

ILLEGAL REPORT

CMS to Send 500 Hospitals Financial Disclosure Survey in September



BY RICH SANDERS

As if hospital-physician joint ventures weren't already strained by new developments at the federal and state level, two new regulatory statements from CMS have put further constraints on hospitals desiring to do business with physicians in their communities. First, CMS recently announced that it is planning to issue a "new mandatory disclosure instrument" to hospitals. The Disclosure of Financial Relationships Report ("DFRR") will be sent to 500 specialty and general hospitals in September 2007 (if they have not already been sent by press time). The DFRR will require hospitals to provide information on their investment and compensation relationships with physicians. CMS said the information collected through these surveys will be used to assess all investment interests or compensation arrangements between each hospital and its physicians and ultimately to determine compliance with the physician self-referral (Stark) law and the Anti-Kickback Statute.

CMS will require 500 hospitals of all types to respond to the DFRR, including the 290 that did not respond to a similar 2006 survey and another 210 randomly-selected hospitals. CMS intends to eventu-

ally seek such information from all Medicare-participating hospitals. Hospitals will be liable for potential Stark law, Anti-Kickback Statute or False Claims Act violations that could occur when they submit their DFRR forms.

Hospitals will have forty-five days to complete the DFRR after receiving it electronically. Significantly, CMS states that hospitals not submitting the DFRR in a timely manner will be subject to up to \$10,000 in civil monetary penalties for each day after the established deadline. CMS estimates that each hospital will need four hours to complete the DFRR, but most hospitals will require a much greater time commitment to ensure it is accurately completed.

Hospitals should also be aware that the DFRR requests the inclusion of supporting documentation, such as copies of written agreements between the hospital and its physicians, and verification of fair market value of land and building leases. Locating these documents could take a significant additional amount of time. Hospitals will be required to report mundane and often de minimis compensation relationships.

The DFRR isn't the only wet blanket

CMS threw this summer: in its proposed FY 2008 physician fee schedule (published July 12, 2007), CMS took the opportunity to comment on the Stark regulations and introduce some concerns its officials have developed in the last three years regarding potential abuse of the exceptions in those regulations.

Several important issues under Stark were addressed by CMS. First, "under arrangements" arrangements have become more popular in Georgia over the last couple of years, but CMS is now starting to take a more negative view of these ventures. Specifically, CMS suggests a rule change to prohibit physicians from referring patients to a hospital or joint venture with which the physician has an "under arrangement" agreement. In many cases, of course, this new rule would gut the business purpose of many "under arrangement" arrangements (although rural exceptions may apply to some).

Second, CMS called the in-office ancillary service exception "one of the most important built into the Stark law", but it said that the nature of in-office ancillary services had changed since the enactment of the law. As a result, some ancillary services arrangements appear "to be nothing more than enterprises established for the self-referral" of designated health services. This exception will likely be narrowed.

Third, CMS challenged per-click leases

of both space and equipment, noting that such arrangements are inherently susceptible to abuse because the referring physician has an incentive to profit from sending a higher volume of patients to the entity providing the designated health services. CMS proposes to disallow such per-click payments.

Finally, percentage compensation arrangements came under CMS scrutiny. CMS now opines that these percentage compensation arrangements should be exclusively for services personally performed by physicians and must "be based on the revenues directly resulting from physician services rather than based on some other factor such as a percentage of the savings by a hospital department." If those of you who have been following the tortured saga of gainsharing, this appears to be yet another swipe at that star-crossed arrangement model.

Hospital-physician joint ventures will not be directly affected by these new developments immediately, but hospital administrators should continue to look out for more formal government action on these issues.

Rich Sanders directs the Health Law Practice Group in the Atlanta office of Ball & Bingham,

He can be reached at (404) 261-6000 and rsanders@balch.c