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Hospital Outpatient 1206(d) Clinics—Legal Considerations Impacting Physicians

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California hospitals are increasingly operating outpatient clinics as a vehicle through which to recruit new physicians or to retain existing physicians, thus helping to develop, expand or preserve key medical programs. In certain settings, hospitals utilize these clinics as a pathway to help insure coverage of a service, including both primary care and surgical services. For example, hospitals have created orthopedic outpatient clinics using this model. These clinics do not require separate licensure; they are exempt because they operate as outpatient departments of the hospitals. This article focuses on key issues that present from the operation of these outpatient clinics.[1]

Medical foundations are another mechanism used by hospitals to integrate with physician practices. For more information, *see* CMA ON-CALL document #0305, "Legal and Practical Considerations Concerning Medical Foundations."

LEGAL AUTHORITY FOR HOSPITAL OUTPATIENT CLINICS

Outpatient departments of a hospital are exempt from clinic licensure laws pursuant to Health & Safety Code §1206(d). The broad language of the statute does not specify or limit the type of outpatient departments that a hospital may operate under their general acute care licenses. Health & Safety Code §1206(d) provides:

> (d) Clinics conducted, operated, or maintained as outpatient departments of hospitals.

Importantly, the statute does not exempt hospitals or physicians from the corporate practice of medicine prohibition (*see* Business & Professions Code §2400). Thus, hospitals may not employ physicians to staff the clinics, retain their professional fees, or otherwise exercise dominion or control over the manner in which professional services are rendered. For more information, *see* CMA ON-CALL document #0200, "Corporate Practice of Medicine Bar." Nor does the law exempt physicians from the anti-rebate and kickback laws (*see* Business & Professions Code §650). For more information, *see* CMA ON-CALL document #1151, "Prohibitions Against Kickbacks and Fee-Splitting."

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ATTRACTION OF OUTPATIENT CLINIC

In the typical private practice setting, physicians are responsible for providing (and paying for) office space, equipment, furniture and furnishings, supplies, personnel, billing and collection, and administrative support (collectively, "Facilities"). Under the outpatient department model, the hospital provides "turnkey" clinic facilities for physicians, which, in turn, reduces the practice overhead significantly. Nonetheless, physicians remain responsible to provide and pay for professional liability insurance, billing and collection services, and individual benefits, e.g., health insurance. In larger practices, physicians typically still need to provide an internal administrative infrastructure as well.

SITE NEUTRAL MEDICARE PAYMENT (APPLICABLE TO NEW OFF CAMPUS OUTPATIENT DEPARTMENTS)

Medicare utilizes several different systems to pay for the same outpatient services furnished to Medicare beneficiaries, depending upon the site where such services were performed. In general, Medicare makes a single (or global) payment for physician services furnished to beneficiaries in the medical office setting pursuant to the Medicare Physician Fee Schedule (MPFS). However, if the same services are furnished in the outpatient department setting, then Medicare pays the physician a "modified" amount pursuant to the MPFS and Medicare pays the hospital a facility fee pursuant to the Hospital Outpatient Prospective Payment System (OPPS). The sum of the amounts payable by Medicare for physician services furnished in the outpatient department setting is typically higher than the single amount payable by Medicare for the same physician services furnished in the medical office setting.

Similarly, Medicare pays an ambulatory surgery center (ASC) a facility fee pursuant to the Ambulatory Surgical Center Fee Schedule (ASC Fee Schedule). The ASC Fee Schedule applies to surgery centers that are only partially owned by hospitals. Medicare utilizes the OPPS to pay a facility fee to a provider-based outpatient surgery department of a hospital. The facility fee payable pursuant to the ASC Fee Schedule, like the MPFS schedule, is less than the fee payable pursuant to the OPPS.

The Bipartisan Budget Act of 2015 (the Act), enacted November 2, 2015, substantially alters how and how much Medicare pays for outpatient services furnished in the hospital setting. Under Section 603 of the Act, effective January 1, 2017, Medicare will no longer pay for items or services furnished at an off-campus outpatient department of a hospital pursuant to the OPPS unless that off-campus location was billing as an outpatient department of a hospital prior to the date of enactment of the Act. Instead, Medicare would pay for such items or services under the MPFS or ASC Fee Schedule, as applicable.

For years, health policy experts have expressed concerns that Medicare should not pay different amounts for the same outpatient services based on location or type of provider. The same health policy experts also argue that the above referenced disparities in payment create improper financial incentives for hospitals to acquire physician practices and ASCs to capture higher payments for furnishing the same services. Section 603 of the Act begins to address the concerns about site-driven payment disparities and the behaviors they motivate. However, this section is much less comprehensive than alternative solutions that could have been advanced.

First, the Section 603 limitation applies only prospectively, meaning any arrangement that is already billing as a hospital outpatient department service prior to the date of enactment of the Act can continue to bill and be paid by Medicare under the OPPS. Of course, the Centers for Medicare and Medicaid Services (CMS), which is responsible for implementing Section 603 of the Act, could in the future attempt to limit the exemption by "freezing" the size and scope of the existing location.

Second, the Section 603 limitation applies only to items and services furnished in an off-campus location. Under existing Medicare regulations (42 C.F.R. §413.65) governing provider-based status, "campus" is defined as the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and other areas determined by CMS on a case-by-case basis. Consequently, this payment limitation technically applies only to those hospital outpatient department locations not meeting the definition of "campus."

Finally, Section 603 does not apply to payments for items and services until January 1, 2017, even locations not billing as hospital outpatient departments as of the date of enactment.

BILLING AND THE POTENTIAL FOR FALSE CLAIMS

For each patient encounter in the outpatient setting, the hospital seeks to recover the cost of providing the Facilities by submitting a separate bill to the applicable third party payer. Correspondingly, the attending physician (or his or her group practice) submits a bill to the same payer with a location modifier to denote that the patient encounter occurred in an outpatient facility. In theory, the hospital should receive reimbursement from the payer for the cost of the Facilities. In turn, the physician should receive a reduced fee from the payer for his or her professional services in recognition of the payment to the hospital for the Facilities. And, in theory, the savings to the physician from not having to provide (and pay for) the Facilities should be greater than the aggregate reduction in fees occasioned by the application of the location modifier in billing for professional services.

The Medicare program recognizes the billing dichotomy in the clinic setting. The Medicare program will reimburse the hospital in respect of the Facilities furnished for each patient visit. Likewise, the Medicare program will reimburse the physician for professional services at a lower rate in recognition of the location modifier. However, a physician submits a false claim when failing to include the location modifier in the bill. (42 U.S.C. §1320a-7b(a)(1).) The lack of the location modifier implies that the physician furnished the Facilities when, in fact, the hospital furnished such items in connection with the patient encounter. By excluding the location modifier, the physician is requesting payment for goods and services not actually furnished to the Medicare beneficiary, the very essence of a false claim.

Surprisingly, the majority of commercial payers are either unable or unwilling to separately reimburse both the hospital and the physician for patient encounters in the clinic setting. Instead, these commercial payers typically reimburse the physician as if the patient encounter occurred in the private practice setting, even when the physician includes the location modifier on the bill. As a result, the physician receives a global fee from the commercial payer that includes reimbursement for the hospital-supplied Facilities.

In addition, a similar billing issue presents when a surgeon receives a ***global surgical fee*** that includes both reimbursement for the surgery and for post-operative visits in the outpatient clinic setting. Under the outpatient clinic model, outpatient visits will typically occur in the outpatient clinic setting in which the physician will utilize the Facilities. However, the facility fee received by the hospital in connection with the surgery (inpatient or outpatient) will not include reimbursement for the Facilities supplied by the hospital in connection with post-operative visits in the clinic setting.

Importantly, the physician should ***not*** retain either the entire clinic-encounter global fee or surgical global fee, even if the hospital permits the physician to do so. Instead, the physician should utilize a portion of the global fee to reimburse the hospital for the Facilities. ***The failure of the physician to reimburse the hospital and/or the unwillingness of the hospital to accept reimbursement from the physician for the Facilities could be construed as consideration paid by the hospital to the physician in exchange of patient referrals, a violation of federal and state anti-kickback laws.*** *See* 42 U.S.C. §1320a-7b.

SELF-REFERRAL PROHIBITION CONCERNS

Aside from the billing-related issues, there are other traps for the unwary. If a physician has relinquished his/her office and *only* uses the outpatient clinic, physicians will no longer be able to operate ancillary services covered by federal and state self-referral prohibitions (e.g., diagnostic imaging and physical therapy) following affiliation with an outpatient clinic.

Physicians typically operate ancillary services pursuant to the so-called "in office ancillary services exception" to the self-referral prohibitions. (42 U.S.C. §1395nn.) This exception requires the physicians to control the office space in which they operate the covered ancillary services. With the exception of a satellite office, a physician gives up his or her private practice office—and the overhead associated with that office—following affiliation with a

hospital and its outpatient clinic. The hospital must control the space in order for the clinic to operate under its general acute care license. As a result, physicians can lose substantial ancillary service revenue. (If the physician continues to operate a part time office and still render ancillary services, a consultation with legal counsel is recommended). However, in some instances, physicians can mitigate this financial loss by attempting to sell their ancillary service product lines to the clinic-sponsoring hospital. In the event of sale, the purchase price must be fair market value and should be determined by an independent third party. Differences of opinion between the hospital and physician often arise over the valuation methodology. For more information, *see* CMA ON-CALL document #1156, "Self-Referral Prohibitions: California Overview."

PHYSICIAN GUARANTEES

Under the outpatient clinic model, physicians that affiliate with an outpatient clinic continue to bill and collect fees for their professional services. In the absence of a valid recruitment arrangement, the sponsoring hospital ***cannot*** guarantee the net income of the physicians that staff the outpatient clinic. Hence, the income of the participating physicians generally remains dependent on their productivity and, correspondingly, their ability to compete successfully with other physicians for patients from traditional referral sources. **There have been instances where aggressive hospitals will attempt to bill and collect the fees for the physicians, and pay the physicians a stipend and retain the balance. With few exceptions (e.g., certain hospital districts), such a scheme likely violates the corporate practice of medicine prohibition and may violate the fraud and abuse laws, too.**

In some instances, an integrated group of physicians will attempt to negotiate the exclusive right to provide services in the outpatient clinic, similar to arrangements under which a hospital "closes" an inpatient department and awards an exclusive contract to a group of physicians; e.g., radiologists. Under California law, however, a hospital that contracts with the Medi-Cal program cannot "close" any department or service other than radiology, anesthesiology and pathology. *See* California Welfare & Institutions Code §14087.28. For more information on exclusive contracts, *see* CMA ON-CALL document #5102, "Exclusive Contracts."

PROFESSIONAL SERVICES AGREEMENT

A physician typically affiliates with an outpatient clinic through a professional services agreement (PSA) with the sponsoring hospital. The PSA is an important document and governs the relationship of the physician and hospital during the term of the affiliation with the outpatient clinic. Among other matters, the PSA should address the obligation of the hospital to furnish the Facilities, the separate billing and collection functions of the parties, and the payment by the physician of a portion of the global fee to reimburse the hospital in respect of facilities furnished for patient visits in the outpatient clinic. The PSA should also cover the obligation of the hospital to provide those ancillary services that are necessary for quality patient care in a convenient location. For example, in an orthopedic outpatient clinic, diagnostic imaging facilities need to be reasonably proximate to the clinic or patient flow, and patient volume, will be impacted. In addition, the PSA should address key insurance requirements, such as professional liability, comprehensive general liability and property damage coverage, and subrogation waivers for insured losses. In many instances, the proposed PSA is either silent on many of these key provisions, or the provisions are *very* hospital friendly. Physicians beware.

The PSA should also address the term of the affiliation, the events that permit either party to terminate the arrangement, and the rights of the physician following dissociation from the outpatient clinic. While the PSA often times will provide for a fixed term, the PSA may also give either party the right to terminate at any time, without cause, with advance written notice. In that case, the term of the PSA is only as long as the notice period, notwithstanding the expectation of the participating physician.

Importantly, the physician needs to consider how he or she will practice following dissociation from the outpatient clinic. For example, the physician may need to lease new office space and fund the cost of tenant improvements. The physician will also have to provide furniture and equipment, and hire support personnel. In essence, the physician will have to recreate the Facilities that the hospital had been providing under the PSA. These costs may be substantial and create a barrier to a physician terminating an otherwise problematic affiliation with an outpatient clinic. As such, physicians may want to demand a longer "without cause" termination provision.

EXIT PROVISIONS

The looming financial exposure to restart a practice can be more acute in the case of a medical group that sells its leasehold interest, tangible assets, and ancillary service product lines to the sponsoring hospital concurrently with the execution of the PSA. For one, even if the medical group could recreate the Facilities, the cost of rebuilding the ancillary service product lines, and especially an ambulatory surgical center, could be prohibitive following the termination of the PSA. This result could be especially problematic for a medical group that had relied on ancillary service revenue to help supplement professional fees, and pay overhead. In short, the "exit" provisions are critical because the proceeds of any sale prior to affiliation with the outpatient clinic are generally not sufficient alone to permit the physician(s) to retire. The time to consider these issues is before the parties execute the PSA, after which the hospital will have substantially greater leverage.

ETHICAL OBLIGATIONS AND REPORTING TO CMA

Apart from these legal ramifications, physicians have an ethical obligation to refrain from contractual relationships that undermine their ethical obligation to advocate for patient welfare. See AMA Ethical Opinion 8.0501, Professionalism and Contractual Relations. Physicians who believe that any proposal or arrangement infringes on their ability to provide quality patient care are urged to contact CMA's Health Law Information Specialists at (916) 551-2872 for further assistance.

CONCLUSION

Physicians should understand that the implementation by hospitals of the outpatient clinic model is a relatively recent development. There are currently no court cases that address many of the legal issues that present, nor has the legislature addressed this expanding health care delivery model through new statutes or regulations. Given this legal vacuum, some hospitals have attempted to structure their outpatient clinic in ways that historically have proven problematic. Physicians are cautioned that such arrangements could run afoul of several federal and state laws, including antitrust, antikickback, and the corporate practice of medicine prohibitions. Physicians should understand that participation in any such improper transaction could constitute unprofessional conduct and expose the physicians to disciplinary action by the Medical Board of California.

In closing, there are pros and cons to the outpatient clinic model. If structured correctly, then physicians or groups of physicians can benefit greatly from their affiliation with an outpatient clinic. That said, and as in many transactions, the "devil is in the detail."

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We hope this information is helpful to you. CMA is unable to provide specific legal advice to each of its more than 41,000 members. For a legal opinion concerning a specific situation, consult your personal attorney.

For information on other legal issues, use CMA's online health law library, CMA ON-CALL, or refer to the *California Physician's Legal Handbook* (CPLH). CPLH is a comprehensive health law and medical practice resource containing legal information, including current laws, regulations and court decisions that affect the practice of medicine in California. Written and updated by CMA's Center for Legal Affairs, CPLH is available in an eight-volume, softbound print format or through an online subscription to www.cplh.org. To order your copy, call (800) 882-1262 or visit CMA's website at www.cmanet.org.