Co-Management Arrangements and Their Continuing Evolution

- Trends
- Issues
- Fair Market Value

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- Co-Management Arrangements: Background
- Overview of Co-Management Arrangement Structures
- Principal Regulatory Considerations
- Typical Features of Co-Management Arrangements
- Fair Market Value (“FMV”): Considerations and Methodologies
- Possible Pitfalls

Measuring, Improving and Buying Quality

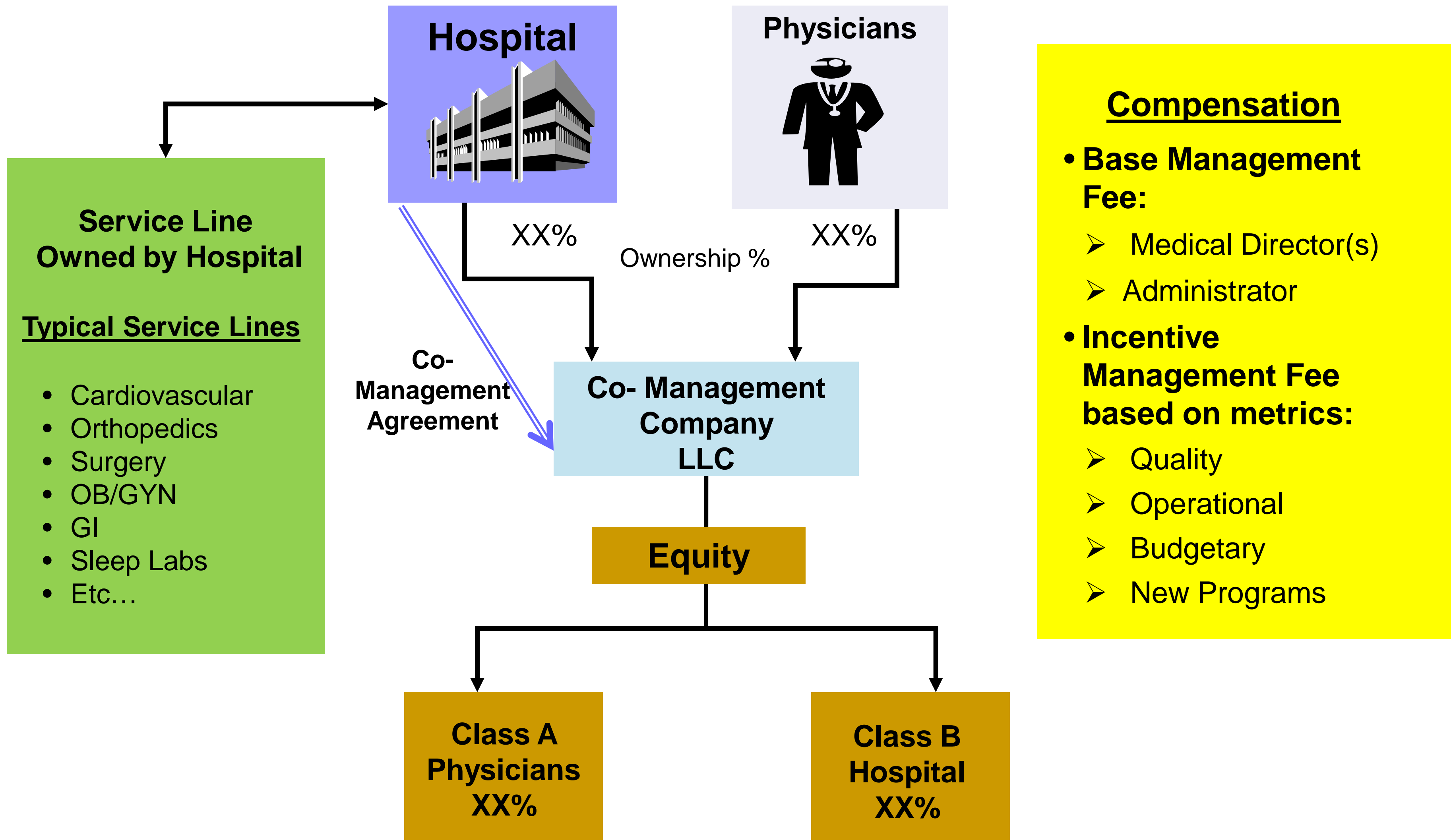
- The Centers for Medicare and Medicaid Services ("CMS") is changing its reimbursement philosophy from volume toward value, as seen most recently in the Affordable Care Act ("ACA")
  - Hospital value-based purchasing [PPACA section 3001]
  - Payment adjustment for conditions acquired in hospital [PPACA section 3008]
  - Hospital readmissions reduction program [PPACA section 3025]

- Increasing competition
- Changing landscape in which services are performed
- Difficulty in securing robust medical directorships
- Increasing hospital costs tied to physician services
- Need for increased efficiencies and quality in patient care
- Government and payer recognition of core measures of quality
- Opportunities for increased hospital-physician alignment

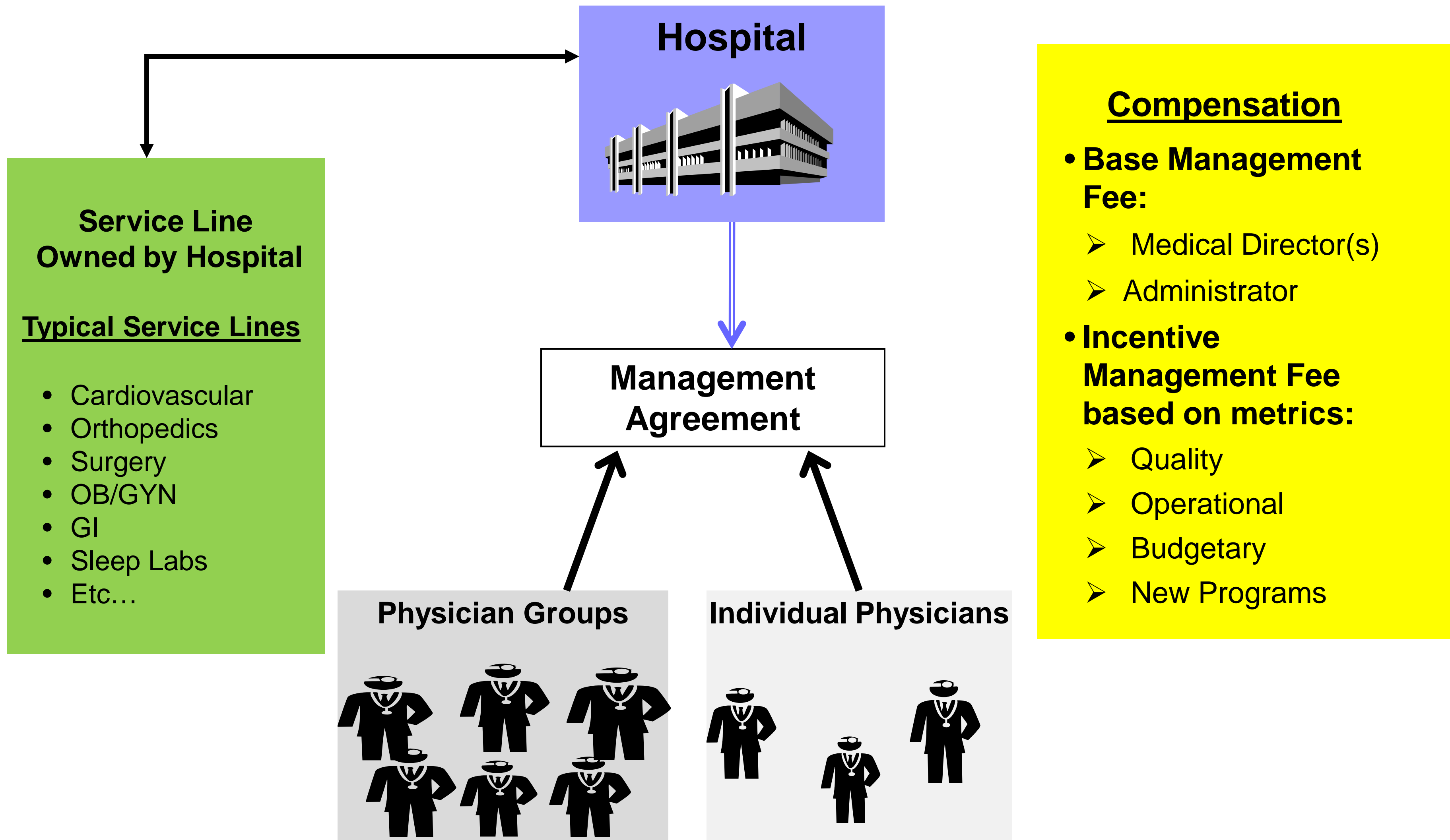
- **Purpose:** Recognize and appropriately reward participants for developing, managing and improving the quality and efficiency of a particular hospital service line.
- **Scope:** May cover inpatient, outpatient, ancillary and/or multi-site services.
- **Participants:** May include one or more physicians,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

- Competition for profitable outpatient services
- Consolidation of medical directorship and other physician duties
- Alignment with payer interests and participation in payer incentive programs
- Matching of physician skill set with hospital quality objectives in effective specialties of care

Service Line Co-Management Model
(Joint Venture Model)



Service Line Co-Management Model



Service Line Co-Management Arrangements

- Governance of the co-management organization should be a shared responsibility between the hospital and the physician-investors.
  - Both would be responsible for an active daily role in shared management.

Service Line Co-Management Arrangements

- Example of scope of services in cardiac CCMA
  - Inpatient and outpatient cardiology floor
  - Cardiac cath lab
  - Cardiac imaging
  - Cardiac surgery
  - Cardiothoracic surgery
  - Vascular surgery
  - Cardiac critical care
  - Cardiac rehab
  - Electrocardiography and stress testing

- Co-management arrangements should not be confused with:
  - Accountable care organizations
  - Gainsharing arrangements
  - Physician pay-for-performance or pay-for-reporting arrangements

Service Line Co-Management Arrangements

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

Service Line Co-Management Arrangements

- Designing means of sharing co-management fee among members
  - Distribution of base management fee
  - Distribution of incentive management fee
    - Based on proportion of ownership
    - Per capita distribution
    - Distribution among and within physician subspecialty groups
- Designing managers' duties and responsibilities
- Contemporaneous documentation of effort and time spent

Service Line Co-Management Arrangements

- Offering the arrangement to medical staff
  - Terms of written agreement
  - Via multiple groups or individual physicians
  - Makeup of physician investors and participants in incentive program
  - Avoid relationships with real, perceived or potential conflicts of interest
  - Avoid prohibited basis on volume or value of referrals
  - Cannot be an inducement to join medical staff
  - Whether offering co-management participation to employed physicians results in “stacking”

Service Line Co-Management Arrangements

- Examples of Co-Management Services
  - Clinical improvements
  - Work flow process improvement
  - Physician and patient scheduling
  - Nurse and non-physician clinician oversight
  - Patient case management activities
  - Credentialing activities
  - Materials management
  - Medical staff committee service and leadership
  - Case management activities (*e.g.,* discharge planning, arranging follow-up services and supplies, call back processes)
  - Coordination with and reporting to hospital
  - Medical Staff-related activities and committee participation

- Provisions applicable to all metrics
  - Rebasing metrics in each year

Service Line Co-Management Arrangements

- Building quality metrics into the co-management program
  - Clinical protocols
    - Begin with core measures and build from there
    - Physician input into most relevant and those that are not “topped out”
    - Recognize independent medical decision-making
  - Performance standards
    - Ensure that financial and performance measures do not result in stinting
  - Satisfaction surveys
    - Patient experience of care surveys
    - Physician and staff satisfaction surveys

- For purposes of our discussion, a co-management arrangement is deemed to have certain common elements.

Service Line Co-Management Arrangements

- Business Considerations
  - Requires active participation and real time and effort by busy physicians
    - Documentation requirements
  - Durability: need to periodically adjust performance standards and targets?
    - Will the parties reach agreement/dispute resolution?
  - Dilution by adding physicians
  - Physicians may not share in reward from growth of service line

- Physician entity to organize participating physicians and allocate payments?
- Cost of independent appraisal (and clinical monitor)
- Legal costs
- Some irreducible legal risk

Typical Features of a Co-Management Arrangement

- As indicated earlier in our presentation, compensation for the manager's services is typically comprised of a *base fee* and an *incentive fee*.
  - However, for smaller services lines or in unique instances (*e.g.,* sleep lab), there may only be a base fee.
- The co-management arrangement may or may not involve the creation of a new entity, which may or may not be owned in part by the hospital.
  - Thus, the "manager" may consist of physicians only, or physicians and hospital management collectively.
- The co-management agreement will replace any existing medical director agreements, *except* for certain agreements that are purposefully kept in place in coordination with the co-management arrangement. However, the medical directors will be paid from the *base fee* management fee.

- The agreement stipulates a listing of core management/ administrative services to be provided by the manager (for which the base fee is paid).
- The agreement includes pre-identified incentive metrics coupled with calculations/weightings to allow computation of an incentive payment (which can be partially or fully earned).
- Compensation is directed towards accomplishments rather than hourly-based services.

Valuation Process – Riskiness of Co-Management Arrangements

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

Valuation Process – Approaches to Value

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

- Civil Monetary Penalty Statute
- Anti-Kickback Statute
- OIG Advisory Opinion 08-16
- False Claims Act
- Physician Self-Referral Statute (Stark)
- Tax Exemption/Intermediate Sanctions
- Provider-Based Status Rules

Civil Monetary Penalties Statute

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

Anti-Kickback Statute, Section 1128B(b) of SS Act, 42 USC 1320a7-b(b)

- Criminal statute - requires intent of an illegal inducement
- Prohibits the knowing and willful offer, solicitation, payment or receipt of anything of value that is intended to induce the referral of an individual for which a service may be made by Medicare and Medicaid or certain other federal and state healthcare programs or to induce the ordering, purchasing, leasing or arranging for, or recommending the purchase, lease or order of, any service or item for which payment may be made by such federal healthcare programs (collectively referred to as an illegal inducement)
- Covers referrals for any item or service that might be paid for by Medicare or any other federal health care program
- Ascribes criminal liability to both sides of an impermissible "kickback" transaction, and has been interpreted to apply to any arrangement where even one purpose of the remuneration offered, paid, received, etc., is to obtain money in exchange for referrals or to induce referrals

Anti-Kickback Statute

- Co-Management contract will not meet Personal Services and Management Contracts safe harbor if "aggregate compensation" is not set in advance.
  - Maximum and minimum compensation may be set in advance, but aggregate compensation may not be.
  - OIG's position is that percentage compensation is not "set in advance".
- Joint venture probably will not meet small investment safe harbor 40/40 tests.
  - More than 40% of interests held by persons in a position to refer.
- Analyze under AKS "one purpose" test.

Anti-Kickback Statute (cont.)

- Volume/revenue-based performance measures implicate the Anti-Kickback Statute.
  - Should not reward increase in utilization, revenue, or profits of service line
  - Should not reward change in case mix
  - Should not reward change in acuity
  - Should obtain independent appraisal of FMV to help negate inference of improper intent
- Advisory Opinions state that the AKS could be violated if the requisite intent were present but that OIG would not seek sanctions.

OIG Advisory Opinion 08-16

- Background
  - Hospital P4P program
    - Up to 4 percent revenue increase from private payer
    - Must attain defined level of quality targets
    - Hospitals represented that it could not achieve clinical quality targets without assistance and cooperation of medical staff.
    - Hospital entered into professional services agreement with physician LLC.
  - Physician rewards
    - Physician LLC receives up to 50 percent of increased Hospital revenue (4%) for the achievement of quality targets.
    - Fair market value and not based on volume or value of referrals
    - Physician bonus compensation divided on a per-capita basis.

Accessed from http://www.oig.hhs.gov, Department of Health and Human Services, Office of Inspector General, OIG Advisory Opinion No. 08-16s, issued October 7, 2008, posted October 14, 2008

OIG Advisory Opinion 08-16 (cont.)

- Background (cont.)
  - Physician Requirements
    - Must be on Hospital staff for at least one year
    - Working capital required to form operating entity
    - Must monitor quality measures by participating in the following:
      - Development policies procedures
      - Conducting peer review
      - Auditing
    - Must achieve target quality performance levels in order for the Hospital to receive additional revenues under the P4P program

Accessed from http://www.oig.hhs.gov, Department of Health and Human Services, Office of Inspector General, OIG Advisory Opinion No. 08-16s, issued October 7, 2008, posted October 14, 2008

OIG Advisory Opinion 08-16 (cont.)

- OIG Ruling
  - The OIG concluded that arrangements between hospital systems and physicians are permissible as long as the arrangements have safeguards in place to protect the patients and program from abuse.

Accessed from http://www.oig.hhs.gov, Department of Health and Human Services, Office of Inspector General, OIG Advisory Opinion No. 08-16s, issued October 7, 2008, posted October 14, 2008

OIG Advisory Opinion 08-16 (cont.)

- Favorable Program Safeguards
  - There is credible medical support that the pay-for-performance program has the potential to improve patient safety and is unlikely to create harms.
  - Provisions are in place for medical exceptions to the quality standards.
  - Quality measures are related to the patient population of the hospitals.
  - Performance measures are clearly identifiable
  - The program will be appropriately monitored for inappropriate reductions or limitations in patient care or services.

Accessed from http://www.oig.hhs.gov, Department of Health and Human Services, Office of Inspector General, OIG Advisory Opinion No. 08-16s, issued October 7, 2008, posted October 14, 2008

OIG Advisory Opinion 08-16 (cont.)

- Safeguards (cont.)
  - Safeguards exist to protect against induced referrals by limiting payments resulting from increased referrals.
  - Bonus compensation is distributed on a *per capita basis among the members of the physician entity.*
  - The program operates with transparency in regard to patient knowledge.
  - The third-party payer will serve to provide oversight of the program.
  - The hospital certified that that achievement of quality measures is not feasible without the assistance of the medical staff.

Accessed from http://www.oig.hhs.gov, Department of Health and Human Services, Office of Inspector General, OIG Advisory Opinion No. 08-16s, issued October 7, 2008, posted October 14, 2008

Impact of Health Care Reform

- PPACA section 6402: Enhanced Medicare and Medicaid program integrity provisions
  - A person may commit a violation of the federal anti-kickback statute without actual knowledge or specific intent.
  - Claims for items or services tainted by a violation of the federal anti-kickback statute constitute false or fraudulent claims under the False Claims Act.

Physician Self-Referral Statute ("Stark Act")

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

Physician Self-Referral (Stark) Law

- The Stark regulations define fair market value as “the value in arm’s length transactions, consistent with the general market value;” and general market value is defined as “the price that an asset would bring as the result of *bona fide* bargaining between well-informed buyer and sellers who are not otherwise in a position to generate business for the other party, or compensation that would be included in a service agreement as the result of *bona fide* bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of the acquisition of the asset or at the time of the service agreement.” [42 CFR 411.351]

Potentially Applicable Stark Exceptions

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

Federal False Claims Act

- Any person who knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; conspires to commit a violation […]
  is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person.
  [31 U.S.C. §3729(a)(1)]
- "Bootstrapped" by prosecutors to AKS and Stark claims

501(c)(3) Tax Exempt Issues

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

Provider-Based Status Rules

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

Typical Features of a Co-Management Arrangement

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

The Income Approach

- General Considerations
  - Valuation under the income-based approach considers the economic benefits inuring to the hospital from the management services furnished under the CCMA.
  - Measurement of these benefits can serve as a proxy for the FMV of P4P arrangements, such as CCMAs.
  - Methodology involves research and financial analysis linking pay-for-performance quality measures and financial benefits to the hospital.
  - Note that benefits attributable to management under the CCMA ***can be*** a result of factors outside of the manager's control.
  - Consider whether methodology values the CCMA's base compensation, incentive compensation, or the aggregate of both.

The Cost Approach

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

The Market Approach

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

Valuation Synthesis

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

What Drives Value?

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

Possible Pitfalls of Co-Management Arrangements

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

Possible Pitfalls of Co-Management Arrangements

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

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