Co-Management Arrangements in Healthcare: Compliance in Hospital-Physician Arrangements

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Today’s faculty features:

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CO-MANAGEMENT ARRANGEMENTS IN HEALTHCARE: LATEST DEVELOPMENTS

COMPLYING WITH LEGAL AND REGULATORY REQUIREMENTS IN STRUCTURING HOSPITAL-PHYSICIAN ARRANGEMENTS
SPEAKERS

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ROAD MAP TO THE PRESENTATION

- Definition and Description of a Co-Management Arrangement
- Discussion of Key Regulatory Concerns
- Review of FMV Considerations
- Commercial Reasonableness Considerations
- Questions & Answers
- Appendix Materials
SERVICE LINE CO-MANAGEMENT ARRANGEMENTS

- Independent contractor arrangement.
- The purpose of the arrangement is to recognize and appropriately reward participating medical groups/physicians for their efforts in developing, managing and improving quality and efficiency of a particular hospital service line.
- Scope of service – The arrangement may cover inpatient, outpatient, ancillary and/or multi-site services.
Example: Potential Scope of Cardiology Service Line

- Open Heart Surgery
- Cath Lab
- Echocardiography
- Vascular Surgery
- Invasive Radiology
- PVL
- Inpatient Cardiac & Vascular
- PCU
- Stress Lab
- ECG
- Cardiac Rehabilitation
SERVICE LINE CO-MANAGEMENT ARRANGEMENTS
DIRECT CONTRACT MODEL

- Multi-party contract
- Allocates effort and reward between groups

Operating Committee

Hospital-licensed services

Payors

Hospital

Service Line

Specialty Group I

Specialty Group II

Other Specialty Group(s)
SERVICE LINE CO-MANAGEMENT ARRANGEMENTS

JOINT VENTURE MODEL

- Payors
- Hospital
- Service Line
- Service Line Physicians/Groups
- JV Management Company

*Co-Management Agreement*
*Profit Distribution*
*Profit Distribution*
*$

Key Points:
- Capital Contributions
- Management Infrastructure
COMPARATIVE STRUCTURAL CONSIDERATIONS

- Simplicity and expense
- Potential securities offering for JV Model
- Physician holding company?
- JV Model better reflective of relative roles/Responsibilities of hospital/MDs?
- JV Model may carry less Stark Law risk
- Direct Contract Model more remunerative?
- Participating MDs performing disproportionate services/Compensation based on relative efforts in Direct Contract Model vs. invested capital in JV Model?
- Antitrust considerations (for bundled payments): JV Model more financially integrated?
There are typically two levels of payment under the service line contract:

- Base fee – a fixed annual base fee that is consistent with the fair market value of the time and efforts participating physicians dedicate to the service line development, management, and oversight process.

- Bonus fee – a series of pre-determined payment amounts contingent on achievement of specified, mutually agreed, objectively measurable, program development, quality improvement and efficiency goals that are consistent with national norms.

- Must be fixed, fair market value arrangement; independent appraisal strongly advised.
SAMPLE CO-MANAGEMENT SERVICES

- Development of Service Line
- Medical Director services
- Budget process
- Strategic/business planning process
- Community relations and education
- Patient, physician and staff satisfaction surveys
- Development of clinical protocols and performance standards
Ongoing assessment of clinical environment and work flow processes
- Physician staffing
- Patient scheduling
- Staff scheduling and supervision
- Human resource management
- Call coverage

Greater value based on service intensity: do, assist, or advise/consult
## Operational Efficiencies Incentive Compensation (OEIC)

<table>
<thead>
<tr>
<th>Incentive</th>
<th>Priority</th>
<th>Allocation</th>
<th>Upper Payment Limit (a)</th>
<th>Current Performance</th>
<th>Performance Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply Cost per Case</td>
<td>1</td>
<td>13.2%</td>
<td>$120,000</td>
<td>$5,670</td>
<td>% of Budget</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>95.0%</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>95.0%</td>
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<tr>
<td>Turn Around Time (c)</td>
<td>2</td>
<td>8.2%</td>
<td>$75,000</td>
<td>2.56</td>
<td># Hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&lt;=1.00</td>
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<td></td>
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<td>&lt;=1.00</td>
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<tr>
<td>On-Time Starts (1st Case of Day)</td>
<td>2</td>
<td>8.2%</td>
<td>$75,000</td>
<td>20%</td>
<td>Improvement On Target</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>&gt;= 95%</td>
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<td></td>
<td></td>
<td>&gt;= 95%</td>
</tr>
<tr>
<td>Room Utilization</td>
<td>1</td>
<td>13.2%</td>
<td>$120,000</td>
<td>76%</td>
<td># Hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&gt;= 85%</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>&gt;= 85%</td>
</tr>
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</table>

## Quality of Service Incentive Compensation (QSIC)

<table>
<thead>
<tr>
<th>Incentive</th>
<th>Priority</th>
<th>Allocation</th>
<th>Upper Payment Limit (a)</th>
<th>Current Performance</th>
<th>Performance Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Rate: Antibiotics Within 30 Minutes Prior to Incision</td>
<td>1</td>
<td>13.2%</td>
<td>$120,000</td>
<td>89%</td>
<td>% Compliance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>98%</td>
</tr>
<tr>
<td>Infection Rate: Insulin Drip for Patients with Blood Sugar Level &gt; 150</td>
<td>2</td>
<td>8.2%</td>
<td>$75,000</td>
<td>0%</td>
<td>% Compliance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td>Return to OR for Post-Op Bleeding</td>
<td>2</td>
<td>8.2%</td>
<td>$75,000</td>
<td>2.9%</td>
<td>% Rate of Return to OR</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&lt;=2.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&lt;=2.5%</td>
</tr>
<tr>
<td>Mortality Rate</td>
<td>1</td>
<td>13.2%</td>
<td>$120,000</td>
<td>(d)</td>
<td>O/E Rate (b)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&lt;=1.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&lt;=0.95</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>3</td>
<td>7.1%</td>
<td>$65,000</td>
<td>Peer Group Percentile</td>
<td>&gt;=80</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&gt;=85</td>
</tr>
<tr>
<td>Peer / Employee Evaluations</td>
<td>3</td>
<td>7.1%</td>
<td>$65,000</td>
<td>360° Feedback Scores</td>
<td>Survey Development / Administration</td>
</tr>
</tbody>
</table>

**Total Incentives** $910,000

**Quality of Service Threshold**

<table>
<thead>
<tr>
<th>Incentive</th>
<th>Quality Threshold would be required to be met in order for any of the above incentives to be paid out.</th>
<th>Gross Mortality % and/or O/E Rate (TBD) (e)</th>
<th>Conversion to O/E Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality Rate (e)</td>
<td></td>
<td>2.98%</td>
<td>2.98%</td>
</tr>
</tbody>
</table>

(a) Based on maximum total incentives payout of $910,000 (Subject to Fair Market Value and Legal Approval)
(b) O/E = Observed v. Expected rate
(c) Turn Around Time Defined as time of incision closure to time of next incision
(d) O/E mortality rate is currently not measured
(e) Assumes Quality of Service Threshold will change from gross mortality % to an O/E rate once available.

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For Illustrative Purposes Only

Prepared by PricewaterhouseCoopers
PRINCIPAL REGULATORY CONSIDERATIONS

- Civil Monetary Penalty Statute
- Anti-Kickback Statute
- Physician Self-Referral Statute (Stark)
- False Claims Act
- Tax Exemption/Intermediate Sanctions
- Provider-Based Status Rules
- Antitrust Issues
As amended by MACRA*, prohibits a hospital (or CAH) from knowingly making a payment, directly or indirectly, to a physician as an inducement to reduce or limit medically necessary services to a Medicare or Medicaid beneficiary who is under the direct care of the physician.

Note that paying a physician to design a plan or to oversee its implementation would not violate the CMP statute if the physician is not directly providing care to Medicare or Medicaid beneficiaries.

- CMP of not more than $2,000 for each such individual with respect to whom the payment is made.
- A physician who knowingly accepts payment subject to a CMP of not more than $2,000 for each individual with respect to whom the payment is made.
- Potential for exclusion from Federal and State Healthcare programs (see 1128(b)(7) of the SS Act).

* Medicare Access and CHIP Reauthorization Act of 2015, section 512
Prior to MACRA, OIG consistently maintained that the CMP Statute must be read as prohibiting even payments to physicians for reducing medically unnecessary services or for using device A or supply A instead of clinically equivalent device B or supply B.

OIG initially hostile to idea of issuing advisory opinions on proposed gainsharing arrangements, but began issuing favorable advisory opinions in 2001 and has issued 15 favorable opinions to date, including 4 in 2008 and 1 in 2009. AO on clinical co-management arrangement (discussed below) in 2013.

Except for aforementioned 2013 AO on co-management, no advisory opinions on gainsharing since 2009.

OIG declined to include a gainsharing waiver in the final ACO waivers, saying it was not necessary to do so in light of MACRA.
In the typical arrangement covered by the AOs, OIG concluded that some or all aspects of the arrangement would constitute an improper payment under the CMP statute but that it would not seek sanctions.

- Product substitutions are found to implicate the CMP Statute. Occasionally, some minor aspects of the arrangement may have no appreciable clinical significance, such as paying physicians to use reusable supplies.

**Safeguards included in the arrangements included**

- Actual verifiable cost savings tied to specific protocol/cost lowering activity. Measure cost savings on basis of existing volume (avoid incentives to change volume)
- Ensure quality is measured and maintained.
- Monitor change in case mix (protection against steering away sicker/more costly patients).
- Disclose to patients.
- Reasonable compensation (based on independent appraisal)
On January 7, 2013 OIG released favorable AO (12-22) on clinical co-management agreement for cardiac catheterization services.

Requestor was large hospital in medically underserved area.

Cardiology group was only provider of CC services in town and only cardiologists on Requestor’s medical staff.

- Requestor said that if other cardiologists joined medical staff it would consider extending arrangement to them.

Requestor pays (1) a guaranteed, fixed payment, and (2) a potential annual performance-based payment.

- Payment is made to the Group, which (to the extent revenue derived from the arrangement results in dividends payable to the Group’s shareholders) then distributes the dividends based on each shareholder’s pro rata share of ownership.

- Performance Fee consists of (1) Requestor’s employee satisfaction (5%); (2) patient satisfaction with Requestor’s CC Labs (5%); (3) improved quality of care within the CC Labs (30%); and (4) cost reduction measures (60%).
OIG said that the Fixed Fee, employee satisfaction, patient satisfaction, and quality components do not implicate the CMP Statute, but the cost savings component does implicate the CMP Statute.

However, it would not seek sanctions because of sufficient safeguards.

First, Requestor certified that the arrangement has not adversely affected patient care, and that it monitors both the performance of the Group under the arrangement and its implementation of the cost savings component to protect against inappropriate reductions or limitations in patient care.

Second, the risk that the arrangement will lead the Group’s physicians to apply a specific cost savings measure, such as the use of a standardized or bare metal stent, in medically inappropriate circumstances is low. Each of the Group’s physicians has access to the device or supply he or she determines to be most clinically appropriate for each patient.

Third, the Performance Fee is subject to a maximum annual cap and the term of the arrangement is limited to three years.

Fourth, receipt of any part of the Performance Fee under the arrangement is conditioned upon the Group’s physicians not taking any of the following actions:
(1) stinting on care; (2) increasing referrals to Requestor; (3) cherry-picking; or (4) accelerating patient discharges.
GAINSHARING IN BUNDLED PAYMENT ARRANGEMENTS

- CMS’s Bundled Payments for Care Improvement (BPCI) implemented by CMMI (Center for Medicare and Medicaid Innovation)

- There are 4 BPCI models with Models 2 and 3 accounting for approx. 75% of all BPCI arrangements.

- Models 2 and 3 use a retrospective payment system. E.g., in Model 2, the bundle or episode of care is defined as certain acute and post-acute services. Hospital and other providers receive their normal Medicare FFS payments. After episode concludes, CMS performs a reconciliation, comparing the total reimbursement paid to the providers for the episode and comparing that aggregate amount to the pre-established bundle price. If the aggregate provider reimbursement amount is less than the bundled amount, Medicare would pay the providers the difference (less the 2% CMS takes off the top). But, if the aggregate payment amount exceeds the bundle price, those at risk under the arrangement are responsible to pay to Medicare the amount over the bundle price.
There are waivers for the BPCI arrangements

- AKS, Stark, and anti-gainsharing and beneficiary inducement provisions of the CMP Statute

There are commercial pay bundled payment arrangements

- There are State no anti-gainsharing statutes per se and no beneficiary inducement statutes
  - However, some States have all-payer anti-kickback statutes
  - Some states also have physician or practitioner self-referral statutes and/or fee splitting statutes

CMS proposes to cut back on CJR program and cancel the Episode Payment Models (EPMs) and the Cardiac Rehabilitation (CR) incentive payment model
ANTI-KICKBACK STATUTE, SECTION 1128B(B) OF SS ACT, 42 USC 1320A7-B(B)

- Criminal statute - requires intent of an illegal inducement

- 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 (collectively referred to as an illegal inducement)

- Covers referrals for any item or service that might be paid for by Medicare or any other federal health care program

- Ascribes criminal liability to both sides of an impermissible “kickback” transaction, and has been interpreted to apply to any arrangement where even one purpose of the remuneration offered, paid, received, etc., is to obtain money in exchange for referrals or to induce referrals
ANTI-KICKBACK STATUTE

- 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 specified in agreement but aggregate compensation may not be, and OIG’s position is that percentage compensation is not “set in advance”.

- Joint venture probably will not meet small investment safe harbor 40/40 tests.
  - More than 40% of interests held by persons in a position to refer

- Analyze under AKS “one purpose” test.
Volume/revenue-based performance measures implicate the Anti-Kickback Statute.

- Should not reward increase in utilization, revenue, or profits of service line
- Should not reward change in case mix
- Should not reward change in acuity
- Should obtain independent appraisal of FMV to help negate inference of improper intent

Advisory Opinions state that the AKS could be violated if the requisite intent were present but that OIG would not seek sanctions

MACRA amendment to gainsharing prohibition does not abrogate all AKS concerns
PHYSICIAN SELF-REFERRAL (STARK)
SECTION 1877 OF SS ACT, 42 USC 1395NN

- Prohibits a physician from making referrals for certain “designated health services” (or 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 for claims to be denied, but enhanced penalties available for knowing violations (CMPs/assessments, exclusion, and False Claims Act liability).
In CY 2009 PFS proposed rule, CMS proposed a stand-alone exception for IP/SS plans.

Invoked authority under section 1877(b)(4) of the Act, which allows Secretary to promulgate new exceptions provided there is no risk of program or patient abuse.

The proposed exception would permit remuneration by a hospital to physicians on its medical staff.

Aimed at permitting appropriate quality improvements and cost-savings programs while guarding against: Stinting; Steering; Cherry picking; Gaming; Paying for referrals/volume increase; Quicker-sicker discharges.
Proposed exception not finalized

CMS received comments critical of the proposed exception as not guarding against program or patient abuse, as required for new exception.

On the other hand, CMS received comments that exception was not particularly helpful.

CY 2009 PFS Final Rule reopened the comment period and solicited comments on 55 specific areas.
In the CY 2016 PFS proposed rule, CMS asked whether...

- Is there a need for new exceptions to support shared savings or “gainsharing” arrangements?

- Could existing exceptions, such as the exception for risk sharing arrangements, be expanded to protect certain physician compensation, e.g., compensation paid to a physician who participates in alternative care delivery and payment model sponsored by a non-federal payor?

- Given the changing incentives for health care providers under delivery system reform, should CMS deem certain compensation not to take into account the V or V of referrals or other business generated by a physician?

- Should certain entities, such as those considered to provide high-value care, be permitted to compensate physicians in ways that other entities may not? For example, should hospitals that meet established quality and value metrics under the Hospital VBP be allowed to pay bonus compensation from DHS revenues to physicians who help the hospital meet those metrics?
Is a stand-alone exception even necessary?

We know that arrangements are taking place in the sunshine, including the arrangements that received favorable AOs from the OIG and have reported data from the arrangements, so some must believe that arrangements can fit into one or more existing exceptions.

Or can Stark can be avoided altogether?
Incentive payments to physicians, or payments to physicians under an incentive payment or shared savings plan may constitute a compensation arrangement, and, if so, an exception is needed.

Need direct compensation exception for service line co-management agreement with participating individual physicians, and medical group owners that “stand in the shoes” of their “physician organization”

Indirect compensation analysis for joint venture model and other physician entities (e.g., faculty practice plans)

Outside of Stark if aggregate compensation to referring physician does not vary with or reflect volume or value of DHS referrals

Otherwise, need to rely on indirect compensation arrangements exception (411.357(p))

Fair market value requirement
Both the PSA and FMV 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) – percentage comp can “be set in advance”

Percentage comp does not satisfy AKS safe harbor, and in fact OIG will consider it to take into account the volume or value or referrals
In order for Stark to be implicated there has to be a “direct compensation arrangement” or an “indirect compensation arrangement” (both terms of art under 411.354)

**GOAL:** Structure the compensation so that there is neither a direct nor an indirect compensation arrangement

**Step 1 – Make sure there is not a direct compensation arrangement**

- A “direct compensation arrangement” is where there is no intervening between the physician and the DHS entity
- Hospital cannot make payment directly to physician
- But if Hospital pays group practice which pays physician, it might still be a direct compensation arrangement. Why?
- Under the SITS rule, Physician owners of a “physician organization” “stand in the shoes” of the PO and are deemed to have the same direct compensation arrangement their PO has with a DHS entity
BUT… no physician is required to stand in the shoes of an entity that is not a PO, such as a management company.

So, Group Practice Physicians form management company, which contracts with Hospital for co-management services.

This means no direct compensation arrangement between Hospital and Physicians.

So far, so good, but is there an indirect compensation arrangement? If so, it will need to meet the exception for indirect compensation arrangements.
STRUCTURING A CO-MANAGEMENT SERVICES AGREEMENT TO FALL OUTSIDE STARK

Step 2 – Make sure there is not an “indirect compensation arrangement”

- An “indirect compensation arrangement” requires that there be an unbroken chain of financial relationships (of more than 1) between the referring physician and the DHS entity.

- We have that here: Physician – Management Company – Hospital

- But an “indirect compensation arrangement” also requires that the referring physician receive aggregate compensation from the person or entity with which s/he has a direct comp arrangement (here the management company) that varies with, or takes into account, the volume or value of referrals to, or other business generated for, the DHS entity (here, Hospital)
Step 2 – Make sure there is not an “indirect compensation arrangement” (cont.)

- Unless the Physicians receive aggregate compensation from the Management Company that varies with or otherwise takes into account referrals for DHS to Hospital for other business generated for Hospital, there is no “indirect compensation arrangement” and payments from Hospital are outside of Stark
  - With respect to physician owners of Management Company it is also necessary that payments from Hospital to Management Company do not vary with, or take into account, the $V$ or $V$ of referrals from the physicians to Hospital or other business generated

- If the “aggregate comp” component of the indirect definition is met, the analysis proceeds to the third component, i.e., knowledge by Hospital as to the compensation structure of how Management Company is paying physicians (knowledge element is already satisfied with respect to physician owners of Management Company as they identify with the compensation arrangement between Management Company and Hospital)

- After completing analysis, if there is an “indirect compensation arrangement” the exception for indirect compensation arrangements must be satisfied
  - FMV is required
FALSE CLAIMS ACT 31 U.S.C. 3729-3731

- As amended by the Fraud Enforcement and Recovery Act of 2009 (FERA), liability under the False Claims Act occurs when a person or entity:
  
  (1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
  
  (2) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; or
  
  (3) 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.

- Whistleblower (qui tam) suits are allowed.

- Reverse false claims provision now may reach self-discovered overpayments.

- FCA actions can be based on Anti-kickback Statute and/or Stark Law violation.
IRC § 501(C)(3)

Tax Exemption Rules
- No inurement, private benefit or excess benefits
- Reasonable compensation (base fee, each component of bonus fee, and in aggregate)
  - Not based on service-line net earnings
- Intermediate sanctions for excess benefit transactions with disqualified persons
- IRS guidance for ACOs participating in the MSSP (See Notice 2011-20 and Fact Sheet 2011-11)
  - Consistent with exempt purposes
  - Not UBIT
IRC § 501(C)(3)

Tax Exemption Rules (cont.)

Follow steps for rebuttable presumption of reasonable compensation under intermediate sanctions regulations (IRC § 4958; 26 C.F.R. 53.4958 – IT et. seq.)

- Board/committee obtains appropriate comparability data.
- Members of Board/committee have no personal interest in the arrangement.
- Board/committee approves the arrangement in advance w/o participation by any person with a conflict of interest.
- Document basis for decision, approval date, members present, comparability data, and members recused.
- Board reviews/approves documentation as being reasonable, accurate and complete.
Rev. Proc. 97-13 durational limits, if agreement involves private use of tax-exempt bond-financed space

Notice 2014-67: 5 years, if eligibility for performance award is based on meeting quality performance standards or data reporting requirements, rather than increases in revenues or decreases in expenses of the facility; and the amount of the award is a stated dollar amount, a periodic fixed fee, or a tiered system of stated dollar amounts or periodic fixed fees based solely on the level of performance achieved with respect to the applicable measure.

Otherwise:

- 5 years with 3 year out – if more than 50% of payments are fixed fee payments
- 3 years with 2 year out – if incentive bonus constitutes 50+% of payments
- Termination without cause or penalty
For hospital to pay for co-management services, the services must be performed at a hospital or hospital satellite location.

Section 603 of BiBA—off-campus provider-based facilities established after 11/2/15 will no longer qualify for Medicare HOPD rates; grandfathering for pre-11/2/15 locations.

21st Century Cure Act and OPPS Final Rule

- Exempt (grandfathered) sites:
  - Can’t relocate
  - May add new services (expand clinical service families) without losing OPPS rates
  - Can’t be separately sold, and transactions must retain provider agreement

- Non-Exempt (non-grandfathered) sites:
  - Will continue to be able to bill on a UB
  - Will get paid appx 50% of OPPS rates (they call it MPFS), for now
  - Lose outlier payments, SCH and other benefits
  - Won’t need to write revenue-sharing agreements with physicians

Dedicated Emergency Departments

Relocation kills exception
To meet provider-based standards for an off-campus location, management contract limitations (413.65(h)) apply to co-management contract: i.e., manager can provide clinical staff for on-campus services; but for off-campus locations, clinical staff must be directly employed by hospital, except for practitioners who can bill independently under Medicare fee schedule (e.g., MDs, NPs)
ANTITRUST CONSIDERATIONS

- Sherman Act, § 1 prohibits contracts, combinations and conspiracies in restraint of trade
- Price fixing is *per se* illegal
- Does Service Line Co-Management Agreement provide sufficient financial and/or clinical integration to permit joint pricing (e.g., global payment)?
  - Bonus payments at risk
  - Common clinical protocols and standards
  - Investment in co-management company
- New FTC/DOJ Safety Zone for ACOs participating in the MSSP; sufficient clinical/financial integration for non-risk contracting
  - Safety Zone: 30% v 20% exclusive/30% non-exclusive
  - Change in clinical integration standards from business review letters?
Valuation Considerations
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).

Whether a JV, or solely owned by physicians, the valuation process is largely the same regardless.

Nuances abound however; for example, if solely owned by physicians, Hospital must extricate itself from any “active” participation in committee meeting settings.

The co-management agreement will require replacement or redefinition of existing medical director agreements to accommodate the services provided by the managers. Any remaining medical directors must be paid from the base fee portion of the management fee.
TYPICAL FEATURES OF A CO-MANAGEMENT ARRANGEMENT (CONT.)

- 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 (i.e., 100%).
- 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
  - Though certain clients elect to “disburse” the earned Base Fee on an hourly basis.
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.

- 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).
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 can be used to estimate the “replacement” or “replication” cost of the management/administrative services to be provided by the manager.

Key drivers of this approach include:

- Identification of the sub-services lines to be managed
- Size of each sub-service line
- Indications of whether services managed at one location or several
- Consider adjustments for low score on Market approach

Allows the valuator to establish guidelines of reasonable annual administrative hours required in absence of the arrangement

Important that all sub-service lines are represented by physicians from each indicated specialty

Otherwise, management entity can sub-contract out, or the valuator may make an “adjustment” to the findings
The Market Approach recognizes that there are certain management/administrative requirements associated with every service line management arrangement. Each one is unique.

Key drivers of this approach include:

- Annual net revenue (i.e., collections) attributable to Part A services, as an indicator of the size of the service line
- Specific tasks and responsibilities of the managers
- Adjustments for possible overlapping positions
- Indications of whether services managed at one location or several

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.
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 depending on the sources of annual net revenue (e.g., high % of spine revenue in an Ortho arrangement).

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.

- Make an assessment regarding the split between the base fee and incentive fee components.

Make applicable adjustments based on review of metrics

- 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 3.5% (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? (CONT.)

- 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.

- Who is responsible for monitoring and “re-basing” the metrics?
WHAT DRIVES VALUE? (CONT.)

- Arrangements that are paid on an “hours worked” basis.
  - Runs the risk that the Base Fee is paid in its entirety but only a portion of the assigned tasks were completed
COMMERCIAL REASONABLENESS CONSIDERATIONS

- If no baseline performance data is available, can hospital pay performance bonus during initial period for establishing baseline and improvement targets for later periods?
  - To develop standards and process for collecting, tracking and reporting data?
  - Generally no less than 9 months of “measurement”

- Can the hospital pay for “maintenance” of optimized performance standards?
  - Goal of continuous quality improvement
  - Value of preventing back-sliding and of ramping up new physicians
  - Generally, yes, provided that:
    - The performance is equal or greater than national benchmarks
    - No one metric more than 5%, and 25% in the aggregate

- Can targets be graduated? Weighted?
COMMERCIAL REASONABLENESS CONSIDERATIONS

- Can the hospital pay for performance quarterly in advance, subject to annual reconciliation?
- Do the co-management services overlap with services under any other agreement (e.g., medical director, professional services, shared savings agreement)?
- Can participating physicians be paid different amounts?
  - Based on disproportionate services (e.g., medical director)?
  - Based on extent of meeting performance standards?
COMMERCIAL REASONABLENESS CONSIDERATIONS

- If additional physicians are added or the service line grows, can the co-management fees be increased?
  - Dilution by adding physicians
  - Subject to periodic FMV revaluation; may be affected by growth

- Permissible vs. impermissible motives for arrangement
  - Quality/efficiency improvement
  - Foreclosure of competition
  - Grow volume
Duplicative payments?

- Care must be taken to ensure that employed physicians who are part of co-management arrangements are not double paid for their time.

- “Stacked” quality and cost savings incentives (e.g. co-management + standalone “gainsharing” + employer quality bonus + ACO/CIN distributions that are earned by employed physicians based on performance on cost and quality metrics)

- Employment compensation based solely on wRVUs can be self-normalizing
COMMERCIAL REASONABLENESS
CONSIDERATIONS

Reasonable Stacking or Overlap

Physicians can be drivers of change in hospital care and financial incentives may positively motivate physician behavior, so reinforcement of incentives through multiple arrangements and payment channels can be reasonable, **BUT**

Consideration should be given to potential duplication or overlap when determining FMV and commercial reasonableness

Potential FMV/CR Pitfalls:

- Payments for activities already compensated through other channels
- Patient safety/medical ethics concerns if appropriate quality/monitoring safeguards are absent
- Payments for conflicting incentives
- Payments/amounts that are appropriate under some arrangements but not others - e.g., gainsharing in the context of BPCI participation (F&A waivers) **versus** gainsharing that is not subject to F&A waivers
Arrangements that are a bridge or alternative to co-management rather than a supplement

Sometimes called “co-management,” but not consistent with existing models

Case-specific valuation considerations:

- Accurately defining services/sources of value under the arrangement
- Understanding specific facts and circumstances and connection to “traditional” co-management, if any
- Determining valuation approach/assessing merits and detriments of any single valuation approach (market, cost, income)
- Assessing benefits and feasibility of performing multiple valuation approaches
- Incorporating commercial reasonableness analysis into valuation opinion (is FMV affected by commercial reasonableness?)