

CCH Healthcare Compliance LETTER

Volume 7, Issue 13

health.cch.com

June 28, 2004

On The Front Lines 4

The new “white collar” exemption rules
by Lisa Milam-Perez, JD

Fraud & Abuse 1

- New OIG draft guidance warns hospitals on fraud
- OIG permits program offering free pathology and laboratory services
- OIG Advisory Opinion on “insurance only” ambulance service billing

False Claims 2

- Assistant AG asks whistleblowers, defendants not to jam courts with weak *qui tam* cases

Corporate Governance 3

- Experts outline new strategies for compliance

Tax 7

- Insubstantial for-profit activities will not affect status of tax-exempt health care organizations

Antitrust 8

- Antitrust liability for denial of hospital staff privileges reversed
- New Mexico physician group to settle FTC price fixing charges

New OIG draft guidance warns hospitals on fraud

by Suzanne Szymonik, JD, Contributing Editor

Cautioning hospitals that it is looking at a number of new areas ripe for fraudulent activity, the HHS Office of the Inspector General (OIG) issued a draft supplement to its 1998 compliance program guidance. The draft guidance focuses on the need for accurate claims submission using new billing and coding technologies. Out-patient bill coding, due to its complexity with both prospective payment system codes and ambulatory payment classification codes, especially concerns the OIG. Improper coding and billing for “same-day” discharges and readmissions, post-acute care transfers, and partial hospitalizations, resulting in higher reimbursement, are also new problem areas, as are improper claims for “pass-through” drugs, outlier payments, and “provider-based” services.

New Stark and Anti-Kickback problems. The draft guidance highlights new examples of Stark and Anti-Kickback fraud situations, touching on physician-hospital joint ventures, physician recruitment, and physician compensation, all of which could disguise improper referrals. Even hospitals' subsidies of malpractice insurance premiums and their conditioning privileges on performance of a particular number of procedures (“credentialing”) raise flags for the OIG.

Gainsharing arrangements, whereby physicians are paid as an inducement to reduce services to Medicare or Medicaid beneficiaries, are noted in the draft guidance, especially “cherry-picking” healthy patients to hospitals that offer gainsharing while steering sicker patients elsewhere. Related problems such as delaying screening for emergency treatment and transferring uninsured patients, violations of EMTALA, the Emergency Medical Treatment and Labor Act, continue to concern the OIG.

The OIG directed hospitals and beneficiaries to its February 2004 paper, “Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills” for a summary of when discounts, cost-sharing waivers and bad debt forgiveness are appropriate. The OIG will exercise enforcement discretion regarding hospital-based complimentary shuttle-bus transportation programs.

The draft guidance also contains a checklist of questions for a model hospital compliance program, including ideas for: a formal code of conduct, a regular review of compliance program effectiveness, developing open lines of communication, training personnel, internal monitoring and effective claims auditing, responding to detected deficiencies, enforcing disciplinary standards, and self-reporting misconduct. ■

Notice, 69 FR 32012, June 8, 2004

OIG permits program offering free pathology and laboratory services

by **Gené Stephens Connolly, JD,**
Contributing Editor

The Office of Inspector General (OIG) determined that a proposed program offering volunteer pathology and laboratory services

through a charitable foundation's medical assistance project for low-income, uninsured patients would not violate the anti-kickback provisions of the Social Security Act or the civil monetary penalty provisions of section 1128A(a)(7) of the Act.

The proposed program would provide s referred by one of the Project's volunteer physicians. The program implicated

the anti-kickback statute because of its potential for federal health care program referral business from the Project's physician volunteers and other participants to the volunteer labs.

The OIG determined that both the volunteer nature of the project and the charitable medical services provided for low-income, uninsured patients would increase the public good and availability of services for under-served populations. ■

OIG Advisory Opinion 04-05, June 2, 2004, ¶150,217

False Claims

Assistant AG asks whistleblowers, defendants not to jam courts with weak *qui tam* cases

by **Catherine Hubbard, MA,**
Contributing Editor

Peter Keisler, Justice Department assistant attorney general for the Civil Division, is asking *qui tam* whistleblowers and defendants not to push weak cases through the courts, warning that an abundance of these cases could jeopardize application of the False Claims Act.

Addressing a recent meeting of American Bar Association in Washington, DC, Keisler said some defense attorneys argue the government doesn't go to court often enough to get *qui tam* cases dismissed. "The department doesn't want to clog the courts," was his response. He said the government does not intervene in about 80 percent of cases and that only about 5 percent of the \$8 billion recovered through *qui tam* since 1986 has been through declined cases.

Declined cases "tend to generate bad law and problematic decisions with respect to the False Claims Act," Keisler warned. He also cautioned that bringing weak cases to court may lead to problematic application of the law down the road. "If you are unlikely to prevail ultimately, it may be appropriate to consider voluntary dismissal," he advised.

Keisler also asked attorneys who advise clients on *qui tam* cases to prepare their cases thoroughly. Whether representing a whistleblower or a defendant, attorneys should spend plenty of time gathering information and checking the facts, he said during a June

15 luncheon. "The more thorough you are, the better for all of us," he stressed.

Lawyers representing relators should provide any additional witnesses that they can and provide any supporting documents, he said. In addition, defense attorneys should provide clear and specific drafts, he added. "The more specific and well researched, the better," he said. "An early investment in developing the case will be a good investment," he added.

Moreover, counsel should keep the government informed of the status of *qui tam* cases on which the government has not intervened, he said. In some cases, the government may want to file an amicus brief, he said, urging counsel to give the government attorneys time to analyze the facts. "We often learn about these cases for the first time after the deadline for filing amicus has passed," he said.

Keisler also responded to several complaints that his office has received over the years. For example, some relators' counsel want to participate in the negotiations. Keisler noted there isn't a hard and fast rule precluding counsel. "We don't apply a presumption here," he said, adding that government attorneys "should decide case by case who should be there." In some cases, he pointed out, counsel can be helpful, but in others they can increase the volatility of the negotiations.

Relators' lawyers also have complained that whistleblowers need more recourse when they believe their reward is not large enough. Yet Keisler said there are few disputes that end up in court, noting that many have been resolved through mediation. "The rewards are serving their purpose," he said. ■

CCH Washington Bureau, June 18, 2004



Managing Editor
Pamela K. Carron, J.D.

Coordinating Editors
Angela Fanelli, J.D.
Sharon Sofinski

CCH Washington Bureau
Paula Cruickshank
DOJ, FTC—John Scorza
SEC—Peter Feltman
Health Law—Catherine Hubbard
Tax—Jeff Carlson, David Hansen

Designer
Jason Wommack

Comments from readers are welcome and should be directed to Sharon Sofinski at SOFINSKS@CCH.COM, Tel. 847-267-7860, Fax 847-267-2514. Customer service inquiries should be directed to 800-449-9525.

CCH Healthcare Compliance Letter is published 24 times a year by CCH INCORPORATED, 4025 W. Peterson Avenue, Chicago, IL, 60646. Subscription rate is \$305 per year. First-class postage paid at Chicago, Illinois, and at additional mailing offices. POSTMASTER: SEND ADDRESS CHANGES TO CCH Healthcare Compliance Letter, 4025 W. PETERSON AVENUE, CHICAGO, IL 60646. Printed in U.S.A. All rights reserved. ©2004 CCH INCORPORATED, A WoltersKluwer Company.

No claim is made to original government works; however, the gathering, compilation, and arrangement of such materials, the historical, statutory and other notes and references, as well as commentary and materials in this Product or Publication are subject to CCH's copyright.

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering legal, accounting or other professional service. If legal advice or other expert assistance is required, the services of a competent professional should be sought.

Unless otherwise noted, all paragraph references are to the CCH Healthcare Compliance Reporter.

Experts outline new strategies for compliance

by Catherine Hubbard, MA,
Contributing Editor

Health care organizations need to revamp their compliance programs to make compliance part of the culture, to coordinate compliance officers with the board's efforts and to adopt an integrated view of compliance. "A new strategy is required," said Joe Atkinson of PricewaterhouseCoopers Philadelphia, Pennsylvania, during a June 17 audioconference sponsored by the Health Care Compliance Association.

Paul Belton, vice president of corporate compliance at Sharp HealthCare, San Diego, California, said compliance must be implemented at all levels, including the board, senior management and employees. "Compliance is everyone's business," he said. "Board involvement is just as important as senior management support," he added.

Atkinson said the new compliance approach must enable senior management and the board to use information about risk in making key business decisions, to cost effectively manage governance, risk and compliance processes and to avoid surprises. "Clearly surprises in the current environment tend not to be good events," he said.

The new strategy should include an integrated view of governance, risk management and compliance, said Atkinson, suggesting management and the board embrace a definition of compliance that includes complying with laws and regulations; internal policies and procedures; codes of conduct; contractual commitments and voluntary standards.

"Use a systematic approach for planning and meeting governance, risk and compliance requirements," Atkinson recommended. "The governance and risk management functions should have the same rigor and systematic approach as you would in any other business process."

Kelly Sauders, director of healthcare compliance at PricewaterhouseCoopers, Syracuse, New York, urged compliance officers to "think about your compliance program in a comprehensive way."

In a successful compliance program, Sauders said, a code of business conduct is in place and applicable to all levels within the organization. In addition, she outlined the following practices of successful programs:

- Conflicts of interest are clearly identified and addressed.
- Everyone shares the responsibility for compliance and ethics, not just the corporate compliance officer.
- An appropriate level of resources is dedicated to providing comprehensive training and education.
- Employees at all levels of the organization are recognized and rewarded for ethical behavior and compliance is a component of the evaluation process. "If it's not a part of the evaluation process, you don't have a comprehensive process in place," she cautioned. At Sharp, Belton noted, compliance is a component of job performance.
- Risk and compliance activities are integrated and streamlined across the organization, rather than aligned within departments, such as compliance internal audit, quality and risk management. "Making sure you're streamlining is important," she emphasized.
- Key monitors are in place throughout the organization and are based on identified risks and results that are

routinely reported and assessed.

- Policies and procedures are written to clearly articulate desired behaviors rather than restating laws, regulations or risks.

Technology also can be used as a cost-effective tool to further compliance, Sauders suggested. She suggested managers consider implementing computer-based training programs; purchasing automated risk assessment and tracking tools; and posting policies and procedures on the company intranet site.

In addition, Belton said the board must be educated on both an informal basis and formal basis. He noted that Sharp has a board education program that covers several subjects, including fiduciary issues, regulations, their own personal liability and employee training programs. "Board training is a continuous process," he said.

Compliance officers, in turn, must have the appropriate authority, structure, access and resources to enable the board to perform its role, Belton said. They also need to integrate requirements into the culture of the organization, develop a close working relationship with the board and become an effective facilitator between management and the board in implementing and monitoring corporate governance reform, he added. "It's not an easy job," he concluded. ■

CCH Washington Bureau, June 21, 2004

CCH Healthcare Compliance Editorial Advisory Board

Timothy P. Blanchard, Esq.
McDermott, Will & Emery

Patricia L. Brent, J.D., M.P.H.
President, Morgan Hill Associates

Neil B. Caesar, Esq.
President
The Health Law Center

Paris Cavic, Esq.
Albany, New York

Bill Dacey, MBA, MHA, CPC
President, The Dacey Group

Allan P. DeKaye, MBA, FHFMA
DeKaye Consulting, Inc.

Paul R. DeMuro, J.D., MBA
Partner
Latham & Watkins

Louis H. Feuerstein
Corporate Compliance Program National Leader
Ernst & Young

Michael A. Murer, J.D.
Murer Consultants, Inc.

Cynthia Reaves, Esq.
Honigman Miller Schwartz and Cohn

Theodore J. Sanford, Jr., MD
Chief Compliance Officer for
Professional Billing
University of Michigan Health System

William P. Schurgin, Esq.
Seyfarth, Shaw, Fairweather & Geraldson

Nancy L. Shalowitz, MHA, J.D.
Director for Health Law & Graduate Programs
DePaul University College of Law

John E. Steiner, Jr., Esq.
Chief Compliance Officer for
Cleveland Clinic Health System

Sanford V. Teplitzky, Esq.
Ober, Kaler, Grimes & Shriver

The new “white-collar” exemption rules

by Lisa Milam-Perez, JD

The U.S. Department of Labor (DOL) has revised the “white-collar” exemptions to the Fair Labor Standards Act (FLSA), the federal wage-hour law. The regulations define which employees fall under the executive, administrative, or professional exemptions of the Act. These definitions are critical—the classifications determine which employees enjoy federal law's overtime and minimum-wage protections. The DOL announced the revisions April 20, 2004; the new rules take effect August 23, 2004. However, opposition to the rules continues.

The agency first proposed its rule revisions in March 2003. The final regulations are, in some ways, much closer to the existing rules than those originally proposed. For example, the “duties” tests that were outlined under the proposed rules would likely have drawn many more employees within the scope of the white-collar exemptions. These changes have since been scaled down. However, the salary minimums required in order for the exemption to apply are notably higher.

Revised salary minimum; new salary maximum

The most dramatic change is the salary floor beneath which workers would automatically qualify for overtime pay. The new rule raises the “salary level test,” the minimum salary level to qualify for exemption, to \$455 per week (from \$155 per week), or \$23,660 annually (previously \$8,060 annually). The proposed rules had only raised the salary level to \$425 per week (\$22,100). This change means that many lower-paid workers who may previously have been considered exempt based on the job duties they perform will now be entitled to overtime pay.

The revised rules also introduce a new provision under which a “highly compensated employee” may more readily be classified as exempt. If an employee earns at least \$100,000 per year, and performs office or non-manual work, the employee will be considered exempt if he or she “customarily and regularly” performs exempt duties. The DOL estimates that 107,000 currently nonexempt workers will lose their overtime protections under this new provision.

Duties tests revised, but only slightly

The new white-collar regulations entail the following three main duties tests of exempt status:

- *Exempt executives* manage the enterprise “or a customarily recognized department or subdivision thereof” as their

primary duty. An exempt employee must regularly supervise two or more other employees, and have the authority to hire or fire other employees, or give recommendations as to hiring, firing, or other status changes that are given particular weight.

- *Exempt administrative employees* perform office or nonmanual work that is directly related to the management or business operations of the employer or the employer’s customers. An important criteria is that exempt administrative professionals must exercise “discretion and independent judgment” with respect to matters of significance.
- *“Learned professionals”* perform work that requires advanced knowledge “in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction” (The professional exemption also entails a “creative professional” classification.)

Whither the 20-percent rule. The prior regulations provided for both a “short” and “long” duties test of exempt status. For employees who earned more than \$250 per week, the short test had to be satisfied, a looser criteria for classifying employees as exempt. However, lower-wage workers earning only \$155 per week, or \$170 per week for the professional exemption, needed to meet the more stringent long-test requirements for the exemption to apply. (Employees earning less than \$155 were automatically non-exempt.) When the DOL revised the rules, they created one “standard” test to replace the short and long tests.

With the demise of the long test came the elimination of the long-test requirement that, to be exempt, an employee must devote no more than 20 percent of his or her work time to “non-exempt” activities. At first glance, its removal seems largely irrelevant, as the long-test salary level was so outdated that it rarely applied. However, in practice, many employers still utilized this “20-percent rule” when determining exempt status. It served as a reliable bright-line rule for cautious employers to apply. The end of the 20-percent rule will likely expand the scope of exemptions.

EXECUTIVE EMPLOYEES

	Former "Short" Test	New Test
Salary Test	Salary minimum of \$250 per week	Salary minimum of \$455 per week
Duties Test	Primary duty is management-related AND Customarily and regularly directs the work of two or more employees	Primary duty is management-related AND Customarily and regularly directs the work of two or more employees AND Has authority to hire or fire, or makes suggestions and recommendations as to the hiring, firing, advancement, promotion or any other change of status of other employees that are given particular weight (Employees earning at least \$100,000 annually must meet only one requirement)

ADMINISTRATIVE EMPLOYEES

	Former "Short" Test	New Test
Salary Test	Salary or fees minimum of \$250 per week	Salary or fees minimum of \$455 per week
Duties Test	Primary duty is office or nonmanual work that directly relates to management policies or general business operations of employer or employer's customers AND Includes work that requires exercise of discretion and independent judgment	Primary duty is office or nonmanual work that directly relates to management policies or general business operations of employer or employer's customers AND Includes work that requires exercise of discretion and independent judgment (Employees earning at least \$100,000 annually must meet only one requirement)

Express statements of non-exempt status. The DOL added language providing expressly that certain employees will not be exempt. For example, the rules state that blue-collar workers and public safety workers such as police officers, fire fighters, paramedics, and emergency medical technicians are entitled to overtime protections. In addition, they state that employers still must comply with union contracts and their specific overtime pay provisions. These additions offer no new substantive protections, however; these workers were generally classified as non-exempt under the old rules as well. It serves more to confirm their non-exempt status, and perhaps to alleviate what the DOL asserts were unfounded fears generated by the rules as initially proposed.

PROFESSIONAL EMPLOYEES

	Former "Short" Test	New Test
Salary Test	Salary or fees minimum of \$250 per week	Salary or fees minimum of \$455 per week
Duties Test	Primary duty involves work requiring knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study AND Work requires exercise of discretion and independent judgment OR Primary duty involves work that requires invention, imagination or talent in a recognized field of artistic endeavor	Primary duty requires knowledge of an advanced type (defined as work which is predominantly intellectual in character, and which includes work requiring the consistent exercise of discretion and judgment) in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction OR Primary duty involves work that requires invention, imagination or talent in a recognized field of artistic or creative endeavor (Employees earning at least \$100,000 annually must meet only one requirement)

Additional provisions

Other key additions to the white-collar rules include:

- A provision allowing employers to make deductions from salaried workers' paychecks of one full day or more for serious infractions like sexual harassment or workplace violence without jeopardizing their exempt status;
- "Safe harbor" for employers who inadvertently make improper deductions from the salary of an exempt employee, provided they have a clearly communicated policy prohibiting improper deductions.

Impact on healthcare employers and employees

Nurses, nurse aids. Opponents of the rules as initially proposed had feared that licensed professional nurses (LPNs) could lose overtime pay because they could be classified as exempt learned professionals. However, as noted, the final rules clearly state that LPNs are nonexempt. Certified nurse assistants as well retain their nonexempt status under the new rules. In contrast, "registered nurse" is notably absent from the list of professions that are expressly non-exempt. This omission raised the ire of the American Nurses Association (ANA), a vocal critic of the new rules.

continued on page 6

On the Front Lines

Continued from page 6

(The issue for nurses, of course, is not merely academic: according to a survey by the ANA, more than two-thirds of nurses report working some form of mandatory or unplanned overtime every month.)

Indeed, the new regulations also clearly explain that RNs satisfy the duties test for the professional exemption—just as in the prior rules. In fact, RNs are learned professionals and have long been treated as such. However, RNs are only defined as exempt if they are paid on a salary basis. Thus, it's not the duties tests that afforded RN's nonexempt status; it's the practice of paying RNs on an hourly basis. Currently 75.5 percent of U.S. registered nurses are paid by the hour, according to the DOL, and therefore are nonexempt, despite the professional duties they perform. (Salaried registered nurses earning more than \$23,660 are exempt learned professionals, though, under both the old and new rules.)

Some employee advocates fear that nurses' hourly pay structure may not be enough to protect their overtime rights, however. The AFL-CIO contends that revised language in the rules will actually loosen the salary basis requirement. In fact the rule does seem to allow for hourly employees to be deemed exempt, so long as the employer guarantees they earn the minimum salary to satisfy the salary minimum requirements for exemption. However, registered nurses will likely continue to earn overtime pay, if not by virtue of their exempt status, then by their union contracts and the bargaining power that a severe nursing shortage affords them.

Other healthcare employees. Recommendations received by the DOL during the comment period advocated that certain positions such as dietary managers in retirement homes, social service case managers, and quality of care staff for social service and medical providers (among others) be clearly identi-

fied as exempt administrative professionals. However, DOL rejected these suggestions. Exempt status of these employees must be analyzed on a case-by-case basis, as their job title itself does not satisfy the duties tests. The rules do formally recognize that dental hygienists, physician assistants, and certified medical technologists generally meet the duties requirements of the learned professional exemption, however.

State laws also control

Healthcare employers in particular must take into account as well the state laws that also govern the wages and hours of professional caregivers. The FLSA provides only minimum standards; states can and often do exceed these standards and provide greater protections to employees than those offered under federal law. In fact, the new federal rules do not automatically take effect in 18 states, either because they have passed legislation in direct response to the DOL rulemaking, or because their existing rules simply were more protective of overtime rights.

In addition to general state wage-hour rules, other state statutes specifically legislate wage-hour issues within healthcare in particular. State law varies considerably in this area, ranging from maximum hour restrictions for in-house companions employed by third-party employers, to bans on mandatory overtime for nurses in acute-care facilities only. Employers must implement the new federal wage-hour rules with an eye to the patchwork of state laws that may also apply. ■

Lisa Milam-Perez, JD, is a legal analyst in CCH Incorporated's Labor and Employment Law Group. Milam-Perez serves as an editor on CCH's Labor Relations and Wages-Hours reporters. She recently co-authored an "HR How-to" book on Wages-Hours. She also provided the labor relations content for CCH's Healthcare HR Answers Now product.

Healthcare employers in particular must take into account as well the state laws that also govern the wages and hours of professional caregivers.

Fraud & Abuse (cont.)

OIG Advisory Opinion on "insurance only" ambulance service billing

by Suzanne Szymonik, JD,
Contributing Editor

A municipal fire department that requires residents to pay only for ambulance services to the extent of their insurance coverage does not generate prohibited remuneration under the anti-kickback statute, according to the

Office of Inspector General (OIG). The OIG interpreted Chapter 16, section 50.5 of the CMS Medicare Benefit Policy Manual, finding that a municipal ambulance supplier falls under the special rule for state or local facilities that reduce or waive charges to patients. These suppliers are not viewed by the OIG as furnishing free services when they waive cost-sharing amounts and they therefore may receive Medicare-Medicaid program payments.

The ambulance service examined by the OIG was a non-profit corporation

used by a fire district. The fire district remained the supplier of, and billed for, emergency ambulance services, including Medicare Part B services.

The opinion cautioned that the special rule only applies to "insurance only" billing for bona fide municipal residents who are taxed and therefore pay for the ambulance services. The advisory opinion does not apply to municipalities that contract with outside ambulance suppliers that bill for their services. ■

OIG Advisory Opinion 04-06, June 14, 2004, ¶150,218

Insubstantial for-profit activities will not affect status of tax-exempt health care organizations

by Catherine Hubbard, MA,
Contributing Editor

As shown by a recent revenue ruling, nonprofit hospitals must protect their exempt purpose whenever they partner with a nonprofit, according to a panel of experts that discussed ancillary joint ventures during a recent American Bar Association teleconference.

In Rev. Rul. 2004-51, 2004-22 I.R.B. (June 1, 2004), the IRS said a nonprofit university will not lose its Code Sec. 501(c)(3) exempt status since its partnership with a nonprofit contributed an insubstantial amount to the university's activities. It also said the joint venture furthered the university's charitable purpose. "The clear takeaway from this ruling is that in the case of a joint venture that represents an insubstantial part of a joint activity, that the exemption is not at risk," said David Flynn of Duane Morris, Philadelphia.

"This ruling has broad application across [Code Sec. 501](c)(3)s, including health care (c)(3)s," said Judith Kindell, IRS Tax Law Specialist TE/GE.

In the ruling, a university offered training seminars for elementary and secondary school teachers and decided to form a domestic LLC with a for-profit company that specialized in conducting interactive video training programs. Both the university and the video company held a 50-percent ownership interest. The LLC arranged the seminars, enrolled students, arranged for the facilities and broadcast the seminars.

Kindell said the ruling shows that an insubstantial amount of activity from a for-profit won't affect tax-exempt status. "We were trying to say that if it's an insubstantial part of your activities, then it is not going to affect your exemption," she said.

Yet Kindell cautioned that if a nonprofit enters into a lot of joint ventures with for-profits, even if each venture is insubstantial, that could jeopardize exempt status. "A single joint venture standing

alone that is insubstantial is not going to affect exemption," she clarified.

Flynn added that the 50-50 voting for the joint venture did not threaten the university's Code Sec. 501(c)(3) status. "The ceding of control issue is not relevant in the context of partnership activities that are insubstantial in relation to the exempt organization's overall exempt activities," he said. "You don't need voting control for exemption purposes," added and Frederick Gerhart of Dechert LLP, Philadelphia.

"The clear takeaway from this ruling is that in the case of a joint venture that represents an insubstantial part of a joint activity, that the exemption is not at risk."

A key factor in the ruling was that the joint venture contract stated the nonprofit participants in the joint venture could not do anything to affect the exemption, such as receive private inurement or conduct any political campaigning, Kindell said. "You can't set up a joint venture to do something that you're absolutely forbidden from doing and hope to avoid an affect on exemption," she warned.

Unrelated business income tax.

Voting control also didn't affect the IRS's UBIT analysis. "Numerical voting control is completely irrelevant to the UBIT analysis," Flynn said. "I don't think there's any requirement under the UBIT rules that says if you're in a joint venture, you must be in a position to control those activities, whether those activities are unrelated or not," he added.

Kindell noted that the university retained effective control over the aspects that made the joint venture substantially related to its exempt purposes. For example, the university still made the decisions about faculty and standards for the classes, she said, noting that the content of the classes was the same as before the joint venture. "That was important to us," she said.

Kindell recommended that to avoid the UBIT, nonprofits should make it

clear that the partner's activities will be substantially related to the charitable purpose. "If you are setting up a joint venture and you don't want to be paying UBIT, you probably should put something in to ensure that it is going to be substantially related. Otherwise you are at the mercy to happenstance as to whether you will be paying UBIT," she warned.

Flynn said that in the absence of more guidance from the IRS, health care organizations should heed the warnings contained in the ruling. "The same legal principles would apply in the health care context," he said. "It's pretty clear the service doesn't have any plans to issue further guidance that would involve health care." ■

CCH Washington Bureau, June 17, 2004

Letters to the Editor

The CCH Healthcare Compliance team welcomes comments or questions regarding articles published in the CCH Healthcare Compliance Letter. Send comments to Sharon Sofinski, Coordinating Editor, at sofinks@cch.com. For more information about the CCH Healthcare Compliance Portfolio visit our online store at <http://health.cch.com>.

Health Law Treatises and Analysis Series now available

CCH INCORPORATED® and Aspen Publishers have joined together to offer you all the latest information regarding health law with the Health Law Treatises and Analysis Series.

Titles in the series include:

- Hospital Law Manual
- Hospital Contracts Manual
- Defending and Preventing Health Care Fraud and Abuse Cases: An Attorney's Guide
- Civil False Claims and Qui Tam Actions



For more information or to order, call 1 800 449 9525 or visit health.cch.com.

Antitrust liability for denial of hospital staff privileges reversed

by CCH Editorial Staff

A board-certified surgeon with a subspecialty in vascular surgery failed to establish a New Jersey Antitrust Act claim based on a denial of the surgeon's request for vascular surgical privileges at a hospital, a New Jersey appellate court has ruled in a not-for-publication opinion (*Patel*, N.J. Super. Ct., App. Div.). A trial judge's opinion on the antitrust claim, which "consisted of one paragraph and made no reference to either state or federal law," was reversed.

The complaining surgeon failed to prove the existence of a conspiracy in restraint of trade and either an unlawful purpose or an anti-competitive effect, the court held. A conspiracy could not be inferred from the mere opportunity or ability to conspire. Not only was the hospital immune from antitrust liability, but it also had absolutely no economic interest in preventing the complaining surgeon from getting privileges. The hospital would either have gained from having additional doctors or have suffered no detriment. Although the hospital might have acquiesced to the unreasonable demands of its chief of vascular surgery in denying the privileges, there was no proof of an unlawful agreement between two separate and independent entities, even if the vascular surgery chief acted in a dual capacity as an agent of the hospital and in his own capacity to further his own economic interests.

Even assuming that the hospital and its chief of vascular surgery conspired, there was no evidence of plainly anticompetitive conduct on the part of these defendants that should have relieved the complaining surgeon of the burden of proving anti-

competitive effect. Thus, the *per se* rule of liability should not have been applied to the New Jersey Antitrust Act claim. The complaining surgeon should have been required to prove the necessary unlawful purpose or anticompetitive effect of the denial of staff privileges.

For purposes of the complaining surgeon's monopoly claim, the relevant geographic market should not have been limited to the defending hospital. The relevant geographic market was the area in which potential buyers might rationally look for the goods or services they sought. It was the area where customers looked to buy products, not the area where the seller attempted to sell its product. The relevant geographic market was more properly defined as the market for vascular surgical services in the community in which the hospital was located. There were numerous other hospitals in the county, even disregarding the readily accessible New York hospital market, including many hospitals that were larger and provided a fuller range of services than the defending hospital. ■

CCH Chicago Bureau, June 16, 2004

New Mexico physician group to settle FTC price fixing charges

by CCH Editorial Staff

A nonprofit independent practice association (IPA) with 68 physician members in Roswell, New Mexico, has agreed to settle Federal Trade Commission (FTC) charges that it orchestrated collective agreements among members to fix prices and to refuse to deal with payors except on collectively agreed-upon terms (*Southeastern New Mexico Physicians IPA, Inc.*). A proposed FTC consent order would bar the association and two of its employees

named in the agency's complaint from engaging in similar action in the future.

According to the FTC, the members of the IPA refused to deal individually with payors and, instead, two of the IPA's employees negotiated price and other contract terms with health plans that wished to contract with physician members. Contracts negotiated by the employees with the payors were presented to the IPA's Managed Care Contract Committee and Board of Directors for approval. Then, the general membership voted on whether to accept them.

The proposed consent order would prohibit the respondents from entering into any agreement between physicians:

- (1) to negotiate with payors on any physician's behalf;
- (2) to deal or not deal with payors;
- (3) with regard to the terms upon which any physician deals with any payor; or
- (4) not to deal individually with any payor, or to deal with any payor only through an arrangement in which the respondents were involved.

The proposed consent order would further bar the employees from negotiating with any payor on behalf of the IPA or any member, and from advising any member to accept or reject any term of dealing with any payor, for a period of three years. The respondents would also be required to notify the Commission for three years before entering into any arrangement to act as a messenger or agent on behalf of any physicians with payors regarding contracts. Finally, the proposed consent order would require the IPA to distribute the complain t and order to all physicians who have participated in the IPA and all payors that negotiated, or indicated an interest in contracting, with the IPA. ■

CCH Chicago Bureau, June 16, 2004