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OIG outlines antikickback landmines for mergers

An exclusive look at the OIG's latest take on physician practice divestiture, PHOs and MSOs

The Department of Health and Human Services' (HHS) Office of Inspector General (OIG) has yet to unleash its complete arsenal of civil remedies to enforce the antikickback statute, says **Mac Thornton**, chief counsel to the HHS Inspector General. But that day may come soon, he warns.

In particular, Thornton says, hospitals should carefully examine potential mergers and acquisitions for potential kickback violations before they enter any new deals.

Thornton outlined the key merger and acquisition arrangements that could trigger the antikickback tripwire. Here is an exclusive rundown in the OIG's own words:

♦ **Acquisition of physician practices.** For years, Thornton says he has been talking about the role "intangibles" can play in establishing the "fair market value" of physician practices in mergers and acquisitions with hospitals. "Of course, I was talking about acquisition of physician practices by hospitals," he added. The current trend of hospital divestiture of physician practices has turned that on its head.

Speaking at the Practicing Law Institute conference on mergers and acquisitions in New York, Thornton illustrated his office's current thinking with an actual case concerning two hospitals in the same locality. Hospital A decided to make an offer on Hospital B, which included a group prac-

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New Civil Monetary Penalty authorities for OIG

The Department of Health and Human Services (HHS) Office of Inspector General's (OIG) final rule on its revised civil monetary penalties (CMP) could have a significant impact on hospitals and other health care providers, according to health care attorney **Gabe Imparato** of the Fort Lauderdale-based firm Broad & Cassel. He says that while most of the changes are not unexpected, since they were mandated by the 1996 Health Insurance Portability and Accountability Act, providers should study the changes carefully.

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How to avoid fraud and abuse in hospital mergers

Health care attorney **Patricia Meador** says hospitals involved in or contemplating mergers and acquisitions should note several key fraud and abuse developments that have unfolded in recent months.

While there has been a renewed enthusiasm for the False Claims Act, Meador says the Department of Health and Human Services (HHS) Office of Inspector General (OIG) has yet to employ its array of administrative remedies to prosecute kickback violations under the civil monetary penalty law.

To head off legal trouble deriving from a merger or acquisition, Meador recommends paying particular attention to the following areas:

1. Due diligence. On the legal side, the most important consideration for hospitals approaching this area is heightened attention to adequate due diligence, says Meador, of the Durham, NC-based Womble, Carlyle Sandridge & Rice.

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Mergers and acquisitions

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tice. An evaluation firm estimated the hard assets at $4 million and the redirection of patients from Hospital B at $5 million.

Outside counsel for Hospital A directed the evaluation firm to perform a new evaluation not prescribing any value to the redirection of the flow of patients by the doctors at Hospital B. The report came back with the $4 million hard assets estimate, along with a list of payments for various intangibles such as the value of patient records and ongoing business, he says.

"Hospital A did acquire the group practice, but it was a little bit dumb about it," paying $12.5 million, Thornton reports. Thornton says this example illustrates the OIG's primary concern in this area. "You can't pay for the future value of the referrals from the doctor," he asserted. "And you can't disguise it by pumping up the value of intangibles."

Today, valuation experts may reduce their estimates of intangibles based on the current health care environment, according to Thornton. "It may be true that physician practices were not nearly as profitable as the hospitals thought," he says. "And it follows that the intangibles are not worth nearly as much as they thought."

While that makes sense, Thornton says the same principle holds, and if the doctors will be sending the hospital patients, the deal still has to be based on fair market value. "It is going to be hard to justify giving the practice back to the doctors for a nominal value," he argued. "There is going to have to be some documentation that that is what the fair market value is now."

♦ **Physician-hospital organizations.** According to Thornton, hospitals and doctors that get together to bill managed care can also run into trouble. If the ownership and payout from the physician hospital organization is based on a 50/50 formula but the hospital puts up 90% of the capital to form the organization, the arrangement may violate the antikickback statute, Thornton warns.

"We would construe that as a transfer of something of value to the doctors," he asserted. "If the doctor is sending patients to the hospital, there is a problem." Thornton says he has also seen deals structured where each side puts up 5% and the remaining 90% is financed with a loan backed by the hospital. "That is okay," he says, "as long as the terms of the loan are at full fair market value accounting for the degree of risk on what is being financed."

♦ **Management service organizations.** Hospitals and the management service organizations that acquire certain assets of a physician practice should also be scrutinized for potential violations of the statute, according to Thornton. "The payment must be at no more than fair market value," he asserted.

If the management service organization is also rendering services such as billing services to the physician practice, Thornton says the doctors have to pay the full fair market value of those services. "You can't give those services to the doctors and have the doctors send their patients to the hospital," he asserts. ■

Avoid merger trouble

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"When you look at what providers are continuing to pay out in settlement of false claims, it makes it increasingly important that you know what it is you are buying and what possible contingent liabilities are associated with that provider," she asserts.

2. E-health commerce. The second area to watch closely is the emerging area of e-health commerce. But Meador says it is not yet clear how the application of the fraud and abuse rules

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might restrict or limit the way e-health companies can conduct business as compared to their counterparts outside of health care.

For example, Meador says most e-commerce advertising that offers links from one site to another are based on a percentage of products sold. If health care providers are linking their site to the site of a health care provider that might be in a position to steer patients or make referrals, the fraud and abuse rules might limit whether they can pay on a percentage basis without violating the antikickback statute.

Meador says the first threshold is what they are delivering. "Are they providing health education or are they actually providing medical care in the form of physician or nursing consults?" she explains.

"What we are seeing is mostly enforcement at the state level," Meador reports. If the companies are delivering medical services, most state Attorneys General are suing for practicing medicine without a license, she says.

3. Hospital/physician relationships. Meador says the third major area for concern is hospital/physician relationships — specifically the rise and fall of gainsharing and the divestiture of physician practices.

One important area regarding these relationships stems from the final safe harbors for ambulatory surgery centers (ASC) that came out last year. That safe harbor changes the way physician ownership must be structured in order to comply with the antikickback statute. Meador says that had an impact on hospital/physician-owned ASCs as well as physician-owned ASCs.

Meador notes there used to be no requirement that the physician used the facility. There were also no "buy-out" provisions stipulating that if the physician retired or left the area that his or her interest must be bought out by the partnership.

Under the new rules, to fall under a safe harbor, in many instances you must demonstrate that your physician owners use that facility at least one-third of the time, says Meador. "You now have to rethink the fact that if a physician retires or moves, you may have to buy out their interest or reevaluate the selection of physician investors to those who actually are going to be users," she says.

Meador also warns that those new principles can't be applied to other physician-owned ventures such as cardiac cath labs, sleep labs or other joint ventures that hospitals and physicians enter into.

"What is not clear is the distinction between a physician-owned ASC and a physician-owned cardiac cath lab in terms of the potential abuse the might result," she explains. "It is not clear why the government is treating ASCs specially but not applying those same rules to other physician-owned therapeutic joint ventures."

4. Medicare reimbursement. The fourth major area for hospitals to watch is the massive changes taking place in Medicare reimbursement. For example, skilled nursing facilities are moving to a consolidated billing payment structure and that will dramatically impact the incentives that exist between ancillary providers and skilled nursing facilities.

"Nursing homes now have to look at their relationships with ancillary providers very differently," warns Meador. She says the government believes there is some "swapping" taking place, where ancillary providers are willing to provide services to the nursing home that are covered under the nursing home's resource utilization group (RUG) for less than fair market value in exchange for the referral of other business to the ancillary provider that can be billed to Medicare separately.

She also points to the OIG's report released in March that examined nursing home billing and concluded that in a large number of claims, nursing homes were violating the consolidated billing rules by billing for things outside the RUG payment. "There will likely be further audits to make sure nursing homes are following those rules," she predicts. ■

Civil Monetary Penalties

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For example, Imperato points out that the new CMP authorities apply to all federal health care programs, including Tricare, Veteran's Administration and public health service programs, not just Medicare and Medicaid. "That is a pretty significant change," says Imperato, a leading authority in this area.

In addition, the amounts of the penalties under the CMP law have been raised to the equivalent of the penalties under the False Claims Act,

which is up to $10,000 per false claim, false item or service, and triple damages.

Another significant change is that CMPs will now apply to companies and company officers who retain excluded individuals as employees. "You can now fine the entity," Imperato asserts. "That puts a burden on entities to make sure that they know who they are employing or who they are contracting with, because if they are on the excluded individuals list, they are exposing themselves to civil money penalties."

According to Imperato, the new CMPs also address offering inducements to beneficiaries, including "courtesy issues" such as waiver of co-insurance. "That is important because they actually talk about waivers that are exempt," notes Imperato.

For example, under certain conditions, specific waivers of deductibles and co-insurance would be deemed acceptable.

These include waivers of co-insurance and deductible amounts that are not routine and are not solicited or advertised but rather based on an individualized determination of financial need, he says.

They also include any incentives given to individuals to promote the delivery of preventive care, says Imperato. "That is no different than current law, but this is one of the first times that we have seen explicit types of waiver and co-insurance that they will accept," he adds.

According to Imperato, the other important change included in the regulations is the "state of mind" standard under the CMP law. "It used to be that the Secretary of HHS could impose a civil money penalty where responding parties either knew or should have known that they were violating the law, which is almost a negligence standard," he explains.

But HIPAA changed that standard to make it consistent with the standard in the False Claims Act, which requires deliberate disregard or deliberate ignorance of what the rules of the program are or knowing and willful conduct, says Imperato.

At least in theory, Imperato says that means the net effect of the proposed rule is to toughen the sanctions but also to create a higher standard of proof.

To see the entire regulation, go to www.dhhs.gov/progorg/oig/new.html. ■

New safe harbors excludes hospital-based facilities

The safe harbor proposed by the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) last week to allow independent dialysis facilities to pay the Medicare Part B and Medigap premiums of financially needy end-stage renal disease beneficiaries offers no relief to hospital-based dialysis facilities.

The proposed safe harbor wouldn't apply to any hospital-based dialysis center or independent center owned by hospitals, doctors or other provider that is paid on a fee-for-service basis. "I don't think many facilities will meet that criteria," says a source close to the process.

In addition, the premium payment must not be advertised, the facility must not routinely make payments for such policies, and it must make a good faith determination that the individual is financially needy.

The OIG has issued many kickback safe harbors but this marks the first proposed safe harbor to the OIG's CMP authorities.

There have also been three advisory opinions related to this issue (97-1, 97-2 and 98- 17). The proposed safe harbor was published in the *Federal Register* May 2. To see the safe harbor, go to www.dhhs.gov/progorg/oig/new.html. ■

HCFA hosts summit on third party billing companies

The Health Care Financing Administration will host a summit meeting later today with representatives from third party billing companies, the HHS Office of Inspector General and the General Accounting Office (GAO) to develop a consensus on how to regulate this emerging industry.

HCFA's Director of Program Integrity recently came under sharp attack by members of the House Commerce Committee's Subcommittee on Oversight for not implementing recommendations made by GAO last year.

The Healthcare Billing and Management Association weighed in that while it supports registration of billing companies, that measure is not likely to solve this complex problem by itself. ■