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CORF agreements: Is the revenue worth the risk?

What you need to know to avoid running afoul of federal anti-kickback and self-referral laws

If you're looking to generate a fresh revenue stream by leasing office space for a comprehensive outpatient rehabilitation facility (CORF), make sure you go into the arrangement with your eyes open and your backside covered, experts say. That's because some federal investigators and even Rep. Pete Stark (D-CA) have begun scrutinizing such agreements for possible violations of the anti-kickback statute and Stark self-referral laws.

CORF rental agreements have become more common largely in response to recent Congressional action that placed caps on physician reimbursement for physical therapy and other rehab services. "Federal laws are limiting rehab payments per provider to $1,500 per case," says **Craig Cuden**, JD, a health care attorney and CEO of Tomorrow Care Interactive, a Greenville, SC-based practice management company. Now, Cuden says, providers who used to get $2,000 to $3,000 per case are asking themselves, "Where else do I look for revenue sources, because my business has been literally cut in half?" For many, the only solution seems to be increasing the patient load to make up for the revenue shortfall.

But others are accepting offers from private companies proposing to rent space in the physician's office to set up a separate CORF. Under such an agreement, the CORF is the provider of

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How your practice can achieve Y2K compliance

You've probably heard the doom-and-gloom predictions about what the Y2K computer bug could do to your computerized billing system and even the biomedical equipment in your office. Now for some good news: If you're even minimally organized and put forth a reasonable effort, you can be Y2K compliant within 90 days, says Clearwater, FL-based health care technology consultant **Frank Cohen**, author of *The Y2K Compliance Manual for the Medical Practice.*

You don't have to be at the high end of the

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Privacy legislation suffers Congressional setback

Congress' optimism over the possibility of passing medical records privacy legislation before its self-imposed August 21 deadline may be waning as differences among the competing players become more entrenched. Indeed, a patchwork bill containing language from three competing medical records privacy bills has garnered little support from anyone on Capitol Hill.

Because of legislators' tepid response to the compromise bill, a mark-up scheduled for May 25 has been pushed back to June 9, at which time the competing stakeholders are expected to battle over additional changes. According to the Health Insurance Portability and Accountability Act of 1996, if Congress doesn't pass a bill by August 21, then the Department of Health and Human Services will be charged with coming up with regulations of its own by Feb. 21, 2000.

The compromise bill, S. 578, combines elements of bills sponsored by Senators James

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CORF agreements

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record and the physicians receive no direct per-patient payments. Even so, investigators remain wary of this type of rental agreement, arguing that by their very nature they imply a kickback-type relationship.

Indeed, in a public statement, Stark says, "Implicit in the deal is the message, 'Doctor, you can make a lot of money by renting spare office space to me, but I will have to keep busy — through referrals of your patients for rehab and physical therapy."

Stewart Kurlander, JD, a health care attorney with Latham and Watkins in Washington, DC, advises physicians to be wary of the motives of the companies that approach them.

"If they wanted to rent space and have no connection to the doctor, that would be one thing," Kurlander says. "But I don't think that's why they're doing it. They do it to have the connection to the doctor. And the doctor needs to make sure that his compensation is not connected to the volume or value of the referrals for [rehabilitation] services."

Robert Schwartz, MD, a physiatrist at Piedmont Physical Medicine and Rehabilitation in Greenville, SC, says it's always important to check out any company that approaches you for rental space because of the possible risks involved.

"Make sure you know somebody that knows them, and check with the local medical association to see if they know about them," Schwartz says. "You might not want to call up the FBI, but at least you can talk to someone who's familiar with the law and ask them to tell you what's going on."

If you're still thinking of engaging in this type of relationship with a CORF, make sure that any agreement you sign employs the following "legal instruments," Cuden recommends:

1. Whenever you lease space in your office, make sure you're receiving fair market value consistent with existing safe harbors under the anti-kickback statute, and with the exemptions contained in the Stark self-referral laws.

2. The same thing goes for renting out equipment. In both cases, the space and equipment are provided for a flat rate every month and aren't based on the volume or value of activity at the CORF. Negotiate that rate up front and include it in a contract that can't be altered for one calendar year.

3. While it's permissible to have one physician in the group serve as a medical director to oversee the activities of CORF patients, be very careful if you choose to go this route. "This is the one people have tended to abuse by just throwing dollars at a doctor holding a medical directorship," Cuden says. "And that's not permissible."

As with space and equipment rental, any medical directorship agreement must be established using fair market rates. And the medical director must provide appropriate and "true" services to earn the money being paid. Services might include utilization review, quality assurance, or undertaking monthly record review to make sure the proper clinical indicators are in place at the CORF.

4. The only area in which payment needn't be based on a flat rate per month is management services. The physician group can charge to provide a host of nonmedical services, such as scheduling patients and providing security and janitorial services for the location. In exchange for those services, the CORF pays fair market rates, usually on a "cost-plus" basis. "So the more [the practice] does, the more it can make," Cuden says. He stresses, however, that

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"cost-plus" isn't code for "per patient." The payment is tied to the needs of the CORF for the services provided.

"This is not simply a way to convert some of your patient load into payments by flowing patients to the CORF," Cuden says. "It's a true working relationship where you have to provide services and space and equipment. It's an additional burden on your staff, but it's also an additional revenue stream." ■

Privacy bill

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Jeffords (D-VT), Robert Bennett (R-UT), and Patrick Leahy (D-VT) and includes some original language of its own. Some of the sticking points over S. 578 (which retains the number of Sen. Jeffords' bill) include private right of action, preemption of state privacy laws, research, and law enforcement, says **Pat Smith**, director of government affairs at the Medical Group Management Association in Washington, DC.

With regard to preemption, S. 578 would only supersede state privacy laws enacted after the federal laws take effect. Any state laws currently on the books wouldn't be affected.

Also under the compromise bill, law enforcement officials can get protected health information through any of the following means:

- an administrative, judicial, or grand jury subpoena;
- an administrative summons;
- a civil investigative demand pursuant to federal or state law;
- a warrant issued on a showing of probable cause;
- a law requiring the reporting of information to law enforcement officials;
- a request authorized under federal or state law for the conduct of lawful intelligence activities;
- a request made in connection with providing protective services to the president.

While supporters of the Leahy bill argue that those provisions make it far too easy for law enforcement to gain access to medical records, Smith claims that the bill "would protect the confidentiality of medical information without impeding law enforcement's ability to effectively perform their job."

But Sen. Edward Kennedy (D-MA), co-sponsor of the Leahy bill, already is pushing for language that would tighten restrictions on law enforcement access to medical records. "The current draft still allows law enforcement to use tools that don't require judicial oversight, such as an administrative subpoena," says Kennedy aide **Jim Manley**. "And there are no limitations on the use of the information that is gathered." ■

States plot separate medical records privacy legislation

A draft model state law designed to protect the confidentiality of public health records has been released by a 39-member panel convened under the auspices of the Georgetown University Law Center in Washington, DC.

The model law includes separate sections addressing the acquisition, use, and disclosure of patient-specific information. It also suggests security measures public health entities should take to protect the confidentiality of data, as well as what protections patients have in ensuring that information is accurate and kept confidential.

The model law also describes civil sanctions that can be sought by patients who believe they have been injured by the failure of another party to maintain the security of health information. The law allows punitive damages for willful or grossly negligent violations of the act of up to $10,000 for each violation.

While at least two of the proposed Congressional privacy bills would override any type of state privacy law, **James Hodge**, professor of law at Georgetown and director of the public health privacy project, says he's optimistic that whatever passes will establish a floor from which states can enact stricter regulations.

Hodge adds that the draft Health and Human Services guidelines, which would take effect if Congress passes no privacy legislation by August 21, are consistent with the model state legislation.

The final version of the draft hasn't been released, pending the endorsement of the Centers for Disease Control and Prevention in Atlanta. So far, only Texas has yet introduced legislation based on the draft model. ■

Y2K compliance

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technology spectrum to be affected by the Y2K problem. "While grounded in technology, this is not so much a technical issue as a business issue," says Cohen. "The reality is that everyone will be affected in one way or another, and failure to be prepared is simply negligence on their part."

If you haven't started preparing yet, here are three good reasons why you'd better start soon:

- **Insurance won't help you.** "Most policies exclude avoidable situations, and no one will be able to convince the insurance company that this was a surprise," says Cohen.
- **You are liable and responsible for your patients and your business.** If you have equipment that malfunctions or fails, you run the risk of injuring your patients — and that means liability for you. Without a contingency plan in place, you could be considered negligent by a court of law.
- **Your revenues are at risk.** What if you don't have any revenue in the first three months of 2000?

"Do you really think that HCFA is so efficient that you are willing to risk not being paid in full should something happen to its payment systems?" Cohen asks. And what about commercial payers? Even if commercial systems are not badly affected by the millennium bug, some experts wonder whether this might give some payers another excuse for delaying payments.

Cohen recommends staying focused rather than getting overwhelmed thinking about Y2K. "Most practices can get their risk analysis and contingency plan completed within 90 days with little or no disruption to their daily operations," he says.

Cohen recommends taking the following basic steps to prepare for Y2K:

1. Document or flowchart all the processes in your practice, such as billing, payroll, patient care, etc. List each step you need to take to complete each process.
2. Determine the dependencies for each component. "Dependencies are those things upon which that process is dependent to function," explains Cohen. For example, in the billing process, dependencies may include the computer hardware, software, phone line, printer, etc. "When you have finished, pick the one dependency that, without it, the entire process would fail. This is your primary dependency," he says.
3. For each primary dependency, determine if the risk potential is limited, partial, long-term, or certain failure. Define what that would mean to your practice. This creates what Cohen calls the "risk paradigm."
4. Build a contingency plan that is realistic, affordable, and can be implemented if the need arises. Remember: You do not have to build a contingency plan for every possible problem. If you try to do that, you will never get it done, he notes.
5. Take a complete inventory of items that might be affected by the Y2K problem. Contact the vendors, manufacturers, distributors, and developers of those items to find out if the items are Y2K-ready and, if not, what to do to get them there.

Here are other actions Cohen says should be considered during your Y2K planning process:

— Secure a line of credit with a reputable financial institution equal to at least 90 days of basic operating expenses.

— Have enough cash on hand to cover 30 days' worth of payroll.

— Increase your inventory of patient care-related supplies to a 90-day level. ■

Collective bargaining update

On May 29, the Texas state senate gave final approval to a law that would allow physicians to negotiate collectively with managed care organizations. The bill arrived on Gov. George W. Bush's desk June 1, where it sits along with 1,000 other bills awaiting the governor's signature, according to a Bush spokesman. If Bush neither signs nor vetoes the bill, it will become law on June 20. Bush still has offered no opinion on the collective bargaining legislation, but supporters of the bill remain hopeful, despite a last-minute letter-writing campaign in opposition to the bill from the Austin-based Texas Association of Business and Chambers of Commerce, says **Ken Ortolon**, spokesman for the Texas Medical Association in Austin. ■