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Cash discounts surface as major government concern

Attorneys say cash discount arrangements loaded with land mines

Cash discounts are rising on the government's radar screen, warn health care attorneys, who point to the Department of Health and Human Services' Office of Inspector General special advisory on inducements issued last week **(see related story, below)**. "Whether and to what extent cash discounts to patients are permissible continues to be a source of frustration for physicians, ambulatory surgery centers, and other providers," says **Allison Shuren** of Arent Fox in Washington, DC. While cash discount arrangements are permitted in many situations, she says there is no shortage of potential land mines.

Bill Sarraille, also of Arent Fox, says that list includes Medicare reimbursement limitations, state anti-kickback laws, the anti-beneficiary inducement provision of the Health Insurance Portability and Accountability Act, the Medicare exclusion provision that relates to Medicare and non-Medicare charges as well as state insurance anti-discrimination provisions.

Sarraille says the term "cash discounts" is sometimes used to incorrectly suggest an appropriate reason for improperly waiving on "out of the network" penalties required by a patient's managed care insurance. "Providers, in these situations, are looking for a means of eliminating the 'out-of-network' penalties that would otherwise

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OIG offers 'bright-line' guidance on inducements

The Department of Health and Human Services' (HHS) Office of Inspector General (OIG) released a special advisory bulletin Aug. 29 that attempts to clarify rules surrounding gifts and other inducements to beneficiaries. However, health care attorneys gave the advisory mixed reviews.

"It is somewhat conservative, but I think it does level the playing field," says **Paul Demuro**, a partner with Latham and Watkins in San Francisco. For example, he says the OIG is becoming increasingly consistent regarding the $10 rule for inexpensive gifts.

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OIG advisories get mixed reviews

In recent months, the Department of Health and Human Services' Office of Inspector General (OIG) has issued an increasing number of advisory opinions. The most recent advisory, issued Aug. 20, concluded that a state-chartered hospital authority, which owns and operates a large teaching hospital, can make substantial charitable contributions to an endowment fund affiliated with the university without violating the anti-kickback statute.

Donna Clark, a health care attorney with Vinson and Elkins in Houston, says it is the first opinion to recognize the unique nature of academic medical centers and the various components included in these organizations.

"This is one of the first opinions that recognizes that these are unique situations and recognizes the validity of exchanges of payments that are made to further research and education," she

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Cash discounts

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apply, without reducing the amount that the insurance company pays," he explains.

According to Shuren, another potential problem with a cash discount in connection with Medicare patients is that Medicare pays the lesser of the applicable percentage of the fee schedule allowable or the actual charge for the service. "If a cash discount is offered in connection with a Medicare covered service, the effect of this will typically be to take the actual charge below the Medicare allowable," she explains.

If that fact is not reported on the claim form submitted to the Medicare program, she says the provider will receive an overpayment.

Similar issues may be raised with respect to patients covered by private insurance, says Shuren. She notes that some commercial payer provider agreements have language that follows the Medicare payment rules with regard to the distinction between fee schedule allowables and actual charges.

State insurance fraud and state false claims acts, which generally apply to all payers, can have the same effect on discounts in a private-pay context, as the federal False Claims Act has in a federal level, warns Shuren. In these situations, she says providers are well advised to notify payers, in writing, of the providers' cash discount policy.

In some respects, discounts are already overregulated, argues **Robert Homchick**, a partner with Davis Wright in Seattle. He points out that Congress included a statutory exception for discounts in the anti-kickback law and almost everyone would agree that discounting is a good thing and should generally be permissible.

There are certain issues such as swapping that are legitimate concerns on the part of the OIG, says Homchick. But the discount safe harbor is too narrowly drawn, particularly if the government is taking the position that the only permissible discounts are those that meet the safe harbor's specific requirements.

According to Homchick, the dynamics of the marketplace make the OIG's attempts to rein in discounting practices difficult and the aggressive stance of the regulators on this issue appears to be inconsistent with Congressional intent. ■

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asserts. Clark says the opinion itself acknowledges the complexity of the relationships that exist between the various components of an academic medical center and some of the difficulties in attempting to fit those arrangements into traditional arrangements.

The hospital in question had once been part of the university, which operated the medical school, and the contributions were designed to support and promote education and research at the university's school of medicine through developing a clinical cardiology services program. The state legislature had given the hospital a separate charter as a hospital authority. However, that charter included a requirement for the hospital to continue to support the medical school in its research and education activities. Clark says that made it relatively easy for the OIG to bless the arrangement.

In addition to those factors, the arrangement included very strict language in the physician contracts, notes **Mark Langdon**, an attorney with Arent Fox in Washington, DC. "Like most advisory opinions, it is limited to the facts that were presented but it does let academic medical institutions know that properly structured donation arrangements can pass muster," he says. "If academic

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medical centers want to structure transactions, they can certainly look to this as guidance."

In a separate advisory opinion released Aug. 7, the OIG approved one discount arrangement and disapproved another offered by a vendor to end-stage renal dialysis providers. "Although the outcome is consistent with the OIG's overall conservative approach on advisory opinions, the quality of the analysis contained in the advisory opinion falls well short of the OIG's usual standards, and raises more questions than it answers in this complex area," argues **Charles Oppenheim**, a partner with Foley and Lardner in Los Angeles.

In this case, the vendor proposed two different discounts. One was a uniform discount based on the purchaser's aggregate annual purchases of any and all dialysis equipment and supplies sold by the vendor. The other was a discount based on total annual purchases of certain designated items sold by the vendor if the purchaser buys a minimum quantity of certain items.

The OIG concluded that the first discount is outside of the safe harbor, but concluded it is unlikely to present significant risk of program abuse. The agency concluded the second arrangement also is outside of the safe harbor, but disapproved it because it potentially presents more than minimal risk of program abuse.

Several health care attorneys criticized OIG in this instance. "A careful reading of the advisory opinion suggests that OIG should have concluded the first arrangement is in the safe harbor and the second presents little, if any, risk of program abuse," says Oppenheim. ■

OIG guidance

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He also endorses how OIG handled the chronic conditions issue, and says providers sometimes argue they can offer things to beneficiaries because they have chronic conditions. However, the OIG maintains that there should not necessarily be an exception for these patients because they represent one of the bigger areas for abuse.

Charles Oppenheim, a partner with Foley and Lardner in Los Angeles, says the OIG's bulletin glosses over the nuances of the prohibition such as the fact that the remuneration must be an inducement. "That implies that any remuneration over $10 per item or $50 a year violates the statute unless it comes within a specific exception, which is untrue," he asserts.

"Whether the remuneration would induce a patient to select the provider depends on many factors and requires a more subtle analysis," he maintains. For example, he argues that if a patient is choosing which hospital to use for open-heart surgery, a gift worth $11 will not influence that decision. However, it might if a patient is deciding what dentist to use to fill a cavity.

"It also matters whether the remuneration is tied to the choice of provider," argues Oppenheim. For example, he says that gifts that are specifically tied to the use of services are different than a $15 item given to each person with no obligation to the first 100 people who stop by a booth at a health fair.

OIG says the bulletin is designed to provide "bright-line guidance" to protect federal health care programs and "level the playing field" among providers. The OIG points to four main principles. First, it says it has interpreted the prohibition to permit "inexpensive gifts" to Medicare or Medicaid beneficiaries if the retail value is no more than $10 individually and no more than $50 in the aggregate annually per patient.

Second, the OIG says providers may offer beneficiaries more expensive items or services that fit within one of the five statutory exceptions.

The OIG says that it also is considering several regulatory exceptions. Specifically, the agency reports that it may solicit public comments on additional exceptions for complimentary local transportation and for free goods in connection with participation in certain clinical studies.

Regarding the latter, the OIG reports that it may propose a new exception for free goods and services, possibly including waivers of copayments, in connection with certain clinical trials that are principally sponsored by the National Institutes of Health or another component of HHS. ■

Joint ventures present opportunities and pitfalls

A federal court in Texas recently ruled that a non-profit, tax-exempt hospital could have a joint venture with a for-profit organization without risking its tax-exempt status. While hospitals may see it as an advantage from the standpoint of conducting joint ventures with physicians, **Dan Mulholland** of Horty Springer in Pittsburgh warns that hospital-physician joint ventures carry other risks from a fraud and abuse standpoint, if not properly structured.

Joint ventures typically are agreements, exclusive or otherwise, between a hospital and physicians who traditionally treat patients in a hospital setting, often times providing services ancillary to the services that the attending physician provides such as radiologists, anesthesiologists, emergency room physicians and pathologists, he says.

Many of the same principles are applicable to specialties that have not traditionally been considered hospital-based arrangements, he adds. However, these doctors are more and more frequently looking to the hospitals for some kind of contractual relationship not only to establish the terms under which they are going to provide services but also provide them with some kind of financial support or assistance, Mulholland reports.

He says this includes cardiologists, neonatologists, and even cardiac surgeons. "The type of specialty that is involved is not as determinative of what kind of relationship would be entered into as the dynamics of the situation between the hospital and the hospital-based physician."

According to Mulholland, these contracts may or may not be established on an exclusive basis. However, he says hospitals can follow certain steps to determine if they require an exclusive arrangement with hospital-based physicians.

One problem that many hospitals are struggling with is a shortage of physicians in hospital-based specialties along with financial pressures that make it increasingly difficult to provide the level of services that hospitals require, he adds.

Mulholland says hospitals have employed a number of strategies with varying degrees of success to assist with direct or indirect financial input into the hospital-based group to assist in keeping quality physicians in sufficient numbers to meet the needs of the institution.

Hospitals have broad latitude when recruiting a doctor to relocate to a hospital-based service area, says **Henry Casale**, also of Horty Springer. He says the problem when negotiating with hospital-based physicians or physicians who are already located in the hospital service area is that while Stark and the anti-kickback statute offer broad latitude in recruiting individuals who are not currently located in your area, Stark has limited exceptions for physicians who already are on the hospital staff.

Casale notes that in 1992, the OIG issued a fraud alert warning that the hospital-based physician arrangements can give rise to violations of the anti-kickback statute. However, the fraud alert is limited. "The issue is that many of those same legal principles that apply to a hospital and a referring physician will also apply to a hospital-based physician."

The legal principles still apply, he adds. However, he says the ways in which those principles are interpreted are different because the factual relationship between a hospital-based physician and the hospital is very different than they are with a typical referring physician.

According to Casale, a useful discussion with a good legal basis for why a hospital can provide certain types of financial assistance to hospital-based physicians can be found in OIG Advisory Opinion 01-01, which looks at both the physician incentive rules and the anti-kickback statute. "It is very helpful and very telling in the analysis why hospitals can provide financial assistance to hospital-based physicians," he says.

The physicians involved in this arrangement were cardiovascular surgeons and recipients of referrals. "They did not refer patients to the hospital per se, but rather received referrals from cardiologists, internists, and other physicians on the staff," says Casale. The fact that they only worked at that hospital was important to the OIG because the OIG's concern was that if a hospital provides a program to physicians, it may cause a physician to relocate his practice from a different hospital in the same location and act as an inducement to refer.

In terms of the analysis, he says there are many similarities between the OIG's analysis in Advisory Opinion 01-01 and what hospitals are doing when faced with hospital-based physicians who require financial assistance. "You need to look at the specifics involved because some anesthesiologists that perform pain management might refer." ■