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GOVERNMENT

From bedside to business

A host of new regulations are keeping doctors busy outside the exam room

BY CLAY J. COUNTRYMAN

From the regulation of specialty hospitals to tighter scrutiny of physician network arrangements and boards of directors, recent trends in health care regulation are forcing local health care providers to pay almost as much attention to their business practices and relationships as they do to patient care.

Physician ownership of specialty hospitals has been one of the hot topics of discussion in both the Louisiana state capital and Washington, D.C. Specialty hospitals are health care facilities that only provide certain types of health care services such as orthopedic, cardiac and surgical services. Several local physicians are part of the ownership groups of specialty hospitals that recently opened in Baton Rouge.

Although the Louisiana Legislature did not enact any new laws that affect physician ownership of specialty hospitals, Congress and the Centers for Medicare and Medicaid Services continue to debate legislation and regulatory reform that could adversely affect the ability of physicians to refer their patients to a specialty hospital in which the physician has an ownership interest.

U.S. Sen. John Breaux sponsored an amendment to the Medicare reform legislation being debated by Congress that would effectively prohibit physicians from referring Medicare and Medicaid patients to a specialty hospital in which the physician has an ownership interest.

Another trend affecting local health care providers is the scrutiny by federal agencies of physician networks that are used to negotiate agreements with HMOs and insurance companies. Health care providers such as physicians may form a network of similar providers for the sole purpose of jointly contracting with an insurance company.

Recently, several Baton Rouge physician practices entered in a consent decree with the Federal Trade Commission for alleged violations of federal anti-trust law in the operation of their physician network. The FTC alleged that the separately owned orthopedic physician practices utilized their network to jointly demand higher reimbursement for their services from United Healthcare and other insurance companies.

The consent decree, effective for 20 years, prohibits in part these physician practices from collectively negotiating reimbursement agreements with insurance companies.

National trends

The investigation of Health South Corp. and the aggressive enforcement of the corporate oversight law known as Sarbanes-Oxley have caused many local providers to review the roles and responsibilities of their boards of directors.

In the '90s, health care fraud associated with providing health care services was the preferred choice of many federal and state prosecutors. Today, one of the hot trends in health care prosecutions seems to be the fulfillment of responsibilities of corporate officers and directors of health care providers.

Another trend is the scrutiny of business joint ventures between health care providers. The Office of Inspector General released a special advisory bulletin last spring that described joint ventures between health care providers that potentially violated the federal anti-kickback law.

For example, health care providers may enter into a joint venture to provide durable medical equipment such as wheel chairs, nebulizers and other equipment to patients. The OIG asserts that the distribution of profit to one party in these arrangements may effectively be a kickback for making their patients available to the other provider.

Health care providers also should pay attention to the recent criminal indictment against a hospital facility operated by Tenet Healthcare Corp. in San Diego. This indictment is based in part on physician relocation agreements used by Tenet to recruit new physicians.

Local hospitals, physicians and physician groups regularly enter into physician relocation agreements. The OIG commonly takes the position that certain perks in these agreements may violate federal fraud and abuse laws.

Several recent settlement agreements by the OIG have focused on the fair market value of leases, service agreements and other arrangements between health care providers. The focus of these settlements has been on whether one party has paid the other in excess of fair market value for a lease of space or medical services as an inducement for one party to refer patients to the other party.

Health care providers should ensure that they can establish that amounts paid for leases and services with patient referral sources are based on a fair market value for such lease or services.

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