJ Approves Federal Payments to Hospitals in *Orthopaedic Hospital* Case

The U.S. Department of Justice has approved payment of $175 million to hundreds of California hospitals, marking the close of years of litigation.

*Orthopaedic Hospital v. Belshé* was filed in 1990 by Hooper, Lundy & Bookman, Inc., on behalf of the California Association of Hospitals and Health Systems, after the state failed to raise substandard Medi-Cal reimbursement rates to hospitals for the outpatient services they provided to beneficiaries.

After more than a decade of litigation, a settlement was reached in December 2000, contingent on the federal government's assurance that it would reimburse the state for half of the total amount. By the end of 2001, the federal government had not provided the necessary assurance. Hooper, Lundy & Bookman then negotiated an amended settlement with the California Department of Health Services and Department of Finance, in which the state agreed to pay its $175 million portion of the settlement, regardless of whether the federal government paid its portion of the payment. The state issued the $175 million plaintiffs' check, which was recently distributed to hospitals by a court-appointed claims administrator.

Under terms stipulated by the Centers for Medicare and Medicaid Services, approximately $50 million of the federal portion will go directly to Los Angeles County for use in dealing with its current health care crisis. The remaining $125 million will be distributed to hospitals on a prorated basis. The settlement agreement requires court approval before the funds can be distributed.

"We are pleased that after 13 years of litigation, California hospitals will finally be paid the funds they are entitled to," said HLB Attorney Lloyd Bookman, who represented CAHHS throughout the life of the case.

*For more information, please contact Mr. Bookman at (310) 551-8185.*

# Federal, State Bills Target Hospital Ownership

Significant hospital ownership limitations would be imposed under recently introduced federal and state legislation.

The federal bill, HR 1539, was co-authored by U.S. Representatives Pete Stark (D-CA) and Gerald Kleczka (D-WI). The bill would limit the hospital ownership exception to ownership interests

purchased on terms generally available to the public, meaning that an offering could not be directed solely to physicians. The bill is intended to block development of new specialty hospitals owned by physicians, although it is not limited to specialty hospitals. Any ownership interest purchased before July 12, 2001 would be grandfathered. At press time, the bill had not yet been heard in committee.

State legislation targeting physician ownership of hospitals includes:

- SB 828, introduced by Senator Liz Figueroa (D-Fremont ), would prohibit the California Department of Health Services (DHS) from issuing a license to operate a boutique hospital that limits its admissions or services unless that boutique hospital agrees to continuously maintain and operate an emergency department, participate in the Medi-Cal program and provide emergency services and care to nonpaying and low-reimbursed patients. The bill passed Senate Health & Human Services in April and is currently awaiting hearing by the Senate Appropriations Committee.
- AB 1261, introduced by Assemblywoman Rebecca Cohn (D-Campbell ) would prohibit DHS from issuing an initial license for a general acute care hospital or renewing a license originally issued after January 1, 2004, unless the hospital intends to provide a broad range of adult acute inpatient medical and surgical services and basic emergency service at all times during the term of the license. At press time the bill was awaiting hearing in the Assembly Health Committee.

A third California bill specifically targets the ownership of ambulatory surgical centers (ASCs) by physicians. SB 354, by Senator Jackie Speier (D-San Mateo), which was originally introduced to target workers' compensation fraud and limit chiropractic visits, has been amended to add ambulatory surgery services paid for by the workers' compensation program to the California self-referral restrictions. If enacted in its present form, the bill would make it illegal for a physician holding an ownership interest in a joint ventured ASC to refer workers' compensation program patients to that ASC. The bill passed Senate Insurance and has been referred to the Senate Committee on Labor and Industrial Relations.

*For more information, please contact Brad Tully at (310) 551-8160 (wtully@health-law.com) or David Henninger at (310) 551-8177 (dhenninger@health-law.com).*

# HIPAA Enforcement Guidance Released

On April 17th, the Department of Health and Human Services (DHHS) issued an interim final rule discussing DHHS proposal for HIPAA enforcement and the imposition of civil monetary penalties. DHHS stated that they intend this guidance to be the first installment of a rule termed the "Enforcement Rule." The current release discusses the procedural aspects of enforcement and does not answer the substantive question most on everyone's minds — what will be considered a violation where civil monetary penalties will be imposed?

If you wish to comment on the proposed Enforcement Rule, you need to write to DHHS by Monday, June 16, 2003. The proposed rule is available at http://www.hhs.gov/ocr/**hipaa**/ and http://www.cms.gov/**hipaa**/hipaa2.

The civil monetary penalties (CMPs) under HIPAA are a maximum of $100 for each violation with a cap of $25,000 for each violation per year. What remains unclear is what will be considered a "violation." Is a faulty Notice of Privacy Practices one violation or a violation each time a provider gives it to a patient. Obviously, DHHS' answer to this question will mean very different levels of liability for providers.

Again, DHHS emphasized that it "intends to seek and promote voluntary compliance." It also laid out three scenarios where civil monetary penalties (CMPs) would not be imposed:

- Where the act constitutes an offense punishable under the criminal penalty provision.
- If it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision.
- If the failure to comply was due to reasonable cause and not to willful neglect and is corrected within a certain time.

In addition, the CMPs may be reduced, if not waived entirely, to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

Finally, the proposed Enforcement Rule is based almost entirely on the procedural rules used by the Office of the Inspector General (OIG) for health care matters. DHHS states that one reason it has used the OIG regulations as the platform because the healthcare industry has had over a decade of experience with these rules, which should make implementation smoother.

*For more information, please contact Elspeth Delaney at (310)551-8138 or edelaney@health-law.com.*

# CALENDAR

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| May 14 – 16 | HLB Attorneys John Hellow and Pamela Riley speak at the ABA Health Care Fraud 2003 Conference, at the Green Valley Resort, Las Vegas, Nevada. Mr. Hellow will speak on *Advanced Issues in Cost Reporting Fraud.* Ms. Riley will speak on*Advanced Issues in Billing Fraud.* |
| May 20 | HLB Attorney Linda Randlett Kollar speaks on *Responding to Subpoenas, Court Orders and Law Enforcement* at a conference on Mental Health & the Law in California, Radisson Hotel, Los Angeles. |
| May 24 | HLB Attorney Jodi Berlin speaks on *Survey Recovery* at the annual conference of the California Association for Health Services at Home, Sacramento Convention Center. |



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