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Co-Management Relationships With HOPDs

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Presented by:

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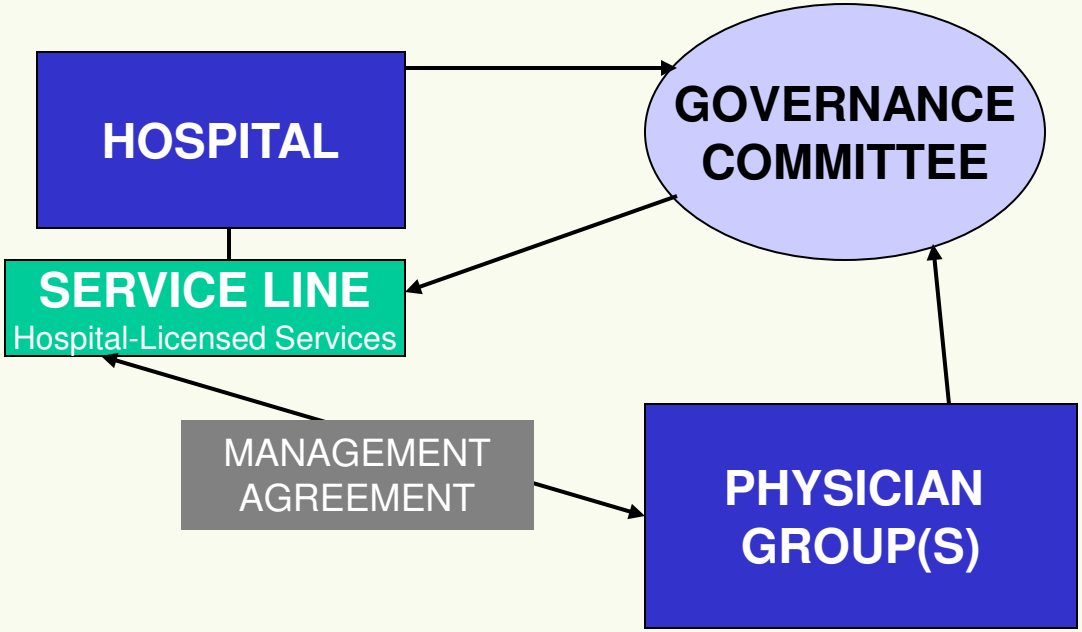
Overview of Presentation

- Overview of Co-Management Arrangement Structures
- Discussion of Key Legal Issues
- Fair Market Value ("FMV") Considerations and Structural Guidance

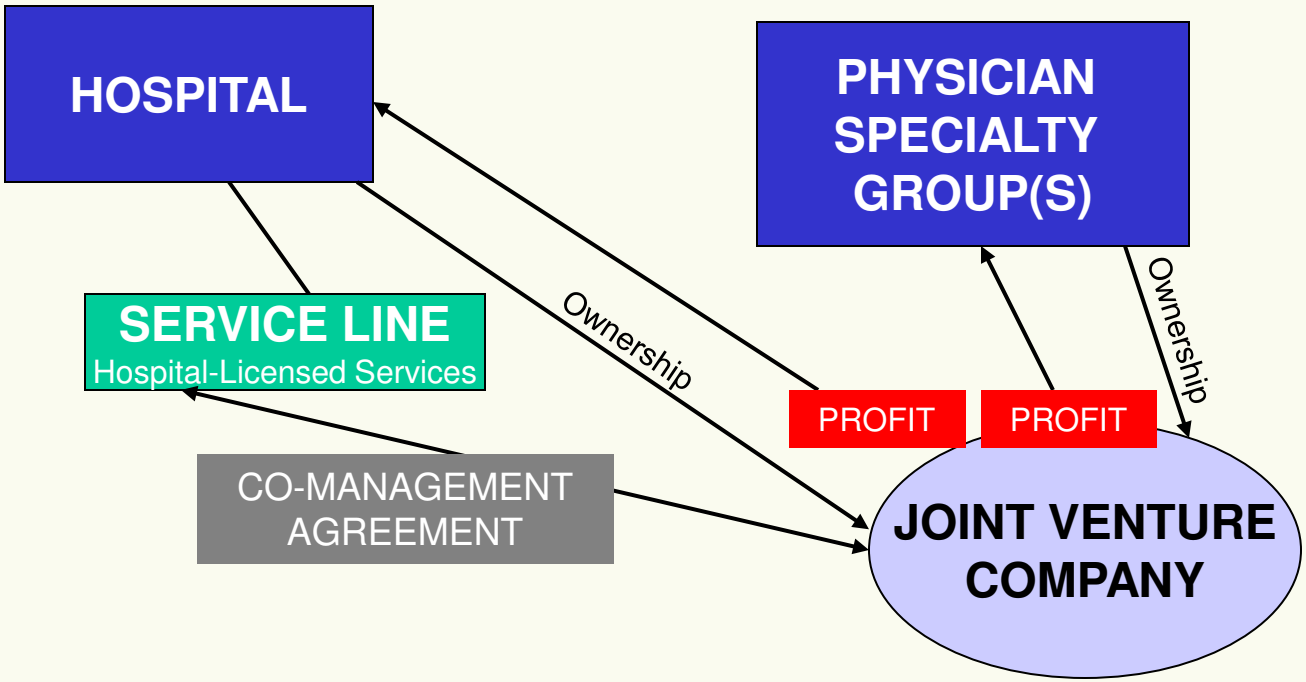
Service Line Co-Management Relationships

- **Purpose:** Recognize and appropriately reward participants for developing, managing and improving the quality and efficiency of a particular hospital service line.
- **Scope:** May cover inpatient, outpatient, ancillary and/or multi-site services.
- **Participants:** May include one or more physicians, medical groups or faculty practice plans, or a joint-venture entity owned in part or entirely by participating physicians or medical groups.

Direct Contract Model



Joint Venture Model



Service Line Co-Management Arrangements

- Typically two levels of payment under the Co-Management Arrangement:
  - **Base Fee** – A fixed annual base fee that is consistent with the FMV of the time and efforts of the participating physicians
    - Includes compensation for service line development, management and oversight
  - **Bonus Fee** – A series of pre-determined payments that are contingent on the achievement of specified, mutually agreed upon targets
    - Targets must be objectively measurable and based on program development, quality improvement and efficiency
  - Fees must be fixed and commensurate with FMV.

Service Line Co-Management Arrangements

- Examples of Co-Management Services
  - Clinical improvements
  - Work flow process improvement
  - Physician and patient scheduling
  - Nurse and non-physician clinician oversight
  - Patient case management activities
  - Credentialing activities
  - Materials management
  - Medical staff committee service and leadership

Key Legal Issues

- Anti-Kickback Statute and Anti-Kickback Statute Safe Harbors
- Civil Monetary Penalty Statute
- Stark Act
- False Claims Act
- 501(c)(3) Tax Exempt Issues
- Provider-Based Status Rules

Anti-Kickback Statute

- Prohibits the knowing and willful offer, solicitation, payment or receipt of anything of value that is intended to induce the referral of an individual for which a service may be made by Medicare and Medicaid or certain other federal and state healthcare programs or to induce the ordering, purchasing, leasing or arranging for, or recommending the purchase, lease or order of, any service or item for which payment may be made by such federal healthcare programs
- "One purpose" test
- Management fees paid to co-management group could be interpreted as remuneration intended to induce referrals to hospital.
- *See 42 U.S.C. 1320a7-b(b)*

Anti-Kickback Statute Safe Harbors

- Safe Harbors - If the requirements of a Safe Harbor are met, individuals and entities are insulated from prosecution under the Anti-Kickback Statute for conduct which would otherwise violate the Anti-Kickback Statute.
  - Personal Services Safe Harbor
  - Management Contracts Safe Harbor
- Key Issue – Compensation paid to physician groups for management or personal services must be FMV.
- Co-Management contract will not meet Personal Services and Management Contracts safe harbor if "aggregate compensation" is not set in advance.
  - Maximum and minimum compensation may be set in advance, but aggregate compensation may not be.
  - OIG's position is that percentage compensation is not "set in advance."

Civil Monetary Penalties Statute

- Prohibits a hospital from knowingly making a payment, directly or indirectly, to a physician as an inducement to reduce or limit services to a Medicare or Medicaid beneficiary
  - Penalties of up to $2,000 for each such individual with respect to whom the payment is made
  - Potential for exclusion from Federal and State Healthcare programs
- Co-Management Agreement and structure that incentivizes behavior to reduce costs could run afoul of the CMP

Physician Self-Referral Statute ("Stark Act")

- Prohibits a physician from making referrals for "designated health services" ("DHS") payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship, unless an exception applies
  - Prohibits the entity from submitting a claim (or causing a claim to be submitted) to Medicare
  - "Financial relationships" include both ownership and compensation relationships.
  - Strict liability statute – no intent to violate necessary
- Financial relationship is prohibited between a physician and a hospital to which the physician refers patients unless an exception applies.
- *See 42 U.S.C. 1395nn*

Potentially Applicable Stark Exceptions

- Stark Law exceptions - must be met absolutely to ensure protection
  - Personal service arrangements
  - Fair market value
- Both exceptions contain requirement that compensation be FMV and "set in advance" and not vary with volume/value of referrals
  - "Set in advance" permits a specific formula that is set in advance, can be objectively verified and does not vary with volume/value of business generated (*e.g.,* fixed payment for objective quality metrics)

2009 Proposed Exception for Incentive Payments/Shared Service Plans

- Proposed exception not finalized
- CMS received comments critical of the proposed exception as not guarding against program or patient abuse.
- CMS also received comments that exception was not particularly helpful.
- 2009 Physician Fee Schedule Final Rule reopened the comment period and solicited comments on 55 specific areas.
- Interplay with proposed ACO/Shared Savings Plan regulations released on March 31, 2011

False Claims Act

- Liability under the False Claims Act occurs when a person or entity:
  - knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
  - knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; or
  - conspires to commit a violation of any of certain provisions of the False Claims Act (including the two listed above).
- Violations are punished by penalties of not less than $5,500 and not more than $11,000 per claim, plus treble damages for the amount of damages the Government sustains.
- FCA actions can be based on Anti-Kickback Statute and/or Stark Law violation.
- If a claim that a hospital submits to Medicare was improperly induced or violated the Stark Act, then it may also be a false claim.
- Whistleblower (qui tam) suits are allowed.
- *See 31 U.S.C. 3729 to 3731*

501(c)(3) Tax Exempt Issues

- Tax Exemption Rules
  - Assets of a 501(c)(3) tax exempt entity cannot be used for private inurement, private benefit or excess benefits.
  - Reasonable compensation must be paid.
  - Compensation should not be based on "net earnings" of hospital or service line.
  - Follow steps to establish ***rebuttable presumption*** of reasonable compensation under intermediate sanctions regulations.
    - Obtain comparability data
    - Independent approvals
    - Documentation

Provider-Based Status Rules

- Provider-based rules can apply to a hospital-licensed service on campus or at hospital satellite.
- If off campus, must be within 35 miles of hospital campus and financially, administratively and clinically integrated with the hospital
  - Management contract limitations apply: clinical staff must be directly employed by hospital, except for practitioners who can bill independently under Medicare fee schedule (*e.g.*, MDs, NPs).
- If management agreement in place for off-campus or joint ventured service line, beware of provider-based rules.
- *See 42 C.F.R. 413.65*

Typical Features of a Co-Management Arrangement

- As indicated earlier in our presentation, compensation for the manager's services is typically comprised of a ***base fee*** and an ***incentive fee***.
  - However, for small service lines and/or in unique instances when the services are very limited in scope (*e.g.*, sleep labs, wound care centers), there may only be a base fee.
- The co-management arrangement may or may not involve the creation of a new entity (*i.e.*, a JV, which may or may not be owned in part by the hospital).
  - Thus, the "manager" may consist of the physicians only, or the physicians and the hospital within the framework of a joint venture.
- The co-management agreement will require replacement or redefinition of existing medical director agreements to accommodate the services provided by the managers. Notwithstanding, all medical directors must be paid from the ***base fee*** management fee.

Typical Features of a Co-Management Arrangement

- The agreement stipulates a listing of core management/administrative services to be provided by the manager (for which the base fee is paid).
- The agreement includes pre-identified incentive metrics coupled with calculations/weightings to allow computation of an incentive payment (which can be partially or fully earned).
  - Usually tiered in terms of level of accomplishment and associated payouts.
  - Must demonstrate some level of improvement over "current state" in order to receive the "top tier" of compensation.
  - Can provide some level of compensation for maintaining current state, if at national benchmark or better.
- Compensation is directed towards accomplishments rather than hourly-based services.

Valuation Process – Riskiness of Co-Management Arrangements

- Among the spectrum of healthcare compensation arrangements, co-management arrangements have a relatively "high" degree of regulatory risk if FMV cannot be demonstrated.
  - By design, these agreements exist between hospitals and physicians who refer patients to the hospital.
  - Available valuation methodologies are limited and less objective as compared to other compensation arrangements.
  - In most cases, physicians are not being compensated under the traditional "hours worked and logged" approach.
  - The "effective" hourly rate paid to physicians may be higher than rates which would be considered FMV for hourly-based arrangements (since a significant component of compensation is at risk).

Valuation Process – Approaches to Value

- Available valuation approaches include:
  - Cost Approach
  - Market Approach
  - Income Approach
- In considering these valuation approaches, an income approach can likely be eliminated since the possible or expected benefits of the co-management agreement ***may not*** translate directly into measurable income.

The Cost Approach

- The Cost Approach can be used to estimate the "replacement" or "replication" cost of the management/administrative services to be provided by the manager.
- Very difficult, if not impossible, to accurately determine the specific costs involved in managing a service line.
- An analysis by "proxy," or an approach that estimates the number of medical director hours required to manage the service line in the absence of a management arrangement, (which is then multiplied by an FMV hourly rate) yields one indication of value.
  - However, within the framework of a joint venture management company, this approach does not consider the hospital's contribution.
  - Further, a key ideal of most co-management arrangements is to reward ***results*** rather than time-based efforts.

The Market Approach

- The Market Approach recognizes that that there are certain management / administrative requirements associated with every service line management arrangement.
- However, it is also understood that each co-management arrangement is unique and may include and prioritize different market and operational factors.
- Therefore, within the framework of the Market Approach analysis, consideration must be given to the required management tasks.
  - Specific tasks and responsibilities of the managers must be identified.
  - On an item-by-item basis, the relative worth of each task/responsibility is "scored" relative to other comparable arrangements.
  - An indication of value of the management services is then established by comparing the "scoring" of the subject agreement to other service arrangements in the marketplace.

Valuation Synthesis

- The Cost and Market valuation methodologies should be reconciled to arrive at a final conclusion of value.
  - The Cost Approach may "underestimate" the value of the arrangement because in the case of joint ventures, the Cost Approach only considers physician participation (*i.e.*, medical directors),
  - The Market Approach may "overestimate" the value of the arrangement because market comparables may not be exact.
- While it may be appropriate to give equal weighting to the two approaches, the valuator may conclude that one method should be weighted more heavily than the other.
- Once the FMV of the ***total management fee*** is established, an assessment must be made regarding the split between the ***base fee*** and ***incentive fee*** components.
- The FMV of the base fee must encompass payment of any medical director fees or administrative services related to managing the service line.

What Drives Value?

- As a percentage of the service line net revenues, the *total fee* payable under a co-management arrangement typically ranges from 2% to 6% (on a calculated basis).
- The fee is fixed as a flat dollar amount, including both base and incentive components, for a period of at least one year.
  - Commonly, the base fee equals 50-70% of the total fee.
- The extent and nature of the services drive their value. Thus, the valuation assessment is the same whether the manager consists of only physicians or physicians and hospital management.
- Determinants of value include:
  - What is the scope of the hospital service line being managed?
  - How complex is the service line? (*e.g.,* a cardiovascular service line is relatively more complex than an endoscopy service line)
  - How extensive are the duties being provided under the co-management arrangement?
  - How many physical locations are being managed?

What Drives Value?

- Size adjustments based on service line revenue:
  - Large programs may be subject to an "economies of scale" discount.
  - Small programs may be subject to a "minimum fee" premium.
- Consider the appropriateness of the selected incentive metrics:
  - Is the establishment of the incentive compensation reasonably objective?
  - Consider the split of base compensation and incentive compensation.
- Occasionally, certain other services (*e.g.*, call coverage) may be included among the co-management duties.
  (Some hospitals prefer to embed call coverage in the co-management fee to avoid a separate compensation arrangement with the physicians.)

Possible Pitfalls of Co-Management Arrangements

- The service line/revenue stream to be managed must be defined objectively, and there should be no overlap between multiple service lines which may be subject to co-management arrangements (*e.g.*, surgery service line and orthopedic surgery service line).
- A co-management arrangement typically contemplates that no third-party manager is also providing similar services on behalf of the hospital or its service line.
- Care must be taken to ensure that employed physicians who are part of co-management arrangements are not double paid for their time.
  - Employment compensation based solely on wRVUs is self-normalizing.

Possible Pitfalls of Co-Management Arrangements

- Medical director agreements related to the managed service line must be compensated through the base management fee.
- There can be no passive owners, active participation and significant time and effort are required by busy physicians.
  - Documentation requirements

Questions?

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