

MEDICAL/LEGAL NEWSLETTER



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SHARED FACILITIES: A VIABLE OPTION FOR PHYSICIAN PRACTICES UNDER THE STARK LAW

For clinical, competitive and economic reasons, including patient convenience, quicker access to diagnostic test results and the development of alternate revenue streams, many physicians seek to offer ancillary services to their patients. Offering a new service line may be an option for those physicians having access to capital and a patient base to support the new service line. But what about physicians whose financial situation or practice cannot independently support a new service?

A shared facility arrangement is one way for a physician practice to offer ancillary services to its patients. Participants in a shared facility arrangement can aggregate capital to purchase expensive equipment, spread risk and provide for full use of a new service line. As an example, shared arrangements to offer imaging services – including MRI, CT and nuclear camera services – among solo physicians, physician groups and hospitals are becoming more common.

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In essence, a shared facility arrangement will involve two or more parties sharing the costs, but not the profits or losses, of providing the service including equipment, clinical space and personnel. A shared facility arrangement can be structured in a variety of ways. Generally, one of the participants, or an entity owned by some or all of the participants, will acquire the equipment, lease the space and employ the personnel and then provide such facilities on a lease or time-share basis to the other participants. Each participant separately provides the service to its patients and bills for the service.

Assuming the arrangement works from a business perspective, any shared facility arrangement must

be crafted to comply with the Stark Law (if the service is a “designated health service”), the Federal anti-kickback law (if referring parties are participants in the arrangement), Medicare billing and other compliance requirements. A hospital’s participation will raise additional compliance considerations.

If the ancillary service is a designated health service under the Stark Law (a “DHS”) – which includes the professional and technical components of diagnostic imaging services – each physician participant can bill for services provided to its patients *only if* each can independently satisfy the Stark Law’s “in-office ancillary services exception.” Non-compliance with this Stark Law exception is a deal-killer.

To qualify for the in-office ancillary services exception, a physician participant must satisfy the Stark Law’s billing, supervision and location requirements.

Billing Requirement. Each practice must bill for the services provided to its own patients. If the service includes a technical component, each practice must independently satisfy Medicare’s billing requirements. A shared facility arrangement can be structured to accommodate this requirement.

Supervision Requirement. The services must be furnished personally by the referring physician or a member of his or her group practice or by individuals who are “directly supervised” by the referring physician or group practice member.” Direct supervision” for Stark purposes means that level of supervision required under the Medicare payment and coverage rules for the specific

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service – that is, general, direct or personal supervision. Note that independent contractor physicians in a group practice may supervise in-office ancillary services.

Location Requirement. The referring physician or the practice must have an office in the building in which the ancillary services are provided. A “building” is defined under the Stark Law as a structure with a single street address designated by the post office. For a service to be considered furnished in the “same building” as the practice, one of three tests must be met. All three tests require the referring physician or group practice to have offices in the building that are normally open to their patients a specified number of hours per week. Each test requires the provision of “some” physician services unrelated to the furnishing of the DHS. Physician services that lead to the ordering of a DHS fit within this category. For example, a physician examination will be considered a physician service even if it leads to the ordering of a clinical laboratory test or an x-ray.

To qualify as the “same building,” one of the following three tests must be satisfied:

Full-Time Practice Site With 35/30 Hour Test. The referring physician or his or her group has an office in the building normally open to patients at least 35 hours per week and the referring physician or group furnishes services at least 30 hours per week. Some of the services must be physician services unrelated to the furnishing of federal or private pay DHS (but may lead to the ordering of DHS).

Part-Time Office Site With 8/6 Hour Referring Physician Test. The referring physician or his group has an office in the building normally open to patients at least eight hours per week and the referring physician (**not the group**) furnishes services at least six hours per week. The referring physician also must regularly practice medicine and furnish physician services to his or her patients in that office at least six hours per week (including some physician services unrelated to the furnishing of DHS). Services provided by members of a referring physician’s group practice *will not* count toward the individual referring physician’s six-hour threshold. The building must be one in which the patient receiving the DHS usually sees the referring physician or other members of his or her group practice.

Part-Time Office Site With 8/6 Hour Referring Physician or Group Member Present For DHS Test. This test requires that the DHS being furnished must be in a building in which the referring physician or his or her group practice has an office normally open to their patients at least eight hours per week, and the referring phy-

sician or other group member regularly practices medicine and furnishes physician services to patients at least six hours per week in that office (including some physician services unrelated to the furnishing of DHS). In addition, either (i) the referring physician must be present and order the DHS in connection with a patient visit during the time the office is open or (ii) the referring physician or a member of his or her group practice must be present while the DHS is furnished.

There are a variety of other legal and business issues to be considered when evaluating a new service line, many of which are not unique to a shared facility arrangement. Will the payers pay for the service? What is the economic deal among the participants to the shared facility arrangement? Block lease versus per use lease? How, if at all, can a party get out of the arrangement? Are there any lease restrictions to providing the service? Is landlord consent required? If referring parties are involved, are the terms consistent with fair market value?

OIG’S OPEN LETTER REITERATES IMPORTANCE OF COMPLIANCE PROGRAMS

On April 24, the Office of Inspector General issued an open letter to providers announcing an initiative to promote the use of the OIG’s Provider Self-Disclosure Protocol (SDP) to resolve civil monetary penalty (CMP) liability under the Stark law and anti-kickback statute for improper financial arrangements between hospitals and physicians.

This new initiative supplements the SDP by providing guidance on how these types of disclosures will be resolved. The initiative incorporates the SDP process, whereby OIG confers with the Department of Justice to ensure that it is aware of each disclosure and has an opportunity to opine before OIG accepts a provider into the Protocol and is presented with the results of OIG’s review of the SDP matter before it is resolved under its CMP authorities.

The initiative is limited to matters that, in the provider’s reasonable assessment, involve conduct that subjects the provider to CMP liability under the Stark law and anti-kickback statute. An example would be a physician leasing an office from a hospital at a rate below fair market value.

The OIG noted that depending on the facts and circumstances of each case, the OIG will settle matters on the low end of financial penalties if the provider is cooperative and demonstrates a commitment to an ongoing compliance program.

WHEN IS BIG TOO BIG?

As insurers cut reimbursement rates for physicians, and medical practice operating costs continue to soar, more physicians are examining whether they should join with others through mergers and consolidations to address the challenges ahead.

Size can matter. A large medical practice may have more bargaining clout with third-party commercial payers. With a larger patient base it can justify the investment in higher margin ancillary services like CT, MRI and full-service laboratories. And there may be economies of scale in purchasing supplies and lower per person administrative services.

Of course, big groups can have big problems too. It is not uncommon for a medical practice to develop a style and culture of practice that may not meld well with another group without significant – and sometimes unacceptable – compromises from all participants. A larger

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group will also need a more corporate governing structure than a small group and this may reduce the cohesiveness and camaraderie that is necessary as the “glue” to keep the group together through good times and bad times.

If physicians want to consider banding together in larger groups, at what point can one become too big from a legal standpoint? Is there a limit to a lawful size?

To answer those questions, we must first look at two antitrust statutes – the Sherman Act and the Clayton Act.

Section 2 of the Sherman Act makes it illegal to “monopolize, or attempt to monopolize,” trade or commerce. As that law has been interpreted, it is not necessarily illegal for a company to have a monopoly or to try to achieve a monopoly position. The law is violated only if the company tries to maintain or acquire a monopoly position through unreasonable methods. For the courts, a key factor in determining what is unreasonable is whether the practice has a legitimate business justification.

Section 7 of the Clayton Act prohibits mergers and acquisitions where the effect “may be substantially to

lessen competition, or to tend to create a monopoly.” Determining whether a merger will have that effect requires a thorough economic evaluation or market study.

The Department of Justice (DOJ) and Federal Trade Commission (FTC) have the authority to prohibit mergers which will have the effect of lessening competition; however, to date they have not challenged any physician mergers. Part of the reason for this lack of enforcement is probably due to the fact that most physician practice mergers will not meet the thresholds of the Hart-Scott-Rodino Act and thus will not need to be cleared by the federal agencies before they can be consummated. The New York State Attorney General also has authority to enforce the antitrust laws.

In addition, if third parties – e.g., insurers, hospitals, or consumer groups – do not complain about the mergers the federal agencies will be unaware of them and may lack the resources to take any enforcement efforts. Nevertheless, the regulatory authorities might take action in the case of very large physician practice mergers, especially if there are complaints from payers or consumers.

The DOJ has responded to several requests for advisory opinions called “business review letters” from prospective physician merger participants. Most, but not all, of the proposed mergers have been approved. In 1987 the DOJ refused to approve the merger of two groups of general surgeons in Danbury, Connecticut.

In 1997, the DOJ reviewed the proposed merger of three groups of gastroenterologists in Allentown, Pennsylvania. There were four doctors in each group and the merged group would have comprised 12 of the 14 gastroenterologists with business addresses in Allentown. The payers in the area unanimously expressed concerns about the market power that the merged practice might be able to wield. In refusing to state that it would not challenge the merger, the DOJ noted that if the group used its market power to raise prices it was unlikely that the effect on consumers could be mitigated by other competing gastroenterologists entering the market since the area was already oversaturated with gastroenterologists.

So what practical rules can be derived from the lack of enforcement activity involving physician mergers? First, although there is no clear cut rule, most mergers that involve less than 50% of the physicians in a given specialty should be okay. But each case must be examined on its own particular facts and circumstances.

Probably the most important factor is whether the merger prompts complaints from payers, managed care plans, employers or consumers. If there is enough of an uproar, the antitrust regulators may decide to investigate

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and take action, especially if there is evidence that prices for physician services have gone up as a result of the merger.

In the case of a merger that would involve a high percentage of physicians in the relevant market (i.e., more than 50%), the parties should be prepared to demonstrate that the merger will result in efficiencies that cannot be obtained in the absence of the merger. The DOJ has stated that the greater the potential adverse competitive effect of a merger, the greater must be cognizable efficiencies in order for the DOJ to conclude that the merger will not have an anticompetitive effect in the relevant market. However, the DOJ Merger Guidelines also caution that "efficiencies almost never justify a merger to monopoly or near monopoly." An example of increased efficiencies might be the consolidation of office locations to reduce overhead or administrative expenses, or the elimination of duplicative staff positions.

A merger is less likely to be challenged if there are few barriers to entry from competitors. The theory here is that if the merger results in higher prices, it might trigger other competitors to enter the market and thus bring prices back down. As noted in the DOJ letter regarding the Allentown, PA gastroenterologists, however, if the market is already saturated in the particular specialty there may be little prospect of additional competition entering the market area.

Finally, if the primary motivating factor for the merger is to increase bargaining leverage with payers, the government is more likely to take an interest in the effect on the market. Physicians contemplating a merger are advised to be very discreet in the dissemination of public information about the reasons for the transaction.

CAN I BILL MEDICARE FOR SERVICES PROVIDED TO MY EX-SISTER-IN-LAW?

It depends. Among the categories of charges excluded from reimbursement under Medicare are charges by immediate relatives of the physician. The intent is to bar Medicare payment for services that would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge. Although you might choose not to provide free services to a sister-in-law, Medicare assumes that you would.

Who is considered an immediate relative? Husband and wife; natural or adoptive parent, child, and sibling; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild; and spouse of grandparent and grandchild. *But*, a brother-in-law or sister-in-law relationship does not exist between the physician and the spouse of his wife's or her husband's brother or sister. *And*, a father-in-law or mother-in-law relationship does not exist between a physician and his or her spouse's stepfather or stepmother. A step-relationship and an in-law relationship continues to exist even if the marriage upon which the relationship is based is terminated through divorce or through the death of one of the parties.

So what should you do with your ex-sister-in-law? Have your partner provide the service or provide the service for free and not bill Medicare.

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