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In This Issue

- **OIG Approves Hospital Arrangement to Share Cost Savings with Physicians**
- **Price Fixing Allegations Against Pennsylvania Hospital and Large Insurer**
- **New York's Attorney General Cracks Down on Healthcare Fraud**

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OIG Approves Hospital Arrangement to Share Cost Savings with Physicians

In a June 30, 2009, Advisory Opinion, the Office of Inspector General ("OIG") stated that it would not impose civil monetary penalties under the Social Security Act or the anti-kickback statute, for a hospital arrangement to share costs savings with 3 physician groups. The OIG noted that, unlike typical gainsharing programs that pay physicians a percentage of generalized cost savings not tied to specific, identifiable cost-lowering activities, the arrangement was transparent, set out the specific actions to be taken and tied the remuneration to the actual, verifiable cost savings attributable to those actions.

Under the arrangement, the hospital agreed to share with a cardiology group, a vascular surgical group, and an interventional radiology group (the "Groups") a percentage of the hospital's cost savings arising from standardization of certain cardiac catheterization devices and supplies. The devices and supplies were chosen after a clinical review that took into consideration (i) whether the products were clinically safe and effective; (ii) whether the proposed standardization measures were appropriate on the basis of clinical criteria, and (iii) the cost of the supplies and devices.

The arrangement included a number of safeguards. First, physicians made the ultimate determination regarding devices and supplies on a patient by patient basis and they were not restricted to the list of approved devices and supplies. Second, the hospital monitored quality of care and would not allocate any cost-sharing amounts to the Groups if the cardiac catheterization procedures performed by the Groups involved reductions in quality.

Third, each Group was paid separately by the hospital for 50% of the savings achieved relevant year by that particular Group when implementing the cost savings recommendations. Savings were

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calculated separately for each Group and the payments constitute the entire compensation to that Group under the services contract. Each Group would then distribute its profits pro rata to its members. Cost savings for procedures were not shared to the extent such procedures exceeded the number of like procedures performed in the base year. Moreover a physician could be terminated from the arrangement if the physician altered her referral patterns under the arrangement in a manner benefiting the hospital.

The OIG first addressed the concern that the arrangement served as an inducement to reduce or limit items services to Medicare and Medicaid patients. It listed 8 factors that lessened its concerns, including the fact that the arrangement was limited in duration (1 year) and compensation (50% of savings). It further noted that savings were capped by reference to a base line year beyond which no savings would accrue. The OIG then considered the implication of the anti-kickback statute and noted that the arrangement included safeguards to protect against unlawful referrals and to limit rewards for those who make referrals. In addition the arrangement was specific as to the actions that would generate the cost savings upon which payment was based.

While recent OIG opinions have been increasingly permissive of arrangements to share cost savings, caution must still be taken to structure such plans properly. The OIG itself warned that "payments of 50% of cost savings in other arrangements, including multi-year arrangements or arrangements with generalized cost-savings formulae, could well lead to a different result."

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Price Fixing Allegations Against Pennsylvania Hospital and Large Insurer

A lawsuit was filed in April in a Pennsylvania federal court alleging that Pennsylvania's largest health system, University of Pittsburgh Medical System ("UPMC") and one of Pittsburgh's biggest insurers, Highmark, Inc. ("Highmark") violated antitrust laws by conspiring with each other to reduce competition and to raise prices.

The complaint, filed by UPMC's competitor, West Penn Allegheny Health System ("West Penn"), alleges that UPMC agreed not to contract with Highmark's competitors and to refrain from selling its health insurance affiliate to any other insurers, which has allegedly

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limited participation by other insurers in the market. West Penn claims that in exchange for UPMC's agreements, Highmark agreed to stop selling its low-cost managed care plan and to pay inflated reimbursement rates to UPMC, while lowering rates for all other providers in the area.

West Penn further alleges that the tactics were especially aimed at destroying West Penn business by "raiding physicians" through excessive compensation and high priced real estate deals among other things. West Penn is seeking an order directing Highmark to contract with West Penn on fair and equitable terms, and that the court enjoin UPMC and Highmark from further "predatory and anticompetitive" conduct. They are also seeking treble damages as well as punitive damages.

For their part, UPMC and Highmark have called the lawsuit frivolous and denied the allegations in the complaint. UPMC filed a motion to dismiss the lawsuit on June 11th.

Providers and insurers should be cognizant of antitrust concerns when negotiating payor agreements. While terms may be lawfully, parties may still be called on to defend themselves in lawsuits filed by competitors, particularly the more creative such agreements become.

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New York's Attorney General Cracks Down on Healthcare Fraud

In a 147 – count indictment, New York's Attorney General, Andrew Cuomo, charged a group of health care providers, including doctors and other healthcare providers, with defrauding insurers.

The indictment alleges that a personal-injury attorney was paid by the owner of two medical clinics to bribe hospital workers into providing the names of patients who had recently been involved in motor vehicle accidents. Those patients were eligible for a variety of healthcare services that were covered by auto insurance, including chiropractic and acupuncture treatments. The attorney allegedly provided the patients' names to the clinic owner who would solicit unnecessary medical treatment. Many of the patients had only minor injuries.

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The two clinics allegedly involved in the scheme had accepted patients who were “steered” in by two clinic employees. The employees would direct the patients to exaggerate or fabricate injuries, so that they could receive more treatment. The employees told the patients that the higher their medical bills were the more money they would make in a bodily-injury lawsuit settlement.

Attorney General Cuomo indicated that millions of dollars were fraudulently taken from insurance companies by the clinic owner and his employees, which included a number of doctors including chiropractors, a neurologist, and an acupuncturist. Fourteen people were charged in the indictment. The New York’s Attorney General’s office is still investigating to determine how many patients were treated at the clinics for unnecessary care under the scheme.

This is a prime example of how states, and not just the federal government, are cracking down on healthcare fraud. Healthcare providers should have policies in place that prohibit employees from engaging in fraudulent activities, and have sufficient compliance monitors to ensure that the organization is not taking a blind eye to such behaviors.

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