Structuring Healthcare Practice Leasing, PSA and Other Practice Alignment Arrangements
Complying with Stark, AKS, HIPAA and Maximizing Reimbursement

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Today’s faculty features:

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Structuring Healthcare Practice
Leasing, PSA and Other Practice Alignment Arrangements

Presented By
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Physician Leases

Leased Practices – May include any or all of the following:

- PSA (alternative: Employment)
- Employee Lease (alternative: Employment)
- Equipment Lease (alternative: Purchase)
- Other Resource Arrangements (i.e., overhead of practice)
- Management Services Arrangement (often without remaining transactions)

Leased Practice/Management Lessons Learned
Why Physician Leases?

Traditional (i.e., pre-alignment wave) models of payment developed and deployed to obtain necessary physician administrative or clinical services.

Rationale for transactions may vary, but they are often coupled with, or driven by, desire for alignment. Payment may be required for:

- Services that are administrative in nature with no associated reimbursement
- Services that are reimbursable but physicians are precluded from directly obtaining payment

Though common, the issues of FMV and commercial reasonableness often present...
The term “physician lease” will be applied broadly for this presentation:

- Administrative Services Medical Director
- Part-time clinical services
- Temporary staffing (Locums)
- Full-time clinical – often Hospital-based
First and foremost, is the arrangement *commercially reasonable*? Are the services needed, or is the only reason for the arrangement the fact that the physician makes referrals to the hospital?

What is “opportunity cost,” and is it a reliable indicator of FMV?

Do physician compensation rates differ for clinical vs. administrative services? Does the government draw a distinction?
Approaches to establishing/defending medical director rates

- Beware of tainted data (a recurring FMV theme!)
  - How much reliance should you place on rates being paid by other area hospitals?

- Traditional compensation surveys - clinical (e.g., MGMA, Sullivan Cotter)

- Integrated Healthcare Strategies and MGMA administrative surveys
Examples

- **Part-Time Staffing** – Hospital maintains an OB/Clinic and seeks to have area physicians provide care to indigent patients ½ day per week. Hospital maintains collections and pays physician an hourly rate.

- **Temporary Staffing** – Hospital employs 2 general surgeons who staffed a clinic and provided all ED call coverage. 1 leaves the community. Hospital has a temporary need to obtain physician on-site and on-call coverage. Hospital pays a per day rate for clinic staffing/call coverage.

- **Full-time Staffing** – Hospital compensates an emergency medicine practice to provide staffing to its ED on a full-time basis. Hospital pays a flat monthly payment to practice.

- **Other Services**
  - Hospital seeks ongoing availability and access to cardiologists for EKG reads and compensates physicians a payment per read
  - An imaging center bills globally for its services and contracts with an independent physician to provide professional reads. Compensation is made based on a % of global collections
Physician Lease – Clinical

FMV – Will consider the following:

- Included services (clinical time only)
- Nature of compensation – periodic (hr/wk/month) vs per procedure or other
- Agreement specific issues
  - Magnitude of arrangement
  - Specialized nature of services
  - Underlying reimbursement – In extreme cases (e.g., unfunded OB vs. self pay cosmetic procedures)
Physician Lease – Clinical

- FMV – Clinical time
  - Salary survey data

- FMV – Reimbursement
  - Medicare guidance
  - Charge/Collections benchmark data
  - Collections/Compensation per WRVU in MGMA
Commercial Reasonableness considerations

- Are the services necessary?
- What alternatives does the hospital have for the services?
- Does the payment (FMV) reflect consideration of these alternatives?
- Does payment appropriately match the services provided?
- Can the physician directly bill for the services? Why don’t they?
Role or number of hours are not reasonably needed or required (i.e., medical directorships are still sometimes handed out as a pure form of compensation)

Hours worked are not documented (or did not occur)

Compensation stacking
  - Aggregation of multiple agreements / responsibilities (duplicative duties or excessive hours of service)

Unduly long agreement term

Severance obligation and/or full time benefits in a part-time medical director agreement

Payment to physicians to coordinate their own on-call schedules

Restricted call arrangements involving low patient encounter frequency
Leased Physicians
Legal Considerations

Anti-Kickback Law: Personal services and management contracts safe harbor (42 CFR § 952.1001(d))
- Aggregate compensation set in advance, not vary with referrals
- FMV and commercial reasonableness
- Set out in writing
- One-year rule
- If part-time, precise intervals specified

Stark Law: Personal service/FMV exceptions (42 CFR § 411.357(d) &(l))
- Similar to AKS safe harbor, except:
- Compensation, but not “aggregate compensation”, set in advance
- Master list of agreements
- Agreement does not need to be a year for FMV exception
Leased Physicians
Legal Considerations

- Tax reclassification: IRS 20 factor test for employment
- Malpractice and insurance
  - Independent contractors
  - Should be no direct vicarious liability as employer
  - Apparent agency
  - Negligent credentialing
  - Negligent supervision
Leased Physicians
Legal Considerations

Medicare reassignment rules (Medicare Claims Processing Manual, Chapter 1, Section 30.2.7)

- Joint and several responsibility for Medicare overpayments
- Leased employee has unrestricted access to claims filed by hospital/affiliated group

Leasing, PSA and Other Practice Alignment Arrangements
August 28, 2014
“Under arrangements” transactions indirectly prohibited by Stark Law (42 CFR 411.351) since October of 2009

- Under definition of “entity”, Group is considered to be furnishing DHS if it has “performed services” that are billed by the Hospital as DHS.
- If Group leases entire practice to Hospital (i.e., space, equipment, physicians, other personnel, supplies, etc), Group will be viewed as performing the services, and physician owners will not be able to refer to Group for DHS.
- To avoid this result Hospital should provide sufficient elements of service so that Group is not seen as performing the service.
- Hospital could provide the space by taking assignment of Group lease from prime landlord.
- Hospital could provide the equipment by purchasing Group’s FFE and inventory at fair market value.
- Hospital would need to employ nurses/techs at off-campus locations (to meet Medicare provider-based status rules).
Introduction

Professional Services Agreements

Simple v. Powerful Tool

- To staff existing Hospital clinics or develop new sites
- To convert existing Group sites to Hospital-licensed facilities paid at hospital outpatient payment rates
- To convert existing Group sites to hospital-affiliated group services paid at physician-office rates
- Integrate and align Hospital and Group to improve quality, efficiency and operations of Hospital’s service line
Leased Practices / PSAs

Introduction

Potential economic win-win

- Group remains “independent”
- Paid fair market value compensation on an aggregate fixed fee or wRVU basis
- Eliminates risk of reimbursement reductions and collection risk (free care/bad debt)
- Other: purchase of equipment, management services, employee lease, medical directorships, co-management
Potential economic win-win

- Hospital or affiliated group establishes new satellite sites or facility and new book of business
- Good contribution margin due to combination of hospital rates and physician office cost structure
- Potential 340B pricing opportunity

Potential economic losers

- Payors—higher rates for “same” services
- Higher patient co-pays
- Pharma companies
Hospital provides:
- License
- Provider-based status
- 340B pricing
- Space/equipment
- Nurses/techs (off-campus)

Group provides:
- Physicians/NPs/PAs
- Non-clinical staff
- Nurses/techs (on-campus)
- Administrative services?

Notes:
- FMV for assets and group retains cash and A/R
- PSA on fair market wRVU basis
- Employee lease on a fixed fee or cost plus fair market mark-up basis; or, administrative services as a percentage of collections with a FMV floor and cap
- Billing services at fair market percentage of collections or fixed fee per claim?
Principal Leased Practice/PSA Legal Issues

Stark Law

Under arrangements prohibition: cannot have investment interest in entity (including own medical group) that “performs” the DHS service

Assign leaseholds/Sell equipment?

”Stand in the shoes”

Personal services, fair market value or indirect comp exception: fair market value/independent appraisal advisable

Tuomey case—cannot rely on flawed appraisal that takes into account v/v of referrals
Anti-Kickback Statute

- Personal services and management contracts and/or space or equipment rental safe harbor: fair market value / independent appraisal strongly advised

- Some irreducible AKS risk:
  Aggregate compensation not set in advance if wRVU based
Principal Leased Practice/PSA Legal Issues

Tax Exemption Considerations

- No inurement/private benefit
- No excess benefit transaction
- Rebuttable presumption of reasonable compensation process
- Rev. Proc. 97-13 and private use of bond financed space or equipment/duration limitations (3 years/2 years out)
Principal Leased Practice/PSA
Legal Issues

Provider-based Status Regulations

- Within 35-mile radius
- Hospital license requirements/Physical space standards
- CON issues
- Clinically, financially and administratively integrated
- Hospital reporting lines
- Hospital must directly employ mid-levels/techs at off-campus sites (other than NPs/PAs)
- Medical group can lease non-clinical staff and NPs/PAs to Hospital
- No off-campus joint venture with medical group
340B Drug Pricing

- Discount from average manufacturer price generally based on manufacturer’s best price
- Applies only to outpatient drugs
- Available to DSH hospitals, free-standing cancer hospitals, children’s hospitals, CAHs, RRCs, sole community hospitals, FQHCs, and certain special federal grantee programs
- 8% DSH for RRCs and SCHs; 11.75% for others
- No GPO, except CAHs, RRCs and SCHs
- Not applicable to for-profits
- Must be within 35 miles of main hospital/meet provider-based status standards
- Effective after first cost report filed with CMS and enrollment (quarterly) with HRSA/OPA—up to 16 mos process
Key PSA Deal Maker / Breaker Issues

- Transaction Structuring
- Strategic Alignment
- Trust/Relative Trust
- Governance
- Financial Terms/Valuation
- Term/Duration
- Termination
- Restrictive Covenants/ROFOs
- Unwind Rights
- Addition of New Physicians
- Break-Up Fees?
- Arbitration/Dispute Resolution
Payment Per WRVU including benefits

FMV considerations – Similar to employment, key in on the details of arrangement which can influence value

FMV analysis should consider pre- and post-transaction compensation.
Practice Lease – PSA Valuation

Market Approach

- Compares a physician / practice against available benchmark data

Commonly seen metrics:
- Work Relative Value Units (i.e., wRVUs)
- Professional collections
- Median comp per wRVU

Through a “percentile matching technique,” align each productivity variable with the expected level of compensation.
Make a “weighting” determination based on the unique facts of the particular arrangement and credibility of data.

For example, collections data may be incomplete or misleading; or there may be ambiguity in wRVUs (coding issues?)

Depending on the specialty and/or sources of physician data, it may be that one market indicator is more appropriate than another.
Cost and Income Approaches

Application of these two approaches can offset and mitigate limitations of the market approach.

Provide view into local marketplace

Allow analysis of full array of economic factors affecting physician compensation

Provide a reality check
Cost Approach
- Normalized and adjusted historical compensation
- Realistic numbers for the cost to recruit

Income Approach
- Pro forma based on hypothetical-typical employer basis
- Reflects future market conditions

Earnings Available for Physician Compensation
(i.e., Calculate applicable overhead, deduct benefits and apply a cost of capital)

Synthesize all three approaches
Practice Lease – PSA Valuation Lessons Learned

Example of misuse of data, using MGMA for Orthopedic Surgery: General

- 90th percentile cash compensation - $934,000
- 90th percentile wRVUs – 13,795
- 90th percentile compensation per wRVU - $105.18

Where is this going?

- 90th percentile wRVUs x 90th percentile compensation per wRVU = $1,451,000 (i.e., 155% of 90th percentile compensation)
- MGMA states that there is an inverse relationship between physician compensation and compensation per wRVU
- Median compensation (per wRVU) is a misnomer; no physician wants to be below the median!
- Evaluate comp by quartile of production data; comp per wRVU declines as wRVUs increase
Providers implementing wRVU models have been observed to make errors related to:

- “Total” vs. “Work” relative value units
- GPCI adjustments
- Assistant at surgery
- Multiple procedures
- Mid-level providers (i.e., “Incident to” or “at full rate”)
- Use of “blended” rate for multiple specialties
- CMS changes in wRVUs
- New or discontinued CPT codes
Practice Lease – PSA Valuation Lessons Learned

Should certain payments be passed through or fixed, rather than as a component of a wRVU rate?

- Professional liability expense
- Benefits costs such as insurance coverage for medical, dental, vision or life insurance
- Benefits costs for what is normally an employer-contributed pension or retirement plan
- Employer’s portion of taxes for FICA Medicare and FICA Social Security
- Be wary of “fixed versus variable” expenses
Benefit plans are becoming more robust

- Need to review and evaluate the components

Since likely “baked” into the wRVU value, it is important to determine a “cap” on benefits

- *e.g.*, Tier out the wRVU value to accommodate the benefit ceiling

Is it commercially reasonable to have a non-exclusive arrangement? (*i.e.*, physician gets to maintain certain aspects of the practice?)
Practice Lease – PSA Valuation Lessons Learned

Beware of existing agreements that preceded the PSA, as well as other new terms.

- Sign-on bonus
- Productivity bonus
- Medical directorship
- Co-management agreement
- Quality bonus
- Retention bonus

- Call pay
- Tail insurance
- Excess vacation
- Relocation costs
- Excess benefits
Employee Lease for non-physician staff that will help continue practice operations

**Considerations**

- Clinical vs. Non-Clinical
  - Clinical - Billing implications tied to site of service differential

**Structure of payment**

- $ amount
- Mark-up vs. Margin
Market Approach – Consider margins applicable to:

- PEO’s (1-3%) – A “Professional Employer Organization” allows outsourcing of benefits management

- Staff and employee leasing (15-20+%) - Companies that offer full-time or part-time staffing on a temporary and permanent basis
Practice Lease Valuation
Employee Lease

Key Factors influencing margin

- # of employees
- Compensation level of employees
- Full-time/Part-time mix
- Responsibility for:
  - Payroll processing
  - Benefits Administration
  - Employee replacement
    - Position
    - PTO
  - Employee training
Equipment lease for some or all of the practice equipment necessary to operate practice

Considerations

- Agreement Term

- Lease structure – Operating vs. Capital
  - The above will impact certain other considerations regarding equipment replacement.

Inclusion of other equipment costs – maintenance
Valuation considerations

- Underlying equipment value
  - Based on M&E appraisal
  - FMV in place, or for removal

- Lease calculation
  - Mortgage (capital) vs. auto lease
  - Term
  - Present and future value
  - Interest rate

- Commercial Reasonableness – Ownership / Risk is lessor’s
  No pass-through
Valuation considerations

- Review practice expenses for reasonableness, related party transactions and non-practice expenses.

- Generally historical and prospective cost are best indication of FMV.
Hybrid PSA / Service Line Co-Management Arrangements
Service Line Co-Management Direct Contract Model

Payors → Hospital → Operating Committee

Hospital-licensed services

\[ \text{Co-Management Agreement} \]

- Two, or multi-party contract
- Specifically enumerated services
- Allocates effort and reward between groups

Medical Group I
Medical Group II
Other Group(s)
Service Line Co-Management Joint Venture Model

Payors → Hospital → Service Line → JV Management Company → Specialists/Groups

- Capital Contributions
- Management Infrastructure

Profit Distribution

GoManagement Agreement

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Service Line Co-Management Arrangements

Typically two levels of payment to physician managers:

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

- **Bonus fee** – a series of pre-determined payment amounts, each of which is contingent on achievement of specified, mutually agreed, objectively measurable, program development, quality improvement and efficiency goals

Aggregate payment generally approximates 2-4% of service line revenues

- Fixed, fair market value; independent appraisal advisable
Notes:
- Same as PSA arrangement, plus
  - Service Line Co-Management Agreement (2-4% of Service Line revenue)
  - PSA component – wRVU rate equal to aggregate current physician comp/benefits
  - Employee Lease/Mgmt Agreement – FMV fixed fee or cost plus
  - Co-management component – fixed fair market value fee
  - Incentive component contingent on meeting specified quality and efficiency improvement standards – fixed FMV fee per standard
There are legal constraints on Service Line Co-Management Agreements (i.e., CMP, AKS and Stark):

- No stinting
- No steering
- No cherry-picking
- No gaming
- No payment for changes in volume/referrals
- No payment for quicker-sicker discharge
- No reward for changes in payor mix, case mix
- Must be FMV; independent appraisal required
Additional Legal Considerations

- Some irreducible legal risk because aggregate compensation is not set in advance
- Minimize legal risk by:
  - Internal monitoring with compliance officer review
  - Independent FMV appraisal
  - Independent outside reviewer
Cost savings metrics / incentives implicate Civil Monetary Penalty Law

Hospital cannot pay a physician to reduce or limit services to Medicare/Medicaid beneficiaries under the physician’s care.

Cannot pay for reduction in LOS or overall budget savings

Can pay for cheaper not fewer items of equivalent quality?

Potential to incent verifiable cost-savings from standardizing supplies or reducing administrative expenses as long as quality is not adversely affected and volume/case mix changes are not rewarded
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 indicate that the AKS could be violated if the requisite intent is present, but that OIG would otherwise not seek sanctions.
Co-Management contract will not meet Personal Services and Management Contracts safe harbor if “aggregate compensation” is not set in advance.

- Maximum and minimum compensation may be set in advance, but aggregate compensation may not be.

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; some irreducible legal risk
Co-Management Arrangements
Valuation Considerations
The Cost Approach can be used to estimate the “replacement” or “replication” cost of the management / administrative services to be provided by the manager.

The Market Approach considers compensation as compared to independent management arrangements.

On an item-by-item basis, the relative worth of each task/responsibility is “scored” relative to other comparable arrangements.

An indication of value of the management services is then established by comparing the “scoring” of the subject agreement to other service arrangements in the marketplace.
Services

- Services detailed in agreement, and considered in valuation, are not fully provided
- Ongoing medical director arrangements appear to result in duplication of services (and compensation)

Incentives

- Is there appropriate balance between base and incentive fee?
- To what extent are incentive metrics payable for maintenance
- Bar is set too low for incentive quality metrics

Co-Management

- Valuation of contributions to co-management entity (Hospital’s contribute cash and get 50%/Physicians contribute none and get 50%)
- Is the allocation of duties and responsibilities commensurate with the compensation?
Leased Practices: PSA / Co-Management Lessons Learned
Payor pushback – site of service differential for hospitals may be temporary

- Commercial insurance contract expiration / negotiation
- Assault on Medicare site of service differentials

Pharma pushback on 340B pricing

- Advocating change in HRSA regulations for 340B pricing to apply to indigent patients of DSH hospitals rather than to all patients of DSH hospitals
Co-management requires active participation and real time and effort by busy physicians

- Hours-based v. task-based arrangements/valuation methods
- Documentation requirements

PSA exclusivity, right of first opportunity for new sites / programs, and significant role in governance of service line

- Available to larger, more dominant oncology groups; may not be available to smaller groups in competitive market
- Large group may have footprint that aligns with multiple hospitals/systems (complementary v. competitive markets)
PSA / Co-Management Lessons Learned

Limited opportunity to have PSAs with multiple hospitals

- Not available to smaller groups in market with multiple groups

Generally all service line physicians participate in co-management arrangement because participating physicians are responsible for performance of all physicians in service line.
Governance issues

- Board seats?
- **Joint operating committee**: composition and authority
- Regional councils: Group role
- Medical directorship / sub-directorships?
- **Reporting may be through a middle manager** (service line administrator) and not to hospital decision-makers
PSA operational integration issues

- **IT integration**, interfaces and adoption; and associated **impact on productivity**
- Disruption for **leasehold improvements** to meet hospital license requirements for physical space
- **Split staff** (off-campus) and salary / benefit differentials
- **Union issues**
PSA/wRVU issues

- **Changes in wRVU values** over time vs. lock-in base year wRVU values
- Addition/deletion of CPTs/RVUs over time
- Impact of **sequestration** on payments tied to Medicare Physician Fee Schedule payment methodology
- Difference of opinion regarding how to pay for **supervision of ancillary services** (e.g., chemo administration)
- Will Group get credit for NP / PA wRVUs?
- **Benefit costs** and change in benefit expenses over time
- wRVU may not cover other **continuing Group overhead expenses** (e.g., legal, accounting, insurance)
- wRVUs may not be available for certain **ancillary services** (e.g., imaging)
- **Access to books / records** to confirm wRVU count
Adding additional physicians to co-management arrangement is dilutive to existing physicians

Other PSA Compensation Issues

Will hospital provide base compensation guarantee for transition period (e.g., 85% of base year compensation for 2 years, if Group provides at least 80% of wRVU productivity)?

Will hospital provide anti-dilution protection to protect against internal competition? Loss of referral sources from PCPs associated with competing systems
PSA Compensation Issues (cont.)

- New physician ramp-up / guaranteed compensation or wRVU credits for new physicians
- Compensation caps for tax exempt hospitals
- Harmonizing PSA compensation method with new shared savings, bundled payment, capitation and risk based payments
  - What is tipping point to trigger change in compensation methodology? Who decides?
PSA / Co-Management Lessons Learned

Non-competes, restrictive covenants and unwind rights

- Unwind right is key to preserving leverage and future options
- Hospitals generally oppose unwind rights and may try to limit them.
- Least common denominator may be to unwind to private practice—not to a competing health system.
- Negotiation over unwind triggers: failure to offer FMV compensation; failure to renew; termination without cause; change of ownership; change in law; material decrease in compensation
  
  - Generally, no unwind due to Group breach or Group non-renewal without cause
Unwind rights (cont.)

- Negotiation over what Group gets back in unwind: space and TIs, assets and new or upgraded equipment, staff, medical records, data, cooperation and orderly transition

- Hospital may try to negotiate opportunity to solicit physicians starting at notice of unwind

- Unwind should be exception to non-competes
Durability: Term/Termination

- **Duration of valuation opinion / periodic revaluation**
  - Revaluations have generally retained or increased wRVU rates and co-management fees
  - Past may not be an accurate predictor of future.

- **Periodic reset of performance** standards and targets
  - Continued payment for optimized standards?

- **Rev. Proc 97-13** limits on duration of use of tax exempt bond financed space and equipment

- Potential for breach, change in ownership/control, change in law, change in market and circumstances
PSA / Co-Management
Lessons Learned

- Need good dispute resolution process to focus the parties on maintaining relationship
  - Escalating dispute resolution: CEO meeting, mediation, arbitration is preferable
  - Parties should continue to perform during dispute process.

- Change in administration/leadership can change everything—can test relationship and contracts.

- Good working relationship is key to overcoming speed-bumps as they arise.
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Appendix

Requestor was a large hospital in a remote, medically underserved area.

16-physician cardiology group was the only provider of CC services in town and the only cardiologists on Requestor’s medical staff.

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

Requestor pays (1) a guaranteed, fixed payment, and (2) potential annual performance fees in quarterly installments.

Direct contract model: Payment is made to the Group, which then distributes dividends based on each shareholder’s pro rata share of ownership after payment of medical director fees.

Performance Fee based on (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%)

Graduated targets: 50% for threshold; 75% for mid-point; 100% for target

OIG finds that the Fixed Fee, employee satisfaction, patient satisfaction, and quality components do not implicate the CMP Statute, but the cost savings component does.

Standardization of devices and supplies and limiting use of specific stents, contrast agents and medical devices, might induce physicians to alter their current medical practice and reduce or limit services.

However, OIG will not seek sanctions because of sufficient safeguards.

First, Requestor certified that the arrangement has not adversely affected patient care, and that it engaged an independent reviewer to monitor both the performance of the Group under the arrangement and its implementation of the cost savings component to protect against inappropriate reduction or limitation in patient care.

Second, the risk that the arrangement will lead the 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 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 limited in duration and amount; it is subject to a maximum annual cap and the term of the arrangement is limited to three years.

Fourth, receipt of the Performance Fee is conditioned upon the physicians not: (1) stinting on care; (2) increasing referrals to Requestor; (3) cherry-picking; or (4) accelerating patient discharges.
OIG finds low risk of AKS violation because:

- **First**, Requestor certified that the compensation paid to the Group is fair market value for substantial services provided, based on an independent appraisal;

- **Second**, the compensation paid to the Group does not vary with the number of patients treated, so there is no incentive to increase patient referrals to Requestor;

- **Third**, because Requestor operates the only cardiac catheterization laboratories within a fifty-mile radius, and because the Group does not provide cardiac catheterization services elsewhere, the arrangement is unlikely incent the physicians to refer business to Requester from any competitor;

- **Fourth**, the specificity of performance metrics helps ensure that the purpose is to improve quality, rather than reward referrals; and

- **Fifth**, the agreement is limited in duration (3-year term).
Civil Monetary Penalty Law prohibits a hospital from making a payment, directly or indirectly, to a physician as an inducement to reduce or limit services to a Medicare or Medicaid beneficiary who is under the direct care of the physician.

- OIG maintains that the CMP Statute prohibits reducing medically unnecessary services or substituting clinically equivalent items

- Section 6402 of PPACA exempts from the definition of “remuneration” “any other remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs (. . . as designated by the Secretary under regulations)”

- Potentially broad authority, but requires regulations

- Proposed limited CMP waiver regulation issued on April 7, 2011 with respect to ACOs participating in the MSSP (76 Fed. Reg. 19655):
  - Protects distributions of ACO shared savings from a hospital to a physician if the payments are not made knowingly to induce the physician to reduce or limit medically necessary items or services

- 15 favorable OIG Advisory Opinions on gainsharing—low risk of abuse