Health Law

Final Examination

Spring Semester 1995

Professor Andre' Hampton

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Instructions

1. This examination consists of five (5) pages, including this page as the first, and four (4) problems.

2. You will have two (2) hours in which to complete the examination.

3. St. Mary's Law School prohibits the disclosure of information that might aid a professor in identifying the author of an examination. Any attempt by a student to identify himself or herself in an examination is a violation of this policy and of the Code of Student Conduct.

4. A student should not remove a copy of the examination from the room during the exam time.

5. You may use either the textbook, any handouts provided by the professor during the semester and any notes or outlines prepared in connection with the course in your completion of this examination.

6. At the end of the examination, you must surrender this copy of the examination and the Blue Book in which you have answered the questions.

7. After reading the oath, place your exam number in the space below. If you are prevented by the oath from placing your exam number in the space below, notify the student proctor of your reason when you turn in the examination.

I HAVE NEITHER GIVEN NOR RECEIVED UNAUTHORIZED AID IN TAKING THIS EXAMINATION, NOR HAVE I SEEN ANYONE ELSE DO SO.

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EXAM NUMBER

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QUESTION # 1. (20 points)

Your friend from law school is working at the district attorneys office. He is seeking your health law expertise. The grand jury has issued an indictment against a local physician and General Motors, the owner of the clinical lab where the physician performed his services. The indictment charges General Motors and the physician, who is a pathologist, with criminally negligent homicide. Under the state law a person commits a state law jail felony if he causes the death of an individual by criminal negligence. Pursuant to the law:

> A person acts with criminal negligence, with respect to the circumstances surrounding his conduct or the result of his conduct, when he ought to be aware of a substantial and unjustifiable risk that the circumstances exist or the result will occur. The risk must be of such a nature and degree that the failure to perceive it constitutes a gross deviation from the standard of care that an ordinary person would exercise under all the circumstances as viewed from the actor's standpoint.

According to your friend:

(1) the pathologist misread Pap smears of two women who later died of cervical cancer;

(2) the pathologist was reading and supervising a technician's reading of an average of 125 Pap smears a day;

(3) a medical expert testified before the grand jury that: (a) if the Pap smears had been read correctly, the women could have been effectively treated and would not have died from cervical cancer and (b) it is not a commonly accepted medical practice for a pathologist to read or supervise the reading of 125 Pap smears a day; and

(4) The previous pathologist testified to the grand jury that, when she warned General Motors about the need to commit additional personnel to the task of reading Pap smears, General Motors' response was to terminate her contract.

Your friend informs you that General Motors operates the clinical laboratory as part of its effort to reduce expenditures for health care services for its employees and their dependents. When General Motors' employees need lab tests performed, the test are conducted in the General Motors' clinical laboratory in San Antonio. The two women who died as a result of the misread Pap smears were General Motor's employees.

Given your expertise in health law, what obstacles, if any, do you perceive that the district attorney will face in pursuing the case against General Motors and the physician?

QUESTION # 2. (20 points)

A group of five plastic surgeons have approached you concerning a dispute they are having with an independent practice association ("IPA") in which they are participating. They are concerned about the fee schedule that the IPA has established for reconstructive plastic surgery. In their view, the fee schedule -- which adopts the Medicare RBRVS -- will reduce their reimbursement for services that they provide through the IPA to a level which is below the actual cost for providing the services.

The plastic surgeons want to hire you to negotiate with the IPA on their behalf in order to induce the IPA to increase the reimbursement for reconstructive plastic surgery. They are willing to allow you to hire a reimbursement consultant who will conduct a study of the plastic surgeons existing fee schedules and develop a reasonable alternative to the IPA fee schedule. The consultant would also prepare a report which details how the Medicare RBRVS fails to adequately compensate plastic surgeons. The plastic surgeons basically want you to represent them because they have heard that your are an effective negotiator.

The physician members of the IPA elect the board of directors of the IPA. The board, with the assistance of a outside reimbursement consultant, establishes the fee schedule for the IPA. The plastic surgeons believe that the reason the IPA's fee schedule fails to adequately compensate plastic surgeons is because the IPA's board is dominated by general practitioners who don't understand or refuse to acknowledge the special circumstances of plastic surgeons. They inform you that the IPA's reimbursement consultant proposed a fee schedule that was more generous for reconstructive plastic surgery. The board, however, rejected this recommendation because it would make the IPA less competitive with other groups in San Antonio.

The plastic surgeons indicate that the IPA was formed in 1987. It has 200 members and includes all types of medical specialties in San Antonio as well as general practitioners. There are 16 plastic surgeons in the IPA and 40 plastic surgeons in the city. The IPA does not have a capitation agreement with any payor.

The IPA uses the fee schedule in connection with its negotiation of managed care agreements with local HMOs and PPOs. Each physician is free to accept or reject a proposal with any particular HMO or PPO and to negotiate a separate deal with such HMO or PPO.

The plastic surgeons are also concerned about the fact that their fees have been subject to a 10% withhold. The withhold language provides:

> The IPA shall withhold ten percent (10%) of each IPA physician's fees from services rendered pursuant to the IPA's agreements with HMOs and PPOs and other payors. The IPA will disburse the withheld fees within ninety (90) days following the end of any calendar year, provided that the IPA meets cost containment goals established by the IPA's board of directors. Such cost containment goals shall address items such as: (a) average costs per IPA patient; (b) inpatient hospital days per 1000 IPA patients; (c) reduction in drug costs through the use and prescription of generic drugs and (d) other cost containment goals identified by the IPA's board of directors. The goal for the IPA's costs to be below local averages.

The plastic surgeons are complaining that they have never received any of the withheld fees back from the IPA. They want you to negotiate with the IPA for removal of the withhold provision.

How do you advise the physicians with respect to these two requests?

QUESTION # 3. (20 points)

Your client is an osteopathic surgeon who specializes in hand injuries. She has a great reputation and receives many cases where the patients will need an extended regimen of physical therapy in order to recover. She believes that physical therapy business makes a logical extension for her practice, but at this time she is unwilling to take on the expense of hiring another full time employee.

She desires to enter into an arrangement with a physical therapist. Your client will lease the physical therapist some space in her office and related equipment. Your client's clerical staff will also provide administrative services for the physical therapist's practice, including reception, filing, scheduling appointments and billing and collection. Your client will charge the physical therapist a monthly fee of $2000.00 for such office space and equipment and personnel services. In addition, the physical therapist is obligated to pay your client 15% of any amount of fees that the physical therapist's practice generates in excess of $2000.00 per month.

Do you perceive any problems with this arrangement? If so, how would you restructure the arrangement to comply with the law and still achieve your client's objectives?

QUESTION # 4. (40 points)

A non-profit 501(c)(3) hospital wants to organize a for profit physician hospital organization ("PHO"). The PHO will be an entity that is jointly owned by the hospital and members of the hospital's medical staff who choose to join the PHO (the "Participating Physicians"). The PHO's objective is to better position the hospital and Participating Physicians to compete for contracts with managed care entities (HMOs and PPOs) and direct contracts with self-insured employers.

A board of directors consisting of two classes of directors will govern the PHO. The Participating Physicians will elect one class of directors and the hospital will appoint the members of the second class of directors. The PHO's actions shall require a vote by a majority of the members of each class of directors. The PHO will be involved in: (1) contract negotiations; (2) credentialling and peer review of Participating Physicians and (3) utilization review.

The PHO's estimated operating budget for the first year of operation is $250,000.00. The hospital will contribute approximately 50% percent of the budget and the physicians will contribute the other 50%. The PHO will negotiate contracts with managed care organizations and provide billing and collection services for the Participating Physicians. In exchange for such services the Participating Physicians will pay the PHO fees based on the fair market value for such services.

In connection with the direct agreements with self-insured employers to provide hospital and medical services for the employees of such employers, the PHO will accept capitation payments from the employers. Pursuant to these direct capitation agreements, the PHO will be responsible for reimbursing the Participating Physicians and any outside providers.

The Participating Physicians are required to execute a provider agreement. Pursuant to the provider agreement the Participating Physicians agree to the following:

(1) that any payor (HMO, PPO or self-insured employer) may terminate the Participating Physician's participation in any PHO arrangement with such payor with or without cause upon thirty (30) days notice;

(2) the PHO may provide the payors with any credentialling information requested about the Participating Physician, including notification if the Participating Physician has any disciplinary actions taken against the Participating Physician at the hospital; and

(3) to waive any claims against the PHO or any payor arising from any decision to terminate the Participating Physician from participating any particular agreement between the PHO and the payor.

Assume that ERISA does not preempt any state law requirements concerning this arrangement and that there are no problems involving: (1) prohibitions on physician self referrals (Stark II); (2) anti-kick back (Medicare Fraud & Abuse and state law illegal remuneration statutes); or (3) anti-trust prohibitions. What legal concerns does the hospital need to address? What legal concerns do the Participating Physicians need to address?

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Answer Key

Question #1. One issue is whether ERISA preempts the state law relating to criminal negligence. The laboratory testing is part of a benefits package offered to employees by General Motors as a self funded plan. Therefore ERISA preempts all state laws that "relate to" this employee benefit plan. This preemption applies to state law tort claims that the ERISA beneficiaries might bring against the employer. However, in this case, we a re dealing with a criminal law. It would not be the ERISA plan beneficiary who would be bringing the claim, but a third party. The preemption may not apply to such third party claims . For example, the claims by a provider who wanted to collect the fees owed were not barred by ERISA and therefore the state's criminal negligence claim will probably also not be preempted.

Another problem with this case would be the difficulty of establishing the elements of the case. The statute requires a gross deviation from the standard of care. The problem is that medical practice patterns are established through a decentralized process. Two experts may easily disagree over how reasonable it is to read 125 Pap smears a day. The existence of a respectable minority position could shield the physician from liability.

Question #2. The physicians' request implicates the antitrust laws. They are requesting that you provide them with joint representation vis-a-vis the IPA. This is likely to constitute price fixing unless some type of exemption exists. Their ability to jointly negotiate with the IPA depends on whether the IPA itself is in compliance with the antitrust laws. The whole concept of the IPA's setting fees for constituent members is fraught with antitrust liability unless the IPA is within a safe harbor.

This is a nonexclusive arrangement because each physician is free to accept or reject a particular payor arrangement. Therefore the threshold for the antitrust analysis is that the IPA may not have more than 30% of the physicians or a particular speciality in its geographic region. We do not know the status with respect to other specialties, however, the IPA appears to have 40% of the plastic surgeons in San Antonio, therefore it is not within the safe harbor. Because it is not within the safe harbor, unless it has had its arrangement reviewed by the Justice Department the IPA runs the risk of being in violation of the antitrust laws.

The IPA's questionable antitrust status is both beneficial and detrimental to your ability to negotiate with the IPA on behalf of the physicians. It is beneficial because it provides you with arguments that relate to the IPA ignoring the input from the consultant who recommended the fee schedule that the IPA rejected. This represented a modification of the messenger model in that the IPA's board of directors rejected the consultant's suggestion rather than passing that suggestion along to the physicians to make an independent determination.

However, because the IPA's status is uncertain, this also means that your proposed clients need to

be careful that their joint dealing with the IPA does not violate the antitrust laws. In fact there participation in the IPA itself is cause for concern until its operations are modified to fit within a safe harbor or its has received Justice Department approval.

You are probably going to want to find some way to have the IPA establish a better position with respect to its antitrust status. This means that you will probably not want to have the IPA abolish the withhold arrangement. This is because, in addition to the percentage requirements , the members of the IPA also need to share substantial financial risk. Members may share such risk through capitation arrangements or through having a withhold. Because the IPA does not have any capitation arrangements, the withhold is the only manner by which the members of the IPA share substantial financial risk.

Just because you cannot argue for elimination of the withhold however, does not mean that you can't request the IPA to provide the physicians with a more objective basis by which to evaluate the withhold. The board's determination of its cost containment goals should be related to actuarial data. The board should be required to provide the physicians with access to such data in order for the physicians to be able to have the data evaluated by an independent expert. The cost containment goals should be attainable and not arbitrary and capricious.

On the other hand, you probably should advise the physicians that this withhold arrangement should be disclosed to their patients because of laws like the Texas Commercial Bribery Act.

Question #3. The proposed arrangement implicates the Medicare Fraud and Abuse (as well as the parallel state laws) and Stark II. The physician will refer patients to the physical therapist, therefore any payments that the physical therapist makes need to be examined.

The therapist is paying the physician for office space, services and equipment. The fraud and abuse statute provides a safe harbor for these items, however the payment must be at fair market value and not calculated in a manner that takes into account the value of business between the two parties. Therefore it seems that the 15% of the physical therapist fees above $2000 would not be eligible for the safe harbor under the fraud and abuse law. In addition, the $2000.00 monthly base rent also needs to reflect the fair market value for the items.

The same concerns apply to the Stark II problem, except that it might be possible that the arrangement fits or can be restructured to fit the exemption for in-house ancillary services. These are services provided by individuals under the supervision of the referring physician in a building in which the referring physician furnishes physician services unrelated to the designated health services (the physical therapy services in this case). The services would also need to be billed by the physician, not the physical therapist.

In order to restructure the arrangement, the physician needs to establish the fair market value of the office, services and equipment and charge the physical therapist no more and no less.

Question #4. The first issue that the hospital must examine is whether or not it can safely enter into this arrangement without jeopardizing its tax exempt status. If the arrangement does not

allow the hospital to continue to operate exclusively in furtherance of its exempt purposes and not for the benefit of a private enterprise, the tax exempt status may be jeopardized. A two step test determines whether the tax exempt entity complies with this requirement: (1) does the arrangement substantially relate to the tax-exempt status and (2) does the arrangement allow the tax exempt entity to continue to devote its activities exclusively to its charitable goals and not for the benefit of a private interest. It is questionable whether the PHO's objectives substantially relate to its charitable purpose. The objectives appear to be purely of a competitive nature. The capital that the hospital is investing in the PHO also raises a question about whether the hospital's capital is being used for private interest, in other words there may be a problem with "private inurement."

The physicians should be concerned with the lack of due process. This may allow the PHO to engage in economic credentialling.

The physicians should also be concerned about the termination provision in the agreement. Termination of the agreement will not enable the physician to abandon patients under the physician's care at the time. The physician needs to make sure that the agreement addresses the physician's right to compensation for services rendered to patients following termination of the agreement.

The physician should also be concerned about the provision which allow the PHO to divulge confidential peer review information about the physician to payers. Such payers may not be covered by the Health Care Quality Improvement Act's provisions relating to disclosure of peer review information.

The physician's should also be concerned about the lack of due process because this will mean that the PHO and the physicians acting on its behalf in credentialling matter will not enjoy the immunity provided under the Health Care Quality Improvement Act.

The fact that the PHO contemplates accepting capitation payments from self insured employers means that the PHO will need to be concerned about whether it will need to be licensed as an HMO.

In addition, the fact that the PHO will be responsible for paying the physicians means that the physicians may need to be concerned about the corporate practice of medicine. The PHO will be accepting payments for physician's services and reimbursing the physicians. This appears to be prohibited by the corporate practice of medicine doctrine.