Hospital–Physician Joint Ventures:
New Opportunities After Healthcare Reform
Complying With Stark Law and Anti-Kickback Statute and Protecting Tax-Exempt Status

A Live 90-Minute Teleconference/Webinar with Interactive Q&A

Today's panel 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 March 2010 approximately 265 physician owned hospitals were open for business
  - Approximately 115 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 have Medicare provider agreements as of March 23, 2010 and projects under development on that date which obtain Medicare provider agreements by December 31, 2010 will be grandfathered
  - The extent of physician ownership is frozen in place. The identity of physician owners, however, can change
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
PPACA Impact on Physician Owned Hospitals

- **Questions and Clarifications.** The PPACA contains glaring inconsistencies in the text relating to physician owned hospital deals and substantial questions are created by the legislation’s other provisions
  - Is there really an 18 month “grace period” for compliance as the wording suggests?
  - Can physician ownership levels increase prior to December 31, 2010 for projects under development?
  - How will the prohibitions on expansion be applied?
    - e.g. prevents increase in “licensed” procedure rooms and operating rooms” but those terms are not defined and are not licensed at the federal level.
  - Uncertainty is greatly increased due to lack of legislative history.
PPACA Impact on Physician Owned Hospitals

- **Possible Solutions to Uncertainty:**
  - CMS is aware of concerns and indicates that clarifying statements might be issued soon
  - On June 3, 2010 the PHA and Texas Spine & Joint Hospital filed suit against the Federal government in the Eastern District of Texas seeking to enjoin the enforcement of Section 6001 on the grounds that the legislation:
    - Is unconstitutionally vague and arbitrary
    - Is being enforced retroactively
    - Constitutes a “taking” without due process
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
  - 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
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)
New Payment Models

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• PPACA Title III Improving the Quality and Efficiency of Health Care
  – § 3001 – Hospital value-based purchasing – Incentive program to begin FY 2013, funded by reduction in base payment amount
  – § 3002, as amended by § 10327 – extends Physician Quality Reporting Initiative and imposes penalty for failure to submit measures starting in 2014
  – § 3004, as amended by § 10322 – provides for quality measure reporting programs for long-term care hospitals, inpatient rehabilitation hospitals, psychiatric hospitals and hospices by FY 2014
– § 3006, as amended by § 10301 – directs the Secretary of Health and Human Services to submit to Congress a plan for value-based purchasing for skilled nursing facilities, home health agencies and ambulatory surgery centers by FY 2012

– §§ 3011-15, as amended by §§ 10302-05 – addresses development of a national strategy to improve health care quality, including establishment of a web site by 2011, creation of an Interagency Working Group on Health Care Quality, and funding for development of quality measures
• §§ 3021-27, as amended by §§ 10306-09, address development of new patient care models, including
  – establishment of Center for Medicare and Medicaid Innovation within CMS by 2011 (§ 3021, as amended by § 10306);
  – development of a shared savings program with accountable care organizations by 2012 (§3022, as amended by § 10307);
  – development of a national pilot program bundling payment for hospitals, physicians and post-acute care providers by 2013 (§ 3023, as amended by § 10308); and
  – establishment of a program penalizing hospitals for preventable readmissions (§ 3025, as amended by § 10309).
• Activities to commence January 1, 2011
• 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
Value-Based Payment

- HHS to establish hospital value-based payment program to commence October 1, 2012
- HHS to select measures and establish performance standards
  - Levels of achievement and improvement
- Incentive payment calculated as percentage of hospital’s base DRG payment per discharge
• Program funded through reduction of base DRG rates
  – One percent in FY 2013
  – Increases to two percent in FY 2017 and after
• Alignment of interests with physicians and others necessary to succeed
• HHS to establish shared savings program 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) to participate
• ACO is group of hospitals, physicians and other providers who are jointly responsible for quality and cost of care for a population of beneficiaries
• Organizations that may become an ACO
  – Physicians and other professionals in group practices
  – Physicians and other professionals in networks of practices
  – Partnerships and joint ventures between hospitals and physicians/other professionals
  – Hospitals employing physicians/other professionals
  – Other forms HHS determines appropriate
• Requirements that ACO must meet
  – Willing to be accountable for quality, cost and overall care of beneficiaries
  – Formal legal structure to receive and distribute shared savings
  – Sufficient primary care professionals for the number of assigned beneficiaries
    • Minimum of 5,000
  – Agree to participate for at least three years
Accountable Care Organizations (Cont’d)

- Be able to provide sufficient information concerning participating professionals as HHS determines necessary for beneficiary assignment and determination of payments for shared savings
- Have a leadership and management structure with clinical and administrative systems
- Have defined processes to
  - Promote evidence-based medicine
  - Report data to evaluate quality and cost measures
  - Coordinate care
Accountable Care Organizations (Cont’d)

– Demonstrate it meets patient-centeredness criteria as determined by HHS

• HHS to establish quality measures such as
  – measures of clinical processes and outcomes
  – patient and caregiver experience of care
  – utilization
Accountable Care Organizations (Cont’d)

• HHS to establish form and manner of reporting
  – May include care transitions across health care settings
  – May incorporate reporting requirements and incentive payments from PQRI

• HHS to seek to improve quality over time through higher standards, new measures or both
• Payment mechanism
  – Continue fee-for-service payments
  – ACO eligible for shared savings payment if
    • Meets quality standard, and
    • Produces savings in comparison to benchmark
  – Benchmark based on expenditures for Part A and Part B services during prior three years for the beneficiaries assigned to the ACO
    • Adjusted for beneficiary characteristics and other factors HHS determines appropriate
    • Updated by projected growth in national per capita expenditure
Accountable Care Organizations (Cont’d)

– For each twelve months, ACO receives a share of the savings, subject to such limitations HHS establishes, if actual per capita expenditures are a sufficient percentage below the benchmark

• If it determines appropriate, HHS may use a partial capitation payment or other model designed to improve quality and efficiency
  – May limit to highly integrated systems capable of bearing risk
• HHS may give preference to ACOs that participate in similar private payer arrangements
• HHS may sanction ACOs that take steps to avoid at-risk patients
• Q&A states HHS expects to issue proposed regulations in the fall

Payment Bundling Pilot

• 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
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
Structures for Collaboration

- Fully-Integrated Clinic Model
- Employment of Physicians within Hospital System
- PHO
- Contractual Alliances
Challenges Under Current Laws

- Anti-Kickback Statute
  - Prohibits *knowingly and willfully* paying or offering to pay, soliciting, or receiving any remuneration to induce the referral of patients for services paid under a federal health care program
Potential Anti-Kickback Concerns

- Are payments shared in a way that reflects the ability of recipients to direct referrals?
- Are payments to physician under the program inflated to encourage referrals?
- Are discounted payments offered by post-acute care participants to induce referrals from hospitals?
Existing safe harbors to consider

- Employment
- Personal services
- Discounts
- Small entity investments
Challenges Under Current Laws (Cont’d)

• Civil Monetary Penalty (CMP) Law
  – 42 U.S.C. § 1320a-7a(b); SSA § 1128A(b)
  – Penalty against hospital that “knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who … are entitled to benefits under [Medicare or Medicaid] … and are under the direct care of the physician.”
  – Hospitals and physicians liable for civil monetary penalties of up to $2000 per patient
• OIG Perspective
  – Special Advisory Bulletin on Gainsharing – July 1999
  – CMP proscription is very broad and payment need not be tied to actual reduction in care
  – “[A]ny hospital incentive plan that encourages physicians through payments to reduce or limit clinical services directly or indirectly violates the statute”
  – Violation can occur regardless of whether service is medically necessary or appropriate
Challenges Under Current Laws (Cont’d)

– OIG has issued series of advisory opinions since 2001 permitting gainsharing

  • Cost reduction measures addressed:
    – Standardizing products where medically appropriate
    – Limiting the use of certain devices to an “as needed” basis
    – Substituting less costly items
    – Opening packaged items only as needed
    – Performing blood cross-matching only as needed
    – Substituting less costly items
    – Standardizing certain devices and supplies
    – Limiting the use of certain surgical supplies to an as needed basis
– Focus of OIG in Advisory Opinions (addressing CMP and Anti-Kickback Law)
  • Transparency and accountability
    – Specific, clearly identified actions targeted
  • Quality controls
    – Credible medical support and periodic reviews concerning impact on quality
    – Thresholds to protect against inappropriate reductions in service
  • No improper referral incentives
    – Participation limited to physicians on staff
    – Program limited to one year
– Advisory Opinions Have Limited Application
  • They may be relied upon only by the requestor
  • Opinions state that programs include improper payments under the CMP Law but OIG will not impose sanctions
  • Opinions address CMP Law and Anti-Kickback Statute but do not address Stark Law
Challenges Under Current Laws (Cont’d)

• Stark Law
  – Prohibits a physician from referring Medicare patients to entities with which the physician has a financial relationship for the provision of "designated health services" ("DHS") and prohibits entities from billing for DHS furnished pursuant to a prohibited referral
  – DHS includes hospital inpatient and outpatient services
Challenges Under Current Laws (Cont’d)

- Existing Stark Law does not specifically address incentive payment and shared savings programs with physicians
  - Structure to meet employment, personal services, fair market value or indirect compensation exception
  - Exceptions for community-wide health information systems, e-prescribing and donation of electronic health records may apply to portions of relationship
  - “Stand in the Shoes” changes in Phase III Regulations cause arrangements with physician organizations to be direct
Challenges Under Current Laws (Cont’d)

- Uncertainties in applying current Stark Law exceptions
  - Is payment for shared savings/efficiency directly or indirectly related to volume or value of referrals?
  - Does a change in physician behavior constitute “identifiable services” under employment exception?
  - What is the fair market value of a change in physician behavior?
• Proposed Stark Law exception for “Incentive Payment and Shared Savings Programs”
  – Proposed regulation text has 16 numbered paragraphs with conditions
  – Additional requirements and safeguards proposed without regulatory text
• Concerns with cost-savings programs in proposed exception
  – “Stinting” – physicians limiting use of quality-improving but more costly devices
  – “Cherry picking” – treating only healthier patients
  – “Steering” – avoiding sicker patients at the participating hospital
  – “Quicker-sicker” – discharging patients earlier than clinically indicated
  – Use of program to foster physician loyalty and gain referrals
• Critical elements to avoid abuse –
  – Transparency
  – Quality controls
  – Safeguards against payment for referrals

• Criteria proposed regarding -
  – Design of the program
  – Limitations and conditions on payments
  – Arrangements between hospital and physicians
Challenges Under Current Laws (Cont’d)

- Other Laws
  - Antitrust
  - Tax exemption requirements
  - State anti-kickback and self-referral laws
  - State insurance laws
  - State corporate practice of medicine and fee-splitting
  - HIPAA and other laws protecting patient information
• Center for Medicare and Medicaid Innovation
  – Waiver authority, as necessary to carry out testing of models, with respect to
  • SSA Title XI (includes Anti-Kickback Statute, CMP and HIPAA)
  • SSA Title XVIII (Medicare, includes Stark Law)
  • §§ 1902(a)(1), 1902(a)(13) and 1903(m)(2)(A)(iii) (Medicaid provisions)
• Accountable Care Organizations
  – Waiver authority, as necessary to carry out the shared savings program, with respect to
    • SSA § 1128A (CMP)
    • SSA § 1128B (Anti-Kickback Statute)
    • Title XVIII (Medicare, includes Stark Law)
Bundling Pilot

- Waiver authority, as necessary to carry out the shared savings program, with respect to
  - SSA Title XI (includes Anti-Kickback Statute, CMP and HIPAA)
  - SSA Title XVIII (Medicare, includes Stark Law)
FACILITY JOINT VENTURES

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Facility Joint Venture

- ASC and Surgical Hospital Co-Ownership
- Conversion of ASCs to Hospital Outpatient Departments
- Capturing Anesthesia Revenue
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.
Typical ASC Structure
Hospital and Physician Participants

*Sometimes formed as an LLC or as a Limited Partnership

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- 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.
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)
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,
Typical Physician Owned Hospital Structure
Hospital and Physician Participants

*Sometimes formed as an LLC or as a Limited Partnership

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Hospital Ownership Structure

- Hospital 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 may own equity (optional)*.

- Equity splits will depend upon (i) tax exemption issues, (ii) whether or not the Hospital Member will “compete” with the joint ventured hospital and (iii) whether or not the joint ventured hospital and the Hospital Member will jointly seek managed care and other third party payer arrangements.
- Physician Members (owners) should be limited to those physicians on the active medical staff of the Hospital.

- Aggregate physician ownership limited to the percentage owned by physicians as of March 23, 2010 (PPACA §6001)

- No individual (per physician) limits on ownership
Hospital Ownership Issues

- Physicians will be required to divest their ownership in the event of:
  - Loss of medical staff privileges
  - 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) loss of medical staff privileges

- All owners may be required to guarantee their proportionate percentage (based upon ownership percentages) of Hospital company debt,
Existing Facility Purchase Issues

- Purchase price for existing entity/facility usually based upon, or supported by, independent third party valuation
  - Cannot take into account “lift” from the managed care contracting advantage to be gained from majority hospital investment

- If purchases of equity in existing entity/facility are at fair market value consider the OIG’s position in Advisory Opinion 07-05. In addition, consider the new Stark Law statutory requirement
  - Ownership or investment returns are distributed to each owner in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital

- If physician owners are being diluted by a hospital-investor purchase, consider ratable dilution and the OIG’s position in Advisory Opinion 07-05
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/Hospital 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/Hospital Company.
Structural Antitrust Issues

- If the Hospital Member intends to continue to maintain its outpatient surgery service and if the ASC/hospital 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/Hospital 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/Hospital 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.
Acquisition of Physician Owned ASC Hospital and Physician Participants

Hospital/Health System

Acquisition Co (HOPD).

MD

MD

MD

ASC Co.

ASC Management Co.

Assets

$$$

Management Contract
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
- Capture Anesthesia Revenue
- Minimize Tax Consequences
- Comply with Applicable Laws, Rules and Regs
Common Model
Anesthesia Options

- Free Standing Anesthesia LLC
- Anesthesia LLC Wholly Owned by GI LLP
- Anesthesia LLC Wholly Owned by ASC
Free Standing Anesthesia LLC
(Contracted Anesthesia Services)

Anesthesia Practice

Anesthesia Fees

Anesthesia Services

Anesthesia LLC

Physician Investors
100%

Hospital Investor
90%

Ambulatory Surgery Center
10%

Third Party Payers

$$$AS*

Anesthesia Billing

*Anesthesia Services

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Free Standing Anesthesia LLC (Employed MD/CRNA)

Third Party Payers → Anesthesia Billing → Anesthesia LLC

- Physician Investors: 100%
- Hospital Investor: 90%
- Anesthesia Services (AS): 10%

MD/CRNA Part-Time Employees

Ambulatory Surgery Center

Anesthesia Billing

*Anesthesia Services
Free Standing Anesthesia LLC

- Physician Investors form Anesthesia LLC (PLLC/PA/PC) under relevant state law to provide anesthesia services to the ASC
  - Physician Investors could be a group practice
  - Physician Investors could be a separate LLC
  - Physician Investors could simply be an aggregate of individual doctors

- Anesthesia LLC will apply for a federal employer identification number ("FEIN") for billing purposes

- Anesthesia LLC enrolls in Medicare as an anesthesia practice

- In Model 1 Anesthesia LLC subcontracts with Anesthesia Practice for the services of its MDs/CRNAs (so as to allow Anesthesia LLC to provide anesthesia services to the ASC) and pays Anesthesia Practice a contracted rate for its MD/CRNA services at fair market value

- In Model 2 MDs/CRNAs become part-time employees of Anesthesia LLC

- Anesthesia LLC bills third party payers for anesthesia services provided to the ASC

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Free Standing Anesthesia LLC

**PROS**

- Anesthesia LLC has a separate FEIN for billing purposes
- No risk of violation of corporate practice of medicine doctrine
- Should provide pass-through tax treatment
- So long as the contracted rate paid by Anesthesia LLC to Anesthesia Practice is fair market value, the arrangement appears to present a low risk that it violates the Federal Anti-Kickback statute
- If the MDs/CRNAs are employed, this may present certain state margin tax benefits (e.g., Texas)

**CONS**

- Slight risk that payers could view Anesthesia LLC and Physician Investors as one combined entity (notwithstanding separate FEINs) and bundle the anesthesia fee with the GI professional fees (although there appears to be no legal basis for this approach)
- Possible Stark Law concern with physician owners being members of more than one group practice
- If MDs/CRNAs contract with Anesthesia LLC (as opposed to becoming employees), the amounts paid under the contract may not be deductible for certain state law margin tax purposes (e.g., Texas)
- If the MDs/CRNAs become employees, Anesthesia LLC will be responsible for various withholding taxes, which will increase the cost to Anesthesia LLC
Anesthesia LLC Wholly Owned by ASC
(Contracted CRNAs)

Diagram:
- Anesthesia Practice
- Anesthesia Services
- Anesthesia Fees
- Anesthesia LLC
- Ambulatory Surgery Center
- Anesthesia Services
- $$$
- Anesthesia Billing
- Third Party Payers
Anesthesia LLC Wholly Owned by ASC

- ASC forms Anesthesia LLC (as a wholly owned subsidiary) under relevant law to provide anesthesia services to the ASC
- Anesthesia LLC will apply for a separate federal employer identification number ("FEIN") for billing purposes
- Anesthesia LLC enrolls in Medicare as an anesthesia practice
- In Model 1 Anesthesia LLC subcontracts with Anesthesia Practice for the services of its MDs/CRNAs (so as to allow Anesthesia LLC to provide anesthesia services to the ASC) and pays Anesthesia Practice a contracted rate for its MD/CRNA services at fair market value
- In Model 2 MDs/CRNAs become part-time employees of Anesthesia LLC
- Anesthesia LLC bills third party payers for anesthesia services provided to the ASC
**Anesthesia LLC Wholly Owned by ASC**

**PROS**
- Anesthesia LLC has a separate FEIN for billing purposes
- No risk of violation of corporate practice of medicine doctrine
- Anesthesia revenue runs through the ASC and is shared with Hospital Investor
- So long as the contracted rate paid by Anesthesia LLC to Anesthesia Practice is fair market value, the arrangement appears to present a low risk that it violates the Federal Anti-Kickback statute
- If the MDs/CRNAs are employed, this may present certain state law margin tax benefits (e.g., Texas)

**CONS**
- Slight risk that payers could view Anesthesia LLC and the ASC as one combined entity (notwithstanding separate FEINs) and bundle the anesthesia fee with the ASC facility fee (although there appears to be no legal basis for this approach)
- If Anesthesia Practice contracts with Anesthesia LLC (as opposed to becoming employees), the amounts paid under the contract are not deductible for state margin tax purposes (e.g., Texas)
- If the MDs/CRNAs become employees, Anesthesia LLC will be responsible for various withholding taxes, which will increase the cost to Anesthesia LLC
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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
Management and Co-Management Arrangement

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

  51% physician owned

  49% Hospital owned

Surgical Hospital

LLC Governing Board
- 4-physicians reps
- 3-hospital reps

Management Services Agreement
- FMV Flat Fee Management Fee

Management Services LLC
- 100% owned by physicians
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
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
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.
Management and Co-Management Arrangement

- Sample Co-Management J.V. Model

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**Co-Management Agreement**

- J.V., LLC
  - 80% Physician owned
  - 20% Hospital owned

**Hospital**

Payors

Pro rata capital contribution to support infrastructure

Service Line
- outpatient hospital services, etc

Pro rata distributions according to ownership
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;
Management and Co-Management Arrangements


- 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.
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
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.
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.
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
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
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