



KSDB Health Law INSIGHTS

Kalogredis, Sansweet, Dearden and Burke, Ltd.

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Tips to physicians from recent OIG Compliance Guidance

By Michael R. Burke, Esquire

In January, 2005, the Office of Inspector General of the Department of Health and Human Services (“OIG”) issued Supplemental Compliance Program Guidance for Hospitals (“Guidance”). In this Guidance, the OIG provided guidelines that hospitals should consider when developing and implementing new compliance programs or evaluating their existing programs. In that regard, the OIG provided hospitals with “risk areas” to which they should pay particular attention. Many of these risk areas involve relationships between hospitals and physicians. This article will highlight some of the areas that the OIG noted as being of particular concern and that are relevant to physicians in their

relationships both with hospitals and with other health care providers.

The first risk area that was highlighted by the OIG was the Stark II Legislation. The OIG views Stark II as being a “threshold statute.” Stark II sets a minimum standard for arrangements between physicians and hospitals. Even when a Stark II exception exists for an arrangement, the OIG emphasizes that the federal Anti-Kickback Statute must also be analyzed and satisfied. The OIG notes that any financial arrange-

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Leif C. Beck, J.D., CHBC joins KSDB as Of Counsel

We are pleased to announce that LEIF C. BECK, J.D., CHBC has formally become Of Counsel to KSDB.

Leif has been associated with our affiliated healthcare consulting firm, PROFESSIONAL PRACTICE CONSULTING, INC., as a practice management consultant since January 1, 2004 and has over 30 years of experience as a lawyer and consultant advising healthcare professionals and their practices.

Leif is a great addition to KSDB’s healthcare legal team. ■



Front row: Leif, Bill Back row: Dave, Mike, Susan, Jeff

Tips to physicians*— continued from page 1*

ments (including ownership and compensation arrangements) between referring physicians and a hospital must satisfy Stark II to allow the referring physician to make referrals to the hospital. The OIG emphasizes that it is the actual relationship between the parties, and not merely the paper documents, that must satisfy an exception.

For purposes of both Stark II and the federal Anti-Kickback Statute, the OIG notes that the concept of fair market value compensation is critical. The OIG recommends that hospitals have appropriate processes for making and documenting reasonable, consistent and objective

determinations of fair market value and for ensuring that only needed items and services are furnished or rendered to the hospital.

The OIG notes several risk areas under the federal Anti-Kickback Statute, which prohibits payments made purpose-

fully to induce or reward the referral or generation of federal health care program business. In the Guidance, the OIG expressed its opinion that liability may arise under the False Claims Act where a violation of the Anti-Kickback Statute results in the submission of a claim for payment under a federal health care program. The

OIG also continues to take the position that if any one purpose of an arrangement is an illegal purpose (e.g., inducing federal health care program business), the Anti-Kickback Statute is violated.

The OIG recommends to hospitals that its financial arrangements with referring physicians should satisfy one of the safe harbors to the Anti-Kickback Statute, which serve as exceptions to the prohibitions contained therein. However, keep in mind that compliance with a safe harbor is not necessary, and arrangements that do not fit into a safe harbor must be evaluated on a case-by-case basis.

The OIG highlighted several risk areas under the Anti-Kickback Statute that have potential for abuse and should receive close scrutiny from hospitals. These specific risk areas are: joint ventures; compensation arrangements with physicians; relationships with other health care entities; recruitment arrangements; discounts; medical staff credentialing issues; and malpractice insurance subsidies.

The OIG appears to place special focus on joint ventures in its Guidance, which may indicate that increased scrutiny of joint ventures by the OIG is forthcoming. In addition, the OIG highlights the use of recruitment incentives by hospitals to referring physicians, stating that these arrangements present a high risk of fraud and abuse and have been the subject of recent government investigations and prosecutions.

In its Guidance, the OIG also addressed the issue of exclusive contract arrangements between hospitals and hospital-based phy-

sicians. The OIG notes that requiring a hospital-based physician or group to perform reasonable administrative or limited clinical duties that are directly related to the hospital-based professional services at no or a reduced charge would not necessarily violate the Anti-Kickback Statute, provided the overall arrangement is consistent with fair market value in an arm's-length transaction, taking into account the value received by the group as a result of the exclusivity. However, the OIG remains concerned with hospital-based physicians who perform administrative or clinical services at no or a reduced charge in exchange for the referral of business from a hospital, and indicates that nothing in its compliance guidance should be construed as requiring that no payments or minimal payments for these services be made.

With regard to medical staff credentialing, the OIG indicates that hospital policies which categorically refuse privileges to physicians with significant conflicts of interest would not appear to implicate the Anti-Kickback Statute in most instances. How-

Even when a Stark II exception exists for an arrangement, the OIG emphasizes that the federal Anti-Kickback Statute must also be analyzed and satisfied.

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ever, conditioning privileges on a particular number of referrals or requiring the performance of a particular number of procedures that are greater than necessary to ensure clinical proficiency potentially raises substantial risks under the Anti-Kickback Statute.

The Guidance also discusses the use of professional courtesy by hospitals. The OIG indicates that a key indication as to whether a professional courtesy program violates the Anti-Kickback Statute is whether the recipients of the courtesy are selected in a manner that takes into account, directly or indirectly, any recipient's ability to refer to, or otherwise generate business for, the hospital. Another key point is whether the recipients of the professional courtesy have solicited such courtesy in return for referrals. The OIG also notes that any professional courtesy arrangement should (where applicable) comply with the Stark II exception for professional courtesy, which (in part) requires that insurers be notified if the professional courtesy includes "insurance only" billing. The OIG notes that "insurance only" billing offered to a federal health care program beneficiary may violate the Anti-Kickback Statute, the False Claims Act and the Civil Monetary Penalty provisions prohibiting inducements to Medicare and Medicaid beneficiaries.

The foregoing provisions highlight the issues contained in the OIG's recent Guidance that are of relevance to physicians. If you have any questions with regard to these risk areas or your financial relationships with hospitals, please do not hesitate to contact us. ■

Mergers and acquisitions of healthcare practices

By *Vasilios J. Kalogredis, J.D., CHBC, CFP* and
Leif C. Beck, J.D., CHBC

Although mergers and acquisitions (M & A) sounds like a subject important only to large, publicly held businesses, a "deal" may be extremely useful to medical and dental practices of all kinds and sizes. A solo doctor moving towards retirement may sell his or her practice. A small group might seek to buy a practice either for general growth or to protect against new competition. Same-specialty practices often merge for cost-effectiveness and/or to deal better with third party payers. And our large healthcare clients sometimes merge and acquire to serve their well-laid business plans.

We have also seen doctors buying back practices they had previously sold to hospitals or physician practice management companies, as well as solos and small groups joining physician-owned networks.

Professional and personal value

Regardless of your type of practice, do not ignore M & A possibilities that may serve you well both professionally and personally. If you have a solid practice in your service area with enough "competition" (colleagues nearby in your specialty), recognize that a bright, young doctor coming into your locale could mean an erosion of your patient base, referral status or

even your hospital/operating room set-up. That's why it is sensible to seek out other doctors (or mini-groups) who might otherwise retire and sell out.

Take him, her or them on as short-term partners with an assured buy-out to ease their transition and to keep them from bringing in a potential strong new competitor.

If you are one of several small same-specialty practices that struggle with the complexity and costliness of new practice demands and limited reimbursement clout, consider joining together — or joining a doctor-owned network — for some economies of scale.

Any M & A possibilities raise a number of both practical and legal concerns. Foremost among the practical issues is to assure yourself that the personalities involved will mesh comfortably. Seemingly sensible combinations fail more often because of the doctors' personal chemistry — or lack thereof — than on financial or legal issues.

Price only one factor

In buying a practice, do not be scared off by what may first appear to be a high purchase price. Conversely, if considering sale of your practice, do not be afraid to suggest a high price. Of course, you want to negotiate the price as

Any M & A possibilities raise a number of both practical and legal concerns.

well as possible, but recognize that if a buyer finances the purchase price over a number of years, it may make it affordable. Many practice sales result in retaining up to 80% of the seller's patient revenue. Comparing the annual debt service cost to the incremental revenue may make the

deal more appealing than you might expect.

From a senior doctor's standpoint, a merger/sale to a neighboring practice provides opportunity for an excellent exit strategy.

You cannot, of course, ignore some important legal concerns. Large group transactions present potential Stark, anti-kickback,

Medicare reimbursement and anti-trust issues. We have experience in dealing with all of them.

Each one of the legal concerns would merit their own article. The important thing is to be sure they are recognized and appropriately addressed "upfront," with the assistance of competent advisers. ■

Antitrust laws may assist claim by defunct ambulatory surgical center against community hospital

By David R. Dearden, Esquire

A recent case from New York State shows that when certain market conditions exist and consumers are deprived of surgical options, the federal antitrust laws may provide relief. The case is entitled *Rome Ambulatory Surgical Center v. Rome Memorial Hospital, et al.* and can be located at www.nysd.uscourts.gov/courtweb/pdf/do2nync/04-08591.

Setting

The controversy centers on the right of an ambulatory surgical center ("ASC") to compete

with an established hospital and the right of a community hospital to protect itself from competition. Rome Memorial Hospital is the only full service hospital in the City of Rome (population 35,000) in central New York. In the late 1990s, a group of Rome physicians created a local ASC. The hospital took measures to protect itself from the siphoning off of profitable procedures to the ASC.

Facts

There were two competing groups of physicians. One group

was affiliated with the hospital (Group A) and the other group was not affiliated with the hospital (Group B). The evidence submitted to the trial court revealed that Group A refused to work on-call with Group B physicians. The hospital amended its By-Laws to deny privileges to physicians who referred patients elsewhere. The hospital also opposed a certificate of need ("CON") for the surgery center (even though the major payors in the area supported the ASC), and sent letters to physicians encouraging them to also oppose the CON.

In 2000, Group A referred a total of 1,731 ambulatory procedures to the hospital and only two to the ASC. The ASC eventually went out of business and it filed suit claiming that the hospital and certain local physicians caused the business to fail in violation of sections 1 and 2 of the Sherman Antitrust Act.

Antitrust claims

In the recent ruling, the District Court for the Southern Dis-

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We have extensive experience in speaking and writing on topics of interest to healthcare practitioners. Whether it be your local, state or national society; a group of residents/fellows; or a study group, we would be interested in talking to you about speaking and/or writing. You are encouraged to visit our Website at www.KSDBHealthlaw.com for more information on our areas of expertise and articles we have written and talks we have given. Please contact us if you would like to explore the possibilities.

trict of New York allowed the case to proceed to trial on three distinct claims.

Illegal exclusive contract

One of the defensive tactics employed by the hospital was to negotiate an exclusive contract for ambulatory surgical services with a key payor which had a substantial market share. The evidence that was submitted indicates that fifty percent (50%) of the revenue of the hospital comes from commercial payors and that Blue Cross/ Blue Shield supplied forty percent (40%) of this revenue stream. The exclusive contract in question was between the hospital and BC/BS.

The court found that the ASC's evidence that: 1) patients lost choices because of the closure of the surgery center and may have suffered by a reduced quality of care; and 2) payors now had to pay the hospital more for ambulatory surgical services, satisfied the "rule of reason" actual adverse impact test. The court also found that because the hospital was a large enough player in the small market for ambulatory surgical services it acted unreasonably. The court ruled that the hospital had the right to prove at trial that there were pro-competitive justifications for its conduct.

Attempt to monopolize

The court is also allowing an attempt to monopolize the outpatient market claim to proceed to trial. The court found that the ASC showed that the conduct of the hospital could satisfy the "predatory" conduct test. The evidence that was submitted suggested that the hospital may have

seventy percent (70%) of the relevant market power.

Conspiracy to monopolize

Finally, the court decided that the conspiracy claim to monopolize would also proceed to trial. The court found that there was evidence that the hospital and Group A conspired to monopolize the outpatient market for ambulatory surgical services. Some of the local physicians provided evidence that they knew that they would be retaliated against if they referred ambulatory surgical patients to the ASC and they felt compelled to send such work to the hospital. From this and the overall circumstances the court found that there was an inference that a conspiracy existed to restrict referrals to the ASC which was a significant factor in causing the ASC to go out of business.

Conclusion

At trial, Rome Memorial Hospital will be relying on the argument that it depends upon profitable procedures to subsidize the

wide range of services that it provides to the community. It will argue that it had every right to protect itself from physicians who "cherry pick" the profitable procedures and send them to an ASC for their own enrichment,

The court found that there was evidence that the hospital and Group A conspired to monopolize the outpatient market for ambulatory surgical services.

physicians went too far in their attempts to protect the hospital and engaged in predatory conduct that not only forced the ASC out of business but deprived patients of choice, better prices and quality of care. ■

Retirement plan update

By Jeffrey B. Sansweet, Esquire

There is good news once again for physicians in the retirement plan area. Cost-of-living adjustments have increased the maximum allowable pension and/or profit sharing plan annual contribution from \$41,000 to \$42,000 for plan years beginning in 2005. The annual compensation limit has also increased from \$205,000 to \$210,000 effective with plan years beginning in 2005. For many physician groups, these changes will mean that the practice can contribute an additional \$1,000 in 2005 for the physicians without any increase in the contributions for the staff.

For those of you with 401(k) plans, the annual elective deferral limit for 2005 is \$14,000, and if you are at least age 50 by the end of the plan year, an additional "catch-up" 401(k) contribution is allowed up to \$4,000 in 2005. ■

Dealing with activities ancillary to your practice

By Leif C. Beck, J.D., CHBC

Many of our clients conduct income-producing activities closely related to their practices. Examples include x-ray or lab activities in orthopedic, dental and internal medicine practices; an optical shop in ophthalmology groups; nuclear diagnostic functions in cardiology groups; physical therapy practice within orthopedic, cardiology and even a few rheumatology groups; and ambulatory surgical centers (ASCs) for eye, ENT, plastic and general (among other) surgeons and for GI and some other internal medicine subspecialists.

Indeed, providing ancillary services is one of the best ways to maintain or increase income in these days of flat or declining reimbursement and rising costs. We encourage clients to take this proactive approach for it offers opportunities to provide income beyond just what their own time and direct talents can produce.

Some groups also lease their office space and/or equipment from entities wholly or partially owned by the practice's doctors.

Separate entities

While most of these activities can be conducted within a practice's single entity, it sometimes makes sense to spin them out and conduct them as separate entities. The ancillary may present its own liability risks which are better in-

sulated in a separate corporation. Accounting for an ancillary venture may be enhanced and simplified by placing it in its own entity. There may be tax and financing advantages to keeping things separate.

ASCs are often co-owned by several practices (or members of those several practices). In these cases a separate entity is obviously called for.

This article will focus on other legal and practical considerations assuming that the Stark and anti-kickback laws have been satisfied as to a particular venture.

Full and equal ownership

Of primary importance, we urge making sure that a partner in the practice will also have the op-

portunity to be a full and equal partner in any entity ancillary to the practice. We see too many inter-partner problems and doctor-level turnover

when a qualified physician or dentist is excluded from what is — but for the entity separation — truly related to the practice itself. In almost every case, the bottom line is that keeping the right partners in the practice is more important than keeping one's practice partners out of an ancillary entity. We have seen groups split up and/or experience unpleasant and unnecessary fights because the senior doctors were determined to be the sole owners of the practice-related real estate. The non-own-

ers would often believe the rent was too high, while the realty owners thought it was too low. The parties often argue as to which entity should pay the expenses (e.g. major repairs). Those who own the realty may be in a conflict position and refuse to move the office to the practice's detriment.

This does not, of course, mean that you should give an incoming partner equal ownership of an ancillary for less than it is worth. Some ancillaries produce more income and/or have far greater asset value than the basic practice itself, and it is only fair that someone coming into its co-ownership should pay for its fair value.

Even if buying into an ancillary is expensive, arrange it so the incoming partner can handle it. Or the group might help him/her arrange a bank loan on terms that will fit in with the ancillary's projected finances. Occasionally where the entry price is very high — but fair — the group might permit the new member to delay buying into it for the first few practice years s/he is a practice co-owner, deferring the buy-in until it is affordable.

Paying out

On the other end of the time line, be sure that your ancillary entity documents require buying out a member who leaves his/her practice group — whether by retirement, death, disability, resignation or otherwise. While it might be nice for a senior member to retire and continue receiving income from, say, the real es-

Indeed, providing ancillary services is one of the best ways to maintain or increase income.

tate, the then-outside ownership can cause untold difficulties in succeeding years.

As both an attorney and a consultant, I am struck by the number of new client situations where — although the group’s own documents are well thought out — the ancillary activities’ arrangements are either ignored or casually constructed. While most of the work in crafting group arrangements often deals with the main set of documents, the ancillaries are equally of concern.

Once again, the price for buying out a departing member ought to be fairly determinable in the documents. Unless there is something unusual, it should be on the same formula as for a new member buying in.

Pricing the ancillary

What then should that price be? More properly, what formula should determine the price both

for a member coming into and for one leaving the practice? Different kinds of ancillaries will, of course, deserve different pricing formulas, and there can be far greater differences of view as to ancillaries’ values than as to the value of a practice itself. Our firm has advised on many ancillary activity valuations, including independent reports and even expert witness testimony. For ancillaries that have substantial equipment and only moderate separate income streams — such as in-office lab or x-ray ventures — it may be sufficient to value them on the basis of their equipment values. Major equipment like x-ray, nuclear and audiology often are best valued by appraisal(s) from qualified equipment vendors — you might make their report(s) on “fair market value” binding on the buy-out price.

Other activities like physical therapy and optical shop are of-

ten valued based on their profitability. And this goes in spades for ASCs which sometimes have values in the millions of dollars. Here, the more common business valuation principles of capitalizing earnings will often apply. As an example, we recently encountered a surgery center’s valuation issue and concluded that “five times ebitda” would be fair for a partner’s buy-out. The term “ebitda” means earnings before interest, taxes, depreciation and amortization — essentially equating to the cash flow produced by the business venture. While the resulting price was quite large, so was the capacity to pay it out since the projected cash flow would permit it.

The important point is to be sure to get all practice partners fully on board so they’re all on the ongoing “team.” ■

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