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Hospital-Physician Joint Ventures

Complying With Stark Law and Anti-Kickback Statute When Evaluating Models and Structuring JVs

THURSDAY, JANUARY 26, 2012

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

Today's faculty features:

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Hospital-Physician Joint Ventures: New Opportunities After Healthcare Reform

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PPACA Impact on Physician Owned Hospitals

- As of December 31, 2011 approximately 300 physician owned hospitals were open for business
  - At least 40 hospitals were in various stages of development
- A track record of solid success, technological advances and relatively positive reimbursement (when compared with ASCs) made these increasingly popular vehicles for hospital/physician joint ventures

PPACA Impact on Physician Owned Hospitals

- Effective March 23, 2010, the PPACA Changed (almost) Everything
  - Section 6001 (Reconciliation Act Sec. 1106) provides that:
    - Existing physician owned hospitals which had Medicare provider agreements as of **March 23**, **2010 and** projects under development on that date which obtained Medicare provider agreements by **December 31, 2010** were **grandfathered**
    - The amount of physician ownership was frozen in place. The identity of physician owners, however, can change

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PPACA Impact on Physician Owned Hospitals

- Except in very limited circumstances, physician owned hospitals cannot increase their number of licensed operating rooms, procedure rooms and/or beds over those existing on the date of enactment

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PPACA Impact on Physician Owned Hospitals

- **Clarifications Rendered by Regulations.** The PPACA contained glaring inconsistencies in the text relating to physician owned hospital deals and substantial questions were created by the legislation's other provisions
  - Regulations which were issued by CMS in late 2010 on the PPACA's physician owned hospital provisions substantially cleared up the questions created by the statute itself:
    - "Grandfathered" hospitals have 18 months from the date of enactment to comply with the statute's provisions regarding disclosure of ownership, etc.
    - Ownership by non-referring physicians need not be counted as part of "frozen" physician ownership

PPACA Impact on Physician Owned Hospitals

- **Clarifications Rendered by Regulations cont.**
  - Physician ownership can temporarily decrease (e.g. be redeemed by a hospital joint venture partner) and return back to the higher levels which existed when the PPACA was enacted
  - Though severe restrictions on expansion exist hospitals can increase the number of ORs, procedure rooms, or beds as long as the **aggregate** number of all three does not increase. For example, a hospital could add two ORs if it removed two licensed beds
  - Because of the narrow manner in which items such as "procedure rooms" are defined (rooms in which catheterizations, angiographies, and endoscopies are performed) Physician owned hospitals can expand significantly in the **service lines** they offer, e.g. imaging facilities, hyperbaric medicine chambers, urgent care centers, addition of outpatient beds.

PPACA Impact on Physician Owned Hospitals

- **Bottom Line**: Hospital/physician integration on small, focused facilities is **not** dead in the water:
  - Grandfathered facilities can continue to function as they presently do
  - CMS regulations permit substantial flexibility
  - Although the Stark "whole hospital exception" is closed by the PPACA, other Stark law exceptions are still available
    - Management/Co-Management Relationships (discussed below)
    - Ownership through a public entity
      - Shareholder equity of over $75,000,000 plus listed on an exchange

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PPACA Impact on Physician Owned Hospitals

- **Bottom Line cont.**
  - Integration involving economic ties which do not comprise "financial relationships" for Stark law purposes
    - not for profit entities (foundations, etc)
    - Isolated transactions (non-secured promissory notes)
  - Restrictions on Physician Owned Hospitals might be the first of the PPACA Restrictions on Joint Ventures to be removed.
    - In late 2011 the U.S. House of Representatives passed a provision which would have granted relief to those hospitals which didn't make the December 31, 2010 deadline.

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New Payment Models

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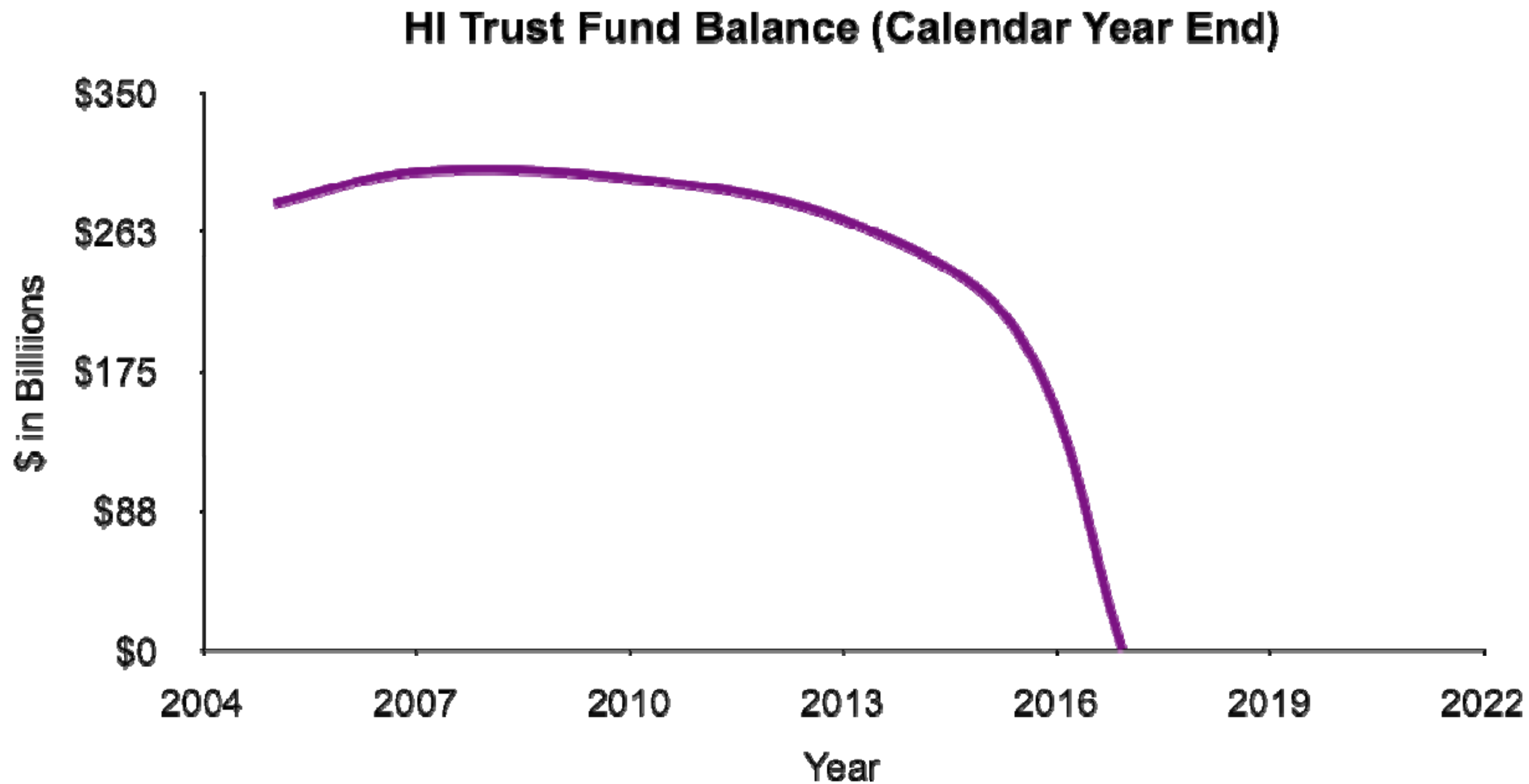
Background

THE DARTMOUTH INSTITUTE
FOR HEALTH POLICY & CLINICAL PRACTICE
Where Knowledge Informs Change

- Dartmouth Atlas of Health Care Spending
  - Higher spending doesn't lead to better quality or outcomes.
  - If the most intensive and expensive hospitals adopted the practices of the high-quality but lower-spending centers, Medicare could save $50 billion a year.
    - » http://www.dartmouthatlas.org/

Background - Bending the Cost Curve



Source: Kaiser Family Foundation, CMS, Social Security Administration, USA Today

Overview of PPACA Payment Reform Provisions

- PPACA Title III Improving the Quality and Efficiency of Health Care
  - Hospital value-based purchasing – Incentive program to begin FY 2013, funded by reduction in base payment amount (§ 3001)
  - Physician Quality Reporting Initiative extended and penalty imposed for failure to submit measures starting in 2014 (§ 3002, as amended by § 10327)
  - Quality measure reporting programs for long-term care hospitals, inpatient rehabilitation hospitals, psychiatric hospitals and hospices by FY 2014 (§ 3004, as amended by § 10322)

Overview (Cont'd)

- Value-based purchasing for skilled nursing facilities, home health agencies and ambulatory surgery centers - Secretary of Health and Human Services to submit a plan to Congress by FY 2012 (§ 3006, as amended by § 10301)
- National strategy to improve health care quality - web site, Interagency Working Group on Health Care Quality, and funding for development of quality measures (§§ 3011-15, as amended by §§ 10302-05)
  - Information on the National Quality Strategy is at http://www.ahrq.gov/workingforquality/#nqs

Overview (Cont'd)

- New patient care models (§§ 3021-27, as amended by §§ 10306-09)
  - Center for Medicare and Medicaid Innovation (§ 3021, as amended by § 10306);
  - Shared savings program with accountable care organizations by 2012 (§3022, as amended by § 10307);
  - National pilot program bundling payment for hospitals, physicians and post-acute care providers by January 1, 2013 (§ 3023, as amended by § 10308); and
  - Program penalizing hospitals for preventable readmissions beginning October 1, 2012 (§ 3025, as amended by § 10309).

Center for Medicare and Medicaid Innovation

- Officially launched in November 2010
  http://innovations.cms.gov/
- Established to test models that will reduce expenditure while preserving or improving quality of care
- Preference given to models that improve coordination, quality and efficiency
- $10 billion budget authority FY2011-2019
- Current initiatives and demonstrations include:
  - Accountable Care Organizations, Pioneer ACOs, Advance Payment Model
  - Bundled Payments
  - Comprehensive Primary Care Initiative
  - FQHC Medical Homes
  - Health Care Innovation Challenge Grants

Hospital Value-Based Purchasing Program

- PPACA requires HHS to select measures and establish performance standards
  - Not to include readmission
  - Measure must be on Hospital Compare for at least one year before performance period
  - Levels of achievement and improvement to be included
  - Must be established and announced at least 60 days before performance period
- Performance period for each fiscal year must end prior to the beginning of that fiscal year
- Incentive payment calculated as percentage of hospital's base DRG payment per discharge

Hospital Value-Based Purchasing Program (Cont'd)

- Program funded through reduction of base DRG rates
  - One percent in FY 2013
  - Increases by 0.25% per year to two percent in FY 2017 and after
  - Hospital notification of 1% reduction amount to be in FY 2013 IPPS final rule
- VBP Final Rule – 76 Fed. Reg. 26490 (May 6, 2011)
  - FY 2013 payment adjustment
  - Baseline period of July 1, 2009 to March 31, 2010
  - Performance period of July 1, 2011 to March 31, 2012
  - 12 clinical process of care measures on heart failure, AMI, pneumonia and surgical care and 8 HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems Survey) dimensions
  - Performance weighted 70% process of care and 30% patient experience
  - Process measures scored based on attainment and improvement
  - For FY 2014, an outcomes domain to be added including three 30-day mortality measures (AMI, HF, pneumonia), 2 AHRQ composite measures (patient safety and mortality) and 8 hospital-acquired conditions

Hospital Value-Based Purchasing Program (Cont'd)

- FY 2012 IPPS Final Rule
  - Adds a fourth efficiency domain for FY 2014
  - Spending per beneficiary using episode of care from 3 days pre-admission to 30 days post-discharge
- CY 2012 OPPS Rule
  - Concluded CMS would publicly report hospital performance on VBP program measures for one year prior to commencement of performance period
  - Suspended effective date for spending per beneficiary domain, AHRQ composite measures and hospital-acquired conditions – not to be implemented in FY 2014. Intend to adopt for future years.
  - Finalized measures for FY 2014 – 13 clinical process measures (added measure for postoperative removal of catheter); 8 dimensions of HCAHPS; 3 outcomes measures – 30-day mortality
  - FY 2014 performance weights: 45% process of care, 30% patient experience, 25% outcomes
    - OPPS proposed rule would have weighted FY 2014 performance 20% process of care; 30% patient experience; 30% outcomes; 20% efficiency

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Hospital Readmissions Reduction Program

- PPACA provides for reduction in base operating DRG payment for hospitals with excessive readmissions
- FY 2012 IPPS Final Rule
  - Applicable conditions for FY 2013: AMI 30-day readmission; heart failure 30-day readmission; pneumonia 30-day readmission (NQF-endorsed measures)
  - Measurement period: Discharges from July 1, 2008 to June 30, 2011
  - Excess Readmission Ratio is ratio of actual readmissions to risk adjusted expected readmissions during measurement period
    - Compares total adjusted actual readmissions at hospital to number that would be expected if hospital's patients treated at an average hospital with similar patients
    - Average rate is one; if worse than average ratio is greater than one; if better than average ratio is less than one
  - FY 2013 IPPS Rule will address calculation of base DRG and adjustment factor

Accountable Care Organizations - Overview

- Under PPACA, HHS to establish shared savings program (MSSP) by 1/1/2012
  - Promote accountability for patient population
  - Encourage investment in infrastructure and redesigned care processes
- Providers must form an Accountable Care Organization (ACO) and apply to CMS to participate
- ACO is legal entity comprised of hospitals, physicians and other providers who are jointly responsible for quality and cost of care for a population of at least 5,000 beneficiaries
- ACO providers receive fee-for-service payments and potentially share in savings or loss

Accountable Care Organizations - Reimbursement

- Track One and Track Two Options
  - Track One shares in savings; Track Two shares in savings and losses
  - Proposed rule - ACOs in Track One required to share in losses during third year of initial agreement period
  - Final rule - ACOs in Track One do not share in losses during the initial agreement period
  - Only Track Two available for participation after the initial agreement period
  - Final rule permits ACO with a net loss during first agreement period to continue to participate if it meets all other requirements
    - Must identify reason for net loss and safeguards to improve

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Accountable Care Organizations - Reimbursement (Cont'd)

- Calculation of Benchmark
  - Benchmark calculated based on Part A and B FFS expenditures of beneficiaries who would have been assigned to the ACO during the prior 3 years, using ACO participant TINs
- Adjustment of Benchmark
  - Benchmark trended forward annually during the agreement period based on national growth rate in Medicare Part A and B FFS expenditures
  - Limited annual adjustment of the risk score
    - Newly assigned beneficiaries – annual update of ACO's CMS-HCC prospective risk score
    - Continuous beneficiaries – adjust using demographic factors; update CMS-HCC prospective risk score only if it declines
  - Benchmark will be re-based for each agreement period

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Accountable Care Organizations - Reimbursement (Cont'd)

- Eligibility for Shared Savings
  - Savings calculated by comparing actual performance year expenditures against benchmark for the performance year (as adjusted)
  - Savings must exceed Minimum Savings Rate
    - Track One - MSR range from 2% for ACO with 60,000 beneficiaries to 3.9% for ACO with 5,000 beneficiaries
    - Track Two - MSR is 2%
  - Eligibility contingent on ACO meeting minimum quality attainment level

Accountable Care Organizations – Reimbursement (Cont'd)

- Quality Measures
  - Attainment of minimum quality required for shared savings, and amount of shared savings or losses will depend on quality score
  - Final rule has 33 quality measures in 4 domains:
    - *Patient/care giver experience* - 7 HCAHPS measures
    - *Care coordination/patient safety* - risk-standardized, all condition readmission; ambulatory sensitive condition admissions for COPD and CHF; percentage of PCPs qualifying for EHR incentive; medication reconciliation after discharge; screening for fall risk
    - *Preventive health* – flu and pneumonia vaccines; weight screening and follow-up; tobacco use and cessation intervention; depression, colorectal cancer and mammography screening; blood pressure measurement
    - *At-risk populations* – measures addressing treatment of diabetes, hypertension, ischemic vascular disease, heart failure, coronary artery disease
  - First year payment based on full and accurate reporting
  - Performance on measures phased in during year two and year three
    - 25 measures subject to pay for performance in year 2
    - 32 measures subject to pay for performance in year 3

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Accountable Care Organizations – Reimbursement (Cont'd)

- Shared Savings Payment - Track One
  - Once savings equal or exceed MSR, ACO shares in savings from first dollar
  - Track One sharing rate of up to 50% based on quality performance score
  - Track One payment limit of 10% of the benchmark for the performance year
- Shared Savings Payment - Track Two
  - Once savings equal or exceed MSR, ACO shares in savings from first dollar
  - Track Two sharing rate of up to 60% based on quality performance score
  - Track Two payment limit of 15% of the benchmark for the performance year

Accountable Care Organizations – Reimbursement (Cont'd)

- Track Two Shared Loss
  - ACO not required to share in losses until losses exceed 2% (Minimum Loss Rate)
  - Once losses exceed MLR, ACO shares in losses from first dollar
  - ACO's loss share depends on quality score
    - Inverse of savings: one minus final shared savings rate
    - ACO loss share maximum of 60%
  - Loss sharing limit equal to percentage of benchmark for the performance year
    - 5% in year one, 7.5% in year two, 10% in year three

Accountable Care Organizations – Waiver Rules

- Waivers address application of Anti-Kickback Statute, Stark Law and CMP Law to ACOs
- Shared savings distribution waiver
  - Laws waived with respect to distribution or use of shared savings earned by an ACO under MSSP if ACO is a participant in good standing in MSSP, shared savings are distributed among ACO participants or used for activities related to the purposes of the MSSP, and with respect to waiver of the CMP Law, not made knowingly to induce physician to reduce or limit *medically necessary* items or services to patients
  - "Purposes of MSSP" are promoting accountability for quality, cost and overall care for Medicare patient population; managing and coordinating care for Medicare beneficiaries through the ACO; or encouraging investment and infrastructure and redesigned care processes for high quality and efficient service deliver for patients, including Medicare beneficiaries
- Waiver for compliance with Stark Law
  - Anti-kickback statute and CMP Law waived for financial relationships among ACO and its participants if ACO is a participant in good standing in MSSP, and the financial relationship is reasonably related to the purposes of the MSSP and fully complies with an exception under the Stark Law.

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Accountable Care Organizations – Waiver Rules (Cont'd)

- Waiver for pre-participation arrangements
  - Laws waived for ACO start-up arrangements for a limited period defined based on the application timeframe, and may be used by an ACO only one time if meet all criteria below
  - Good faith intent to develop an ACO and submit an application
  - ACO and at least one ACO participant eligible to form an ACO participate in arrangement (no drug and device manufacturers, distributors, DME suppliers or home health suppliers)
  - Taking diligent steps to develop an ACO that will meet MSSP rule requirements
  - ACO governing body makes bona fide determination that arrangement is reasonably related to purposes of MSSP
  - Contemporaneous documentation created and retained for at least 10 years containing details specified in the waiver rule
  - Description of the arrangement (not including the financial terms) publicly disclosed in a manner to be established by HHS
  - If the ACO does not submit an application for the targeted year, it files a statement on or before the last application due date for the targeted year explaining why it was unable to submit an application

Accountable Care Organizations – Waiver Rules (Cont'd)

- Waiver for arrangements during MSSP participation
  - Laws waived for arrangements of an ACO, one or more of its participants, or a combination of those parties for a period from commencement of participation agreement until six months after expiration or ACO's voluntary termination of the participation agreement (or until date of CMS termination) if meet all criteria below
  - ACO has entered into MSSP participation agreement and is in good standing.
  - ACO meets requirements of MSSP rules concerning governance, leadership and management
  - ACO's governing body made a bona fide determination that arrangement is reasonably related to purposes of MSSP
  - Contemporaneous documentation created and retained for at least 10 years containing details specified in the waiver rule
  - Description of the arrangement (not including the financial terms) publicly disclosed in a manner to be established by HHS

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Payment Bundling Pilot

- PPACA requires HHS to establish five-year national pilot program by January 1, 2013
  - May expand duration after January 1, 2016
- Entity eligible to apply must include hospital, physician group, SNF and home health agency
  - HHS to develop requirements for participation, quality measures and reporting requirements

Payment Bundling Pilot (Cont'd)

- Bundled payment for single episode of care – unless otherwise determined by HHS, this consists of
  - Three days prior to hospital admission
  - Length of hospital stay
  - Thirty days following discharge
- Bundled payment covers all "applicable services"
  - Acute care inpatient services
  - Physicians' services (inside and outside of hospital setting)
  - Outpatient hospital services (including emergency room)
  - Post-acute services, including home health, SNF, inpatient rehabilitation, LTCH
  - Other services as determined by HHS

Payment Bundling Pilot (Cont'd)

- HHS to establish quality measures, including
  - Functional status improvement
  - Rates of avoidable hospital readmissions
  - Rates of discharge to community
  - Rates of admission to ER after discharge
  - Incidence of hospital-acquired infections
  - Efficiency measures
  - Measures of patient-centeredness
  - Measures of patient perception of care
- Participating entities must submit data in form and manner specified by HHS

Bundled Payment Initiative

- CMMI announced *Bundled Payments for Care Improvement Initiative* and published a request for application for interested providers on August 23, 2011
  - Not a formal precursor to PPACA pilot, but will help inform future activities
  - LOI was due in 2011
- Providers permitted to submit applications to participate in one or more of four different models, which differ in payment methodology, participants and scope of care covered

Bundled Payment Initiative (Cont'd)

- General Provisions
  - Acute care hospitals paid under IPPS, health systems, PHOs, physician group practices and conveners of participating providers are eligible awardees under all of the models. Post-acute care providers are also eligible as awardees under Models 2 and 3.
  - To qualify, hospitals must have received the full IPPS and OPPS annual update for reporting quality measures to CMS since at least FY 2008 and CY 2009, respectively
  - Applicants must propose quality measures; a standardized set of quality measures ultimately will be established for Models 2-4
  - All applicants expected to track and report on various measures, including cost savings, incentive payments, clinical quality and patient satisfaction

Bundled Payment Initiative (Cont'd)

- *Model 1 – Discounted Payment for Inpatient Hospital Stay*
  - Episode is the inpatient hospitalization (including 3-day window)
  - Covers all Medicare inpatient admissions, regardless of MS-DRG
  - Hospital must report full set of measures under IQR, including CMS informational and voluntary measures, and propose additional quality measures
  - Hospital paid a discounted rate on all MS-DRGs (to be proposed, subject to required minimum discounts) and physicians paid at normal Medicare rates
  - Aggregate Medicare Part A and Part B spending monitored during episode of care *and* for 30 days after discharge. If aggregate expenditures exceed trended historical aggregate Part A and Part B payments by more than a risk threshold amount, awardee required to pay Medicare that excess
  - Financial benefit to the hospital is ability to achieve gains by decreasing costs included in the discounted IPPS payment to an extent greater than the discount

Bundled Payment Initiative (Cont'd)

- *Model 2 – Retrospective Bundled Payment for Inpatient Hospital Stay and Post-Acute Care*
  - Episode is inpatient hospitalization (including 3-day window) plus at least 30 days after discharge. All hospital and physician services, plus services of post-acute care providers, included in bundled payment. Applicants to propose the MS-DRGs that will be included, and services, such as unrelated admissions, that will be excluded
  - Standard Medicare payments during episode with retrospective reconciliation against an agreed-upon discounted target price for the episode. Longer post-discharge periods encouraged by permitting lower discount
  - Awardee responsible at reconciliation for all costs, including services of non-affiliated providers. If costs less than agreed target price, awardee paid all savings
  - Awardee also responsible for any excess costs during 30-day post-episode monitoring period

Bundled Payment Initiative (Cont'd)

- *Model 3 – Retrospective Bundled Payment for Post-Acute Care Only*
  - Like Model 2, but covers post-discharge period only
  - Episode begins with date, within 30 days of hospital discharge, that post-acute care services are initiated by a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency, and continues for at least 30 days thereafter
  - All related Part A and Part B services provided during episode, including related readmissions, included in the bundled payment. Applicants to propose MS-DRGs that will be included, and services, such as unrelated admissions, that will be excluded
  - Reconciliation and 30-day post-monitoring period similar to Model 2

Bundled Payment Initiative (Cont'd)

- *Model 4 – Prospective Bundled Payment for Inpatient Hospital Stay*
  - Based on ACE Demonstration
  - Single bundled payment for all hospital and physician services during an inpatient stay (including 3-day window) and any related readmission
  - Applicants to propose the MS-DRGs that will be included, and post-discharge period during which related readmissions included (at least 30 days)
  - Agreed-upon bundled payment made to hospital on claims submission at discharge. Hospital makes payments to physicians at rate agreed upon by physicians; physician bills processed by CMS as "no pay"

Bundled Payment Initiative (Cont'd)

- Gainsharing
  - Initiative contemplates hospital may give physicians a share of any reduction in the hospital's costs for patient care attributable in part to the physicians' efforts
  - Gainsharing implicates CMP Law, which imposes a penalty on any hospital that "knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services" provided to Medicare or Medicaid beneficiaries under the physician's care
  - Gainsharing payments may influence a physician's choice of hospitals, and are not readily amenable to an assessment of fair market value for readily identifiable services – raises risks under the Anti-Kickback Statute and the Stark Law

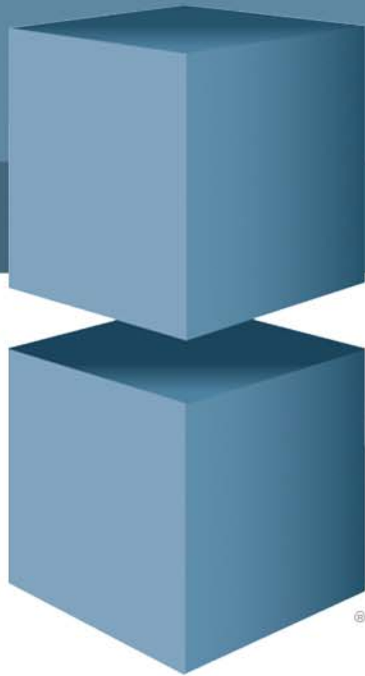
Bundled Payment Initiative (Cont'd)

- CMS use of authority under PPACA to provide waiver under initiative
  - Applicants required to describe gainsharing arrangements in detail in application
  - Physician participation in gainsharing must be voluntary
  - Physicians must not reduce or limit medically necessary services
  - Arrangements must be transparent and auditable
  - Individual physicians and other practitioners must be required to meet quality thresholds and engage in quality improvement to participate in gainsharing
  - Applicants must specify the minimum quality thresholds, monitoring process and metrics for improving quality that will be used
  - Payments may not be based on volume or value of referrals, but payments based on savings achieved are expressly permitted
  - Payments to physicians and other practitioners may not exceed 50% of the professional fees they would normally receive for cases included in the gainsharing program

Paradigm Shift

- From fee-for-service to value-based payment
- From volume to efficiency and quality
- From payment for individual services to payment for coordinated patient care
- From acute care to wellness
- From regulatory scheme that limits financial relationships to one that encourages collaboration?

Physician Employment and Facility Joint Ventures



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Agenda

- Physician Employment Models and Issues
- ASC Co-Ownership
- Conversion of ASCs to Hospital Outpatient Departments

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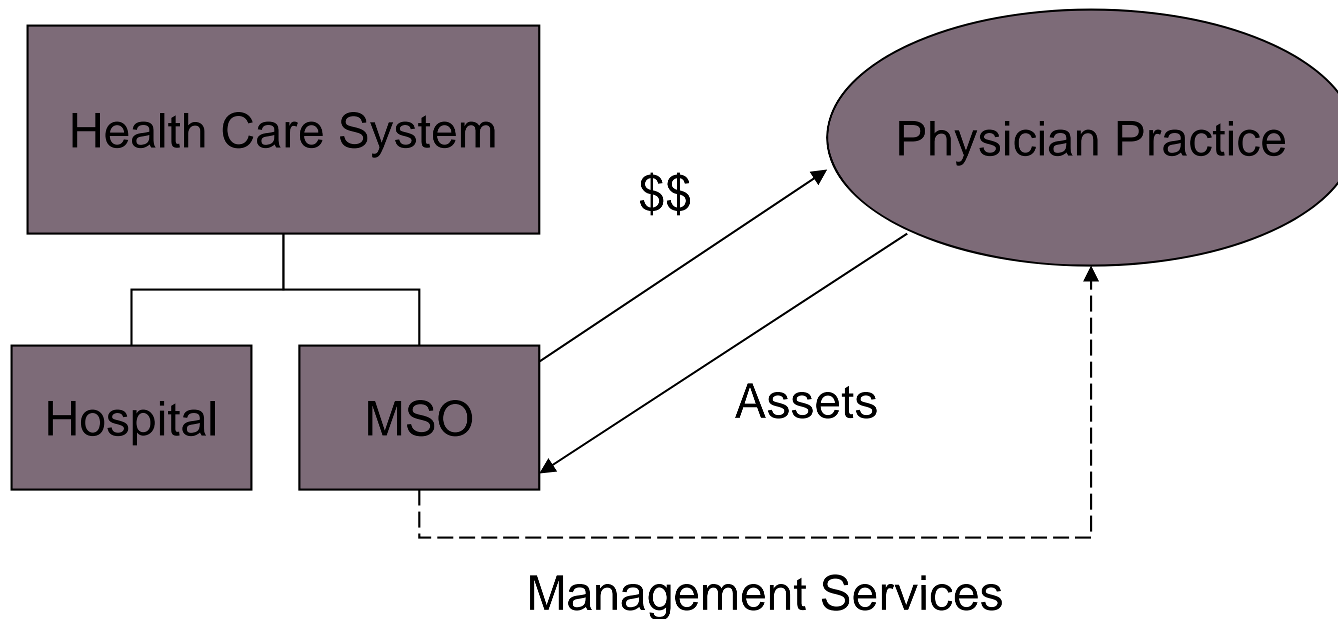
Typical Transaction Structures
MSO Model



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Typical Transaction Structures
MSO Model

- MSO acquires tangible assets of the Physician Practice
- Physician Practice remains independent
- MSO provides turn-key management services to Physician Practice
  - Equipment
  - Physician extenders
  - Billing
  - Collections
  - Accounting

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Typical Transaction Structures
MSO Model

- Purchase price limited to value of hard assets
- Physicians relieved of burdens of:
  - Capital investment
  - Administration of practice
- Physician Practice remains at risk for reimbursement and physician compensation
- MSO services must be provided at FMV

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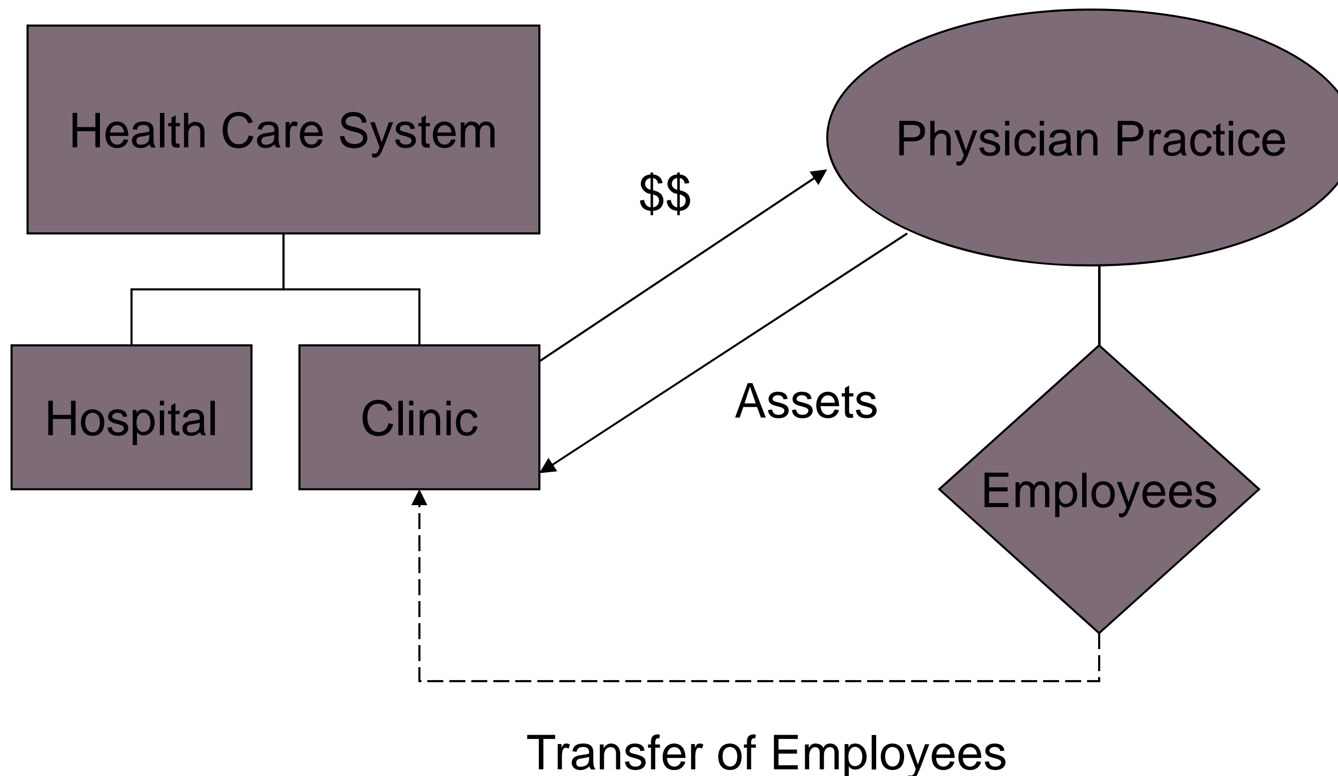
Typical Transaction Structures
Full Asset Purchase/Employment



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Typical Transaction Structures
Full Asset Purchase/Employment

- Assets of Physician Practice are purchased by Health System Clinic at fair market value
- Physician employees, along with clinical and non-clinical staff become employees of Health System Clinic
- Physician employees are compensated at fair market value in Stark Law compliant employment arrangements

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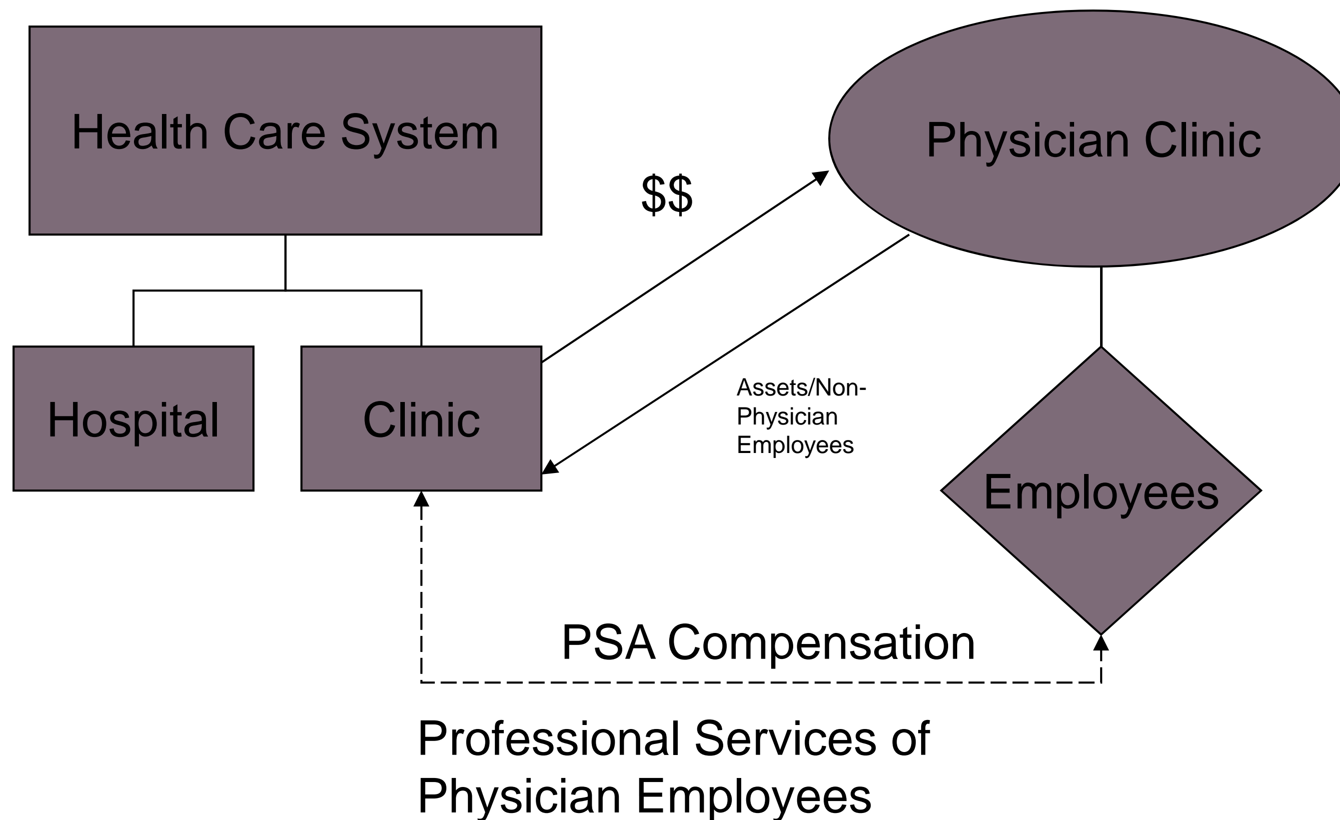
Typical Transaction Structures
Asset Purchase/PSA Arrangement



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Typical Transaction Structures
Asset Purchase/Foundation

Assets

Health Care System
501(c)(3)

Hospital

Foundation
501(c)(3)

Physician Clinic

Employees

PSA Compensation

Professional Services

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Typical Transaction Structures
Asset Purchase/PSA Arrangement

- Assets of Physician Practice are purchased by Health System Clinic or Foundation at fair market value
- Clinical and non-clinical staff become employees of Health System Clinic or Foundation
- Physicians remain employed by Physician Practice and enter into a long-term professional services arrangement to provide professional medical services to Health System Clinic or Foundation for fair market value compensation, which may include a medico-administrative fee
- Health System Clinic or Foundation retains right to bill for physician services
- Clinic or Foundation operated as 501(c)(3) organization

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Typical Transaction Structures
Asset Purchase/PSA Arrangement

- Model works best in states where corporate practice of medicine is an issue
- Physician relieved of burden of capital investment and administration of Physician Practice
- Physicians remain responsible for their compensation utilizing PSA compensation
- PSA compensation can be structured utilizing various compensation methods
- Reasonableness of compensation tested at PSA level and not at the physician practice level

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Physician Compensation Models

- Very few "guaranteed" salary models (mistakes of the 80s/90s transactions)
- Physicians generally compensated through production based models
  - Revenue *minus* expenses
  - Base compensation *plus* incentive compensation (incentive at risk)
  - Work relative value unit production (WRVUs allocated to CPTs)
  - Incentives for quality, good citizenship, etc.
- Compensation must meet Stark Law exception
  - Fair market value a critical component

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Physician Compensation Models

- Physician Compensation
  - Physician compensation must meet Stark Law bona-fide employment exception
  - AKS compliance requires “only” that physicians are bona-fide employees
  - Tax exemption concerned about excess benefit transactions and private inurement/private benefit issues
  - Most compensation plans are production based
  - All plans must yield compensation that is FMV
  - Possible to structure compensation to include ancillaries (DHS)
  - Consider the interplay between the purchase price paid for ancillary service lines and physician compensation

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Critical Business Issues

- Valuation Issues
  - All regulatory analyses turn on FMV
  - Formal valuations close the gap between perception and reality
  - Most tax exempt systems insist on third party valuations of physician practices
  - Physician professional component generally has relatively low valuation
  - Most value embedded in ancillary businesses that spin off cash flow (imaging, ASC, lab)
  - Certain intangible assets have value
    - Workforce in place
    - Medical records
    - Trademarks and trade names
  - Use of “stay bonuses”
  - Payments for covenants not to compete

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Critical Business Issues

- Transaction Issues
  - Purchase price
    - Consider tax consequences to physicians
    - Installment payments v. lump sum payment
  - No more “covenant” light deals
  - Certain percentage of “inked” physicians contracts as a condition to closing
  - Regulatory approvals
  - Indemnity escrows

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Facility Joint Ventures

- ASC facility joint ventures, whether de novo developments or acquisitions of existing facilities, remain a viable means to align physician and hospital interests
  - Physician investments in ASCs, generally, do not implicate the Stark Law
  - Increasing JV activity due to reimbursement “lift” that is possible with a hospital partner (existing ASCs)
  - Some physician-owned facilities are being purchased outright by hospitals and converted into hospital outpatient surgery departments, coupled with physician management/co-management of the department
- Considerable JV activity in the physician-owned hospital space due to changes occasioned by §6001 of the PPACA of 2010.

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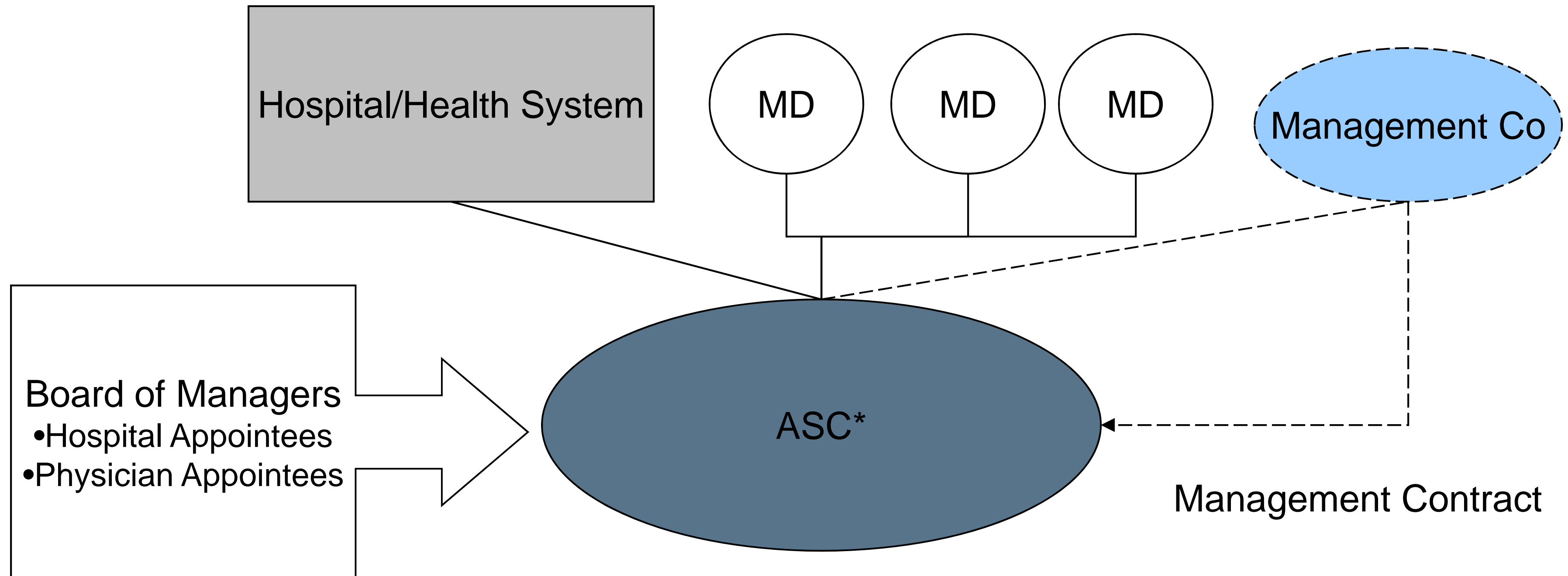
Typical ASC Structure Hospital and Physician Participants



*Sometimes formed as an LLC or as a Limited Partnership

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ASC Ownership Structure

- Ambulatory Surgery Center company is generally formed as a limited liability company. In some states it may be advantageous to form it as a limited partnership
- Ownership interests are owned by the Hospital/Health System and individual physicians. *In some structures, a manager/developer also may own equity (optional).*
- Equity splits will depend upon (i) tax exemption issues, (ii) whether or not the Hospital will “compete” with the ASC and (iii) whether or not the ASC and the Hospital will jointly seek managed care and other third party payer arrangements

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ASC Ownership Structure

- Physician Members (owners) should be limited to those physicians for whom an ASC setting is an “extension” of their practice
  - Physician generates 1/3 of his/her practice income from ASC procedures (surgeon only)
  - Physician will do at least 1/3 of his/her ASC procedures in the ASC (multi-specialty)
  - Failure to meet one or both of the tests can result in loss of ownership
  - 42 CFR §1001.952(r)(1)-(4)

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ASC Ownership Issues

- Physicians will be required to divest their ownership in the event of:
  - Failure to meet "1/3" tests (see previous slide)
  - Death or disability
  - Complete retirement from the practice of medicine
  - Relocation
  - Material breach of operating agreement including failure to meet ownership qualifications (*e.g.,* licensure, malpractice insurance, staff membership, etc.)
  - Regulatory unwind
- Divestiture generally at fair market value, except if for (i) breach of Operating Agreement or (ii) failure to meet "1/3" test
- All owners may be required to guarantee their proportionate percentage (based upon ownership percentages) of ASC company debt,

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Structural Managed Care Contracting Issues

- Most managed care contracts will only allow hospital/health system “affiliates” (or a term of like import) participate in hospital/health system managed care contracts.
- If it is contemplated that the ASC is to benefit from Hospital Member’s current (and future) managed care contracts as an “affiliate” of the Hospital, it likely will be necessary that the Hospital own at least 51% of the equity of the ASC Company

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Structural Antitrust Issues

- If the Hospital Member intends to continue to maintain its outpatient surgery service and if the ASC and the Hospital Member are located in the same geographic market, Federal and state antitrust laws may be implicated
- If the Hospital Member and the ASC wish to jointly (in concert) negotiate managed care contracts and take other joint financial action, the structure should comply with the antitrust laws
- This may require the ASC Company to be structured in a way that allows the Hospital Member to treat it as the economic equivalent of a subsidiary
- This is accomplished by giving the Hospital voting control (either through Board control or as a Member) over certain major financial decisions:
  - Approval of Budgets
  - Approval of Strategic Plans
  - Approval of Managed Care Contracts
  - Approval of the sale of assets, mergers, acquisitions, etc.
  - Approval of incurrence of material indebtedness and material expenditures
  - Etc.
- Physicians may still have control over non-financial (clinical) decisions if so desired

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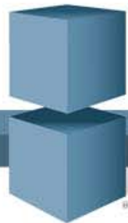

Acquisition of Physician Owned Radiology Hospital and Physician Participants

Hospital/Health System

Rad

Rad

Rad

Assets

Acquisition Co (HOPD)

Imaging Center

Radiology Management Co

$$$

Management Contract

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Acquisition of Physician Owned ASC Hospital and Physician Participants

Hospital/Health System

MD

MD

MD

Assets

Acquisition Co (HOPD).

ASC Co.

ASC Management Co

$$$

Management Contract

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HOPD Acquisitions

- Variation on joint venture structure
- Involves the outright acquisition of physician owned facilities such as ambulatory surgery centers and imaging centers
- Trend is driven by HOPD reimbursement which, in many instances, is 30-40% higher than stand-alone facility reimbursement (IDTF or physician office) and 60% or more than ASC reimbursement
- Business are purchased at fair market value and converted to HOPD
- Physicians form a management company to manage/co-manage the purchased facility
- Consider impact of *Bradford* decision on the purchase price

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Management and Co-Management Arrangements

- A variety of factors have contributed to renewed emphasis on management (and co-management) relationships between hospitals and physicians
  - Pressures imposed by generally **decreasing** reimbursements
  - Increased focus on **quality** and **efficiency**
  - October 2009 changes to Stark law invalidating many "under arrangement" joint ventures
  - Physician and/or hospital reluctance to enter into physician employment arrangements

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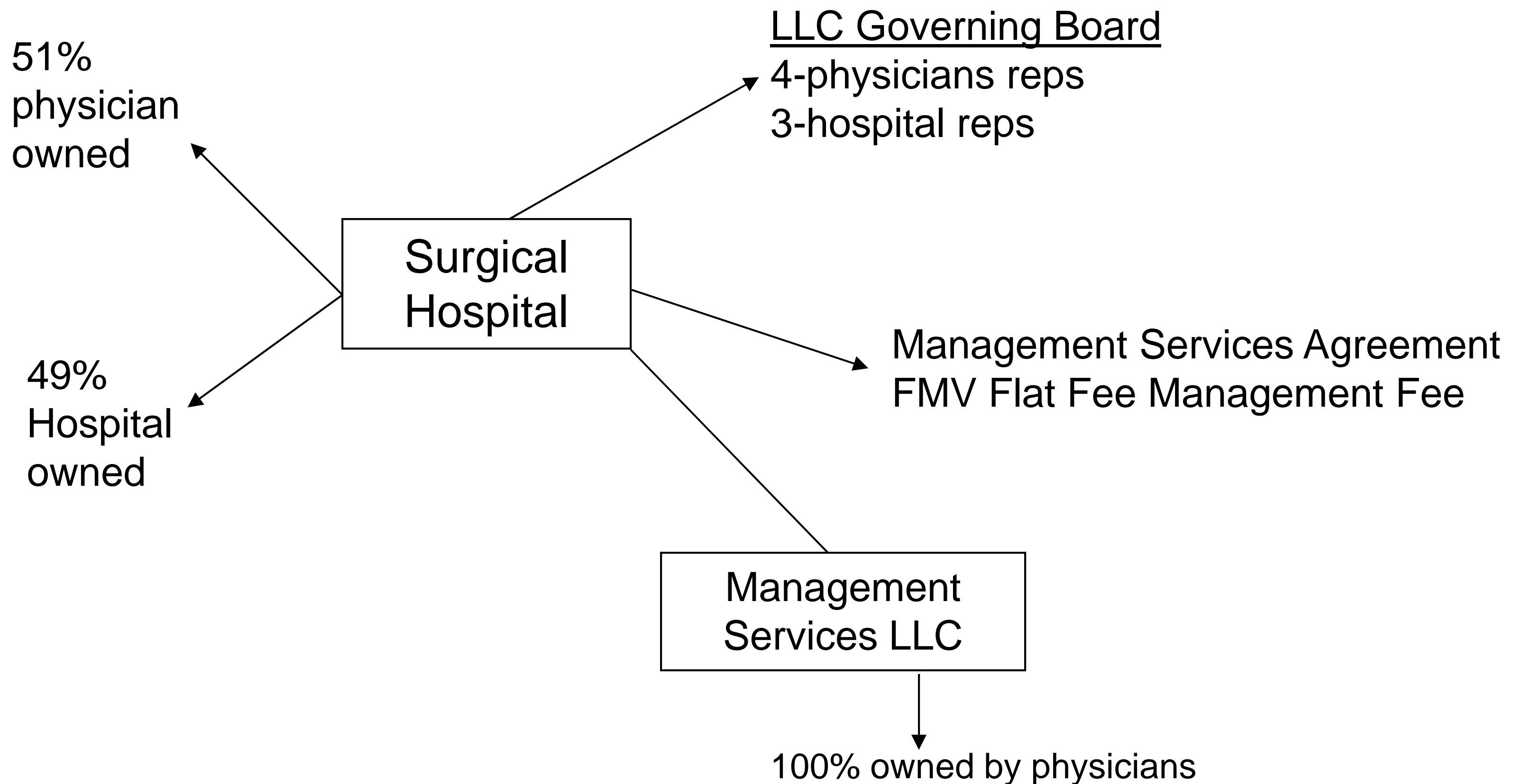
Management and Co-Management Arrangement

- Management Relationships have been a long time fixture on the health care landscape.



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Management and Co-Management Arrangements

- Co-Management Arrangements increasingly utilized to:
  - Directly involve physicians in the performance of a **comprehensive** array of services involved in the delivery of a health care service line (e.g. outpatient surgery, cardiology, etc.)
  - More thoroughly **engage** physicians in the efficient delivery of services by placing a substantial portion of the compensation payable **at risk** if predetermined goals and objectives are not met

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Management and Co-Management Arrangements

- Common Attributes of a Co-Management Arrangement
  - **Uniquely tailored** contract between a physician, group of physicians, or JV entity and a hospital
    - No “off the shelf approach”
    - JV may be 100% physician owned or owned by the physicians at the hospital
    - FMV **fixed** component fee
    - **“At risk**” component of fee payable upon the achievement of numerous administrative and/or clinical benchmarks

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Management and Co-Management Arrangements

- The Co-Management Agreement is intended to absorb the prior relationships between the parties such as medical director agreements and complement them with a more broad slate of services and metrics by which progress will be tracked
  - Services may include patient scheduling, medical director services, case management activities, materials management, etc.
  - Metrics will **specifically** identify the total amount which may be paid if all targets are met and the percentage of the total which is assigned to any particular measured item

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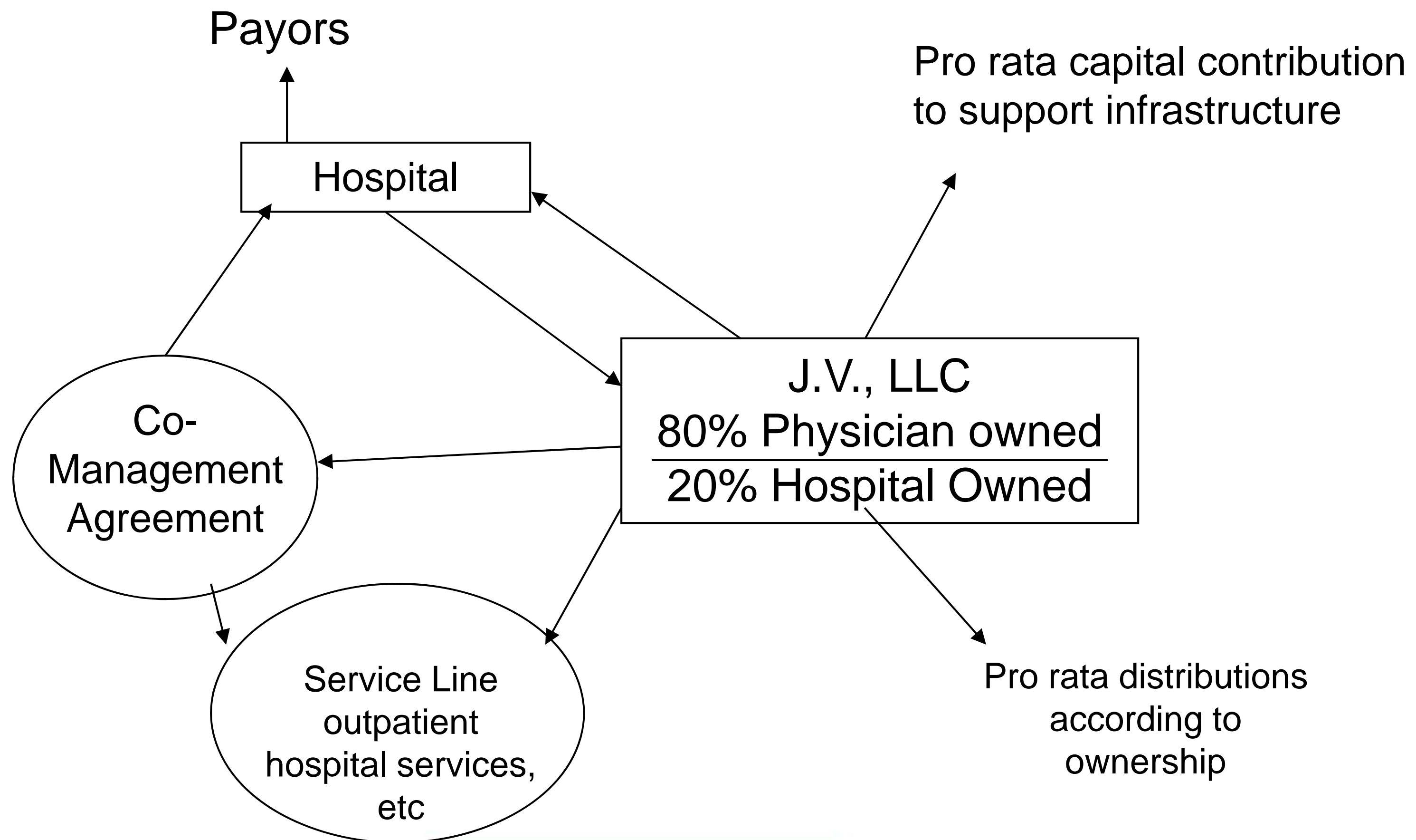
Management and Co-Management Arrangement

- Sample Co-Management J.V. Model



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Management and Co-Management Arrangements

- Regulatory Considerations for both Management and Co-Management Arrangements
  - Third Party Appraisals !!
  - Federal and State Anti-kickback Statute, 42 U.S.C. 1320a7-b(b)
  - Federal and State Self Referral Statute (Stark Law), 42 U.S.C. 1395nn

Management and Co-Management Arrangements

- Federal Anti-kickback Consideration
  - Criminal statute requiring intent to violate
  - Imposes liability on **all** sides where improper remuneration is offered, solicited or received in order to influence referrals of covered services

Management and Co-Management Arrangements

- **Anti-Kickback Statute Personal Services and Management Contracts Safe Harbor - 42 C.F.R. § 1001.952(d)**
  - The agreement is set out in writing and signed by the parties;
  - The agreement covers and specifies all of the services provided for the term;
  - If the services are on a periodic, sporadic or part-time basis, the agreement specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals;
  - The term of the agreement is for not less than one year;
  - The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties;

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Management and Co-Management Arrangements

- **Anti-Kickback Statute Personal Services and Management Contracts Safe Harbor - 42 C.F.R. § 1001.952(d) cont.**

  - The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law; and

  - The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services

- **Note:** The variable bonus component of a co-management fee will **not** meet the "aggregate compensation" requirement set forth above.

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Management and Co-Management Arrangements

- Stark Law
  - **Strict liability** civil statute – intent does not matter
  - Prohibits referrals by physicians for “designated health services” to an entity with which the physician, or an immediate family member, has a **financial relationship** (which can be either an ownership or compensation relationship) **unless** an exception is met
  - For arrangements with individual physicians or groups in which the “stand in the shoes” concept is applicable, a **direct compensation** exception must be available

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Management and Co-Management Arrangements

- Stark Law continued
  - **Stark Personal Services Exception - 42 C.F.R. § 411.357(d)**
    - The arrangement is in writing, signed by the parties, and specifies the services covered by the arrangement;
    - The arrangement(s) covers all of the services to be furnished by the physician (or an immediate family) to the entity. Can be incorporated by reference or cross-reference a master list of contracts;
    - The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement(s);

Management and Co-Management Arrangements

- Stark Law continued
  - **Stark Personal Services Exception - 42 C.F.R. § 411.357(d) continued**
    - The term of each arrangement is for at least 1 year. If an arrangement is terminated during the term with or without cause, the parties may not enter into the same or substantially the same arrangement during the first year of the original term of the arrangement;
    - The compensation to be paid over the term of each arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties; and
    - The services to be furnished under each arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any Federal or State law.

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Management and Co-Management Arrangements

- Stark Law continued
  - The compensation to be paid over the term of each arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties; and
  - The services to be furnished under each arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any Federal or State law.
- **Note:** The co-management bonus fee described above **could** comply with the "set in advance" requirement included above if based on a formula which does not vary based on referrals.

Management and Co-Management Arrangements

- Stark Law continued

  - **Stark Fair Market Value Compensation Exception - 42 C.F.R. §411.357(l)**

    - The arrangement is in writing, signed by the parties, and specifies the services covered by the arrangement.

    - The writing specifies the timeframe for the arrangement, which can be for any period of time and contain a termination clause, provided that the parties enter into only one arrangement for the same items or services during the course of a year. An arrangement made for less than 1 year may be renewed any number of times if the terms of the arrangement and the compensation for the same items or services do not change.

    - The compensation to be paid over the term of each arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

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Management and Co-Management Arrangements

- Stark Law continued
  - **Stark Fair Market Value Compensation Exception - 42 C.F.R. §411.357(l) continued.**
    - The arrangement is commercially reasonable (taking into account the nature and scope of the transaction) and furthers the legitimate business purposes of the parties.
    - The arrangement does not violate the anti-kickback statute, or any Federal or State law or regulation governing billing or claims submission.
    - The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates a Federal or State law.
- **Note:** The above statement regarding “set in advance” compliance will also apply here.

Management and Co-Management Arrangements

- Stark Law continued
  - Indirect compensation exception applicable where JV including physicians is involved, 42 C.F.R. 411.357(p)
    - Stark law not implicated where aggregate compensation to referring physician does not vary with referrals
  - Proposed Exception for Incentive Payments and Shared Savings Plans

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Management and Co-Management Arrangements

- Regulatory considerations applicable solely to Co-Management Arrangements.
  - Civil Monetary Penalty Statute, 42 U.S.C. 1320a-7a(b)
    - Will penalize a hospital for knowingly making a payment to a physician as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries;
    - $2,000 for each patient involved;
  - July 1999 Special Advisory Bulletin
    - Thought to be the “death knell” for gain sharing programs

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Management and Co-Management Arrangements

- Regulatory considerations applicable solely to Co-Management Arrangements continued
  - OIG Gainsharing Advisory Opinions
  - General Theme:
    - Cost savings resulting from specific protocols using current volume
    - Safeguards in place to protect quality
    - Examination of case mix
    - Transparency; disclosure to patients
    - FMV payments

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