Co-Management:

Legal and Operational Components for Hospital/Physician Alignment

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Faculty – Scott Edelstein, JD, MPA

Scott A. Edelstein is of counsel in the Health Law practice of Squire, Sanders & Dempsey's Washington, DC office where he focuses his practice on advising healthcare providers on legal and regulatory issues. He also regularly assists hospitals and physician groups in the formation of integrated delivery systems, mergers and acquisitions, and tax-exempt bond financing.

Scott has extensive experience in structuring hospital co-management arrangements and joint ventures between hospitals and physicians. Scott also works with individual physicians and physician groups to form and/or merge physician practices into community practices, hospital-based practices and ambulatory settings.

Scott has written extensively on healthcare compliance issues including fraud & abuse and the HIPAA privacy and security standards. His frequent lectures on health care issues have included discussions on healthcare compliance in the age of diminishing reimbursement and challenges posed by electronic medical records and outsourcing.

In 2004, 2005 and 2006, he was named as one of Southern California's Rising Stars in health law by *Los Angeles Magazine* and *Legal Times*.

Scott is a graduate of the University of California (B.A.), the University of Southern California (M.P.A.), Oxford University (Certificate of International and Comparative Law) and the University of San Francisco (J.D.). Mr. Edelstein is a member of the American Health Lawyers Association, the Association of Telemedicine Service Providers, and the California and District of Columbia bar associations.

Faculty – Ron Schmidt

Ronald Schmidt, Principal, DMI Transitions, is an experienced healthcare executive with over twenty-one years of experience in financial/operational management, long-range financial/strategic planning, business plan preparation and implementation.

Ron is recognized for his expertise in business and operational management of surgical services. From 1979 to 1995 he held both financial and operational positions at the Cleveland Clinic Foundation (CCF). While at CCF, Ron was responsible for the business planning for satellite operations including ambulatory services. Additional positions held within a hospital setting included Ambulatory Surgery Director; Senior Director of Cardiovascular and Surgical Services, Orthopedic Administrator, and Financial Manager. Ron has an accounting degree and has completed the Executive Program for Practice Management for Healthcare. Ron is a member of the American Academy of Medical Administrators, Cardiovascular Administrators, and the American College of Healthcare Executives.

Learning Objectives

- Definition of co-management, including structure and compensation examples
- How co-management can form the basis for other alignment strategies
- How several organizations utilized co-management as a “first step” to physician alignment
- Legal and business development aspects of co-management

Agenda

- Co-Management
  - Definition
  - Structure
  - Compensation
- Case Studies
- A Legal Perspective
- Co-Management Pros and Cons
- Steps to Collaboration

What is Co-Management?

- *Physicians are engaged by agreement to provide management services in concert with the hospital for certain programs or services. These agreements have performance incentives based on predefined quality, satisfaction and/or efficiency metrics*

What Is the Difference Between Management Services Agreements (MSAs) and Co-Management Agreements?

Traditional Fixed Fee MSA	Co-Management Agreement
❖ Lacks quantitative or qualitative focus	❖ Includes specific performance measures
❖ Lacks outcome focus	❖ Portion of compensation based on achievement of performance targets and outcomes
❖ Lacks alignment with hospital/system strategic priorities	❖ Aligns and advances strategic priorities
❖ Contains subjective (vs. objective measurable) performance criteria	❖ Contains objective performance goals

Co-Management

- Physicians are engaged by agreement, which **may** include the following activities:
  - Medical directorships
  - Efforts devoted to clinical care guidelines and protocol development and operation
  - Clinical outcomes and customer service evaluations
  - Quality improvement services
  - Direct supervision of staff, including teaching and in-service education
  - Operations management

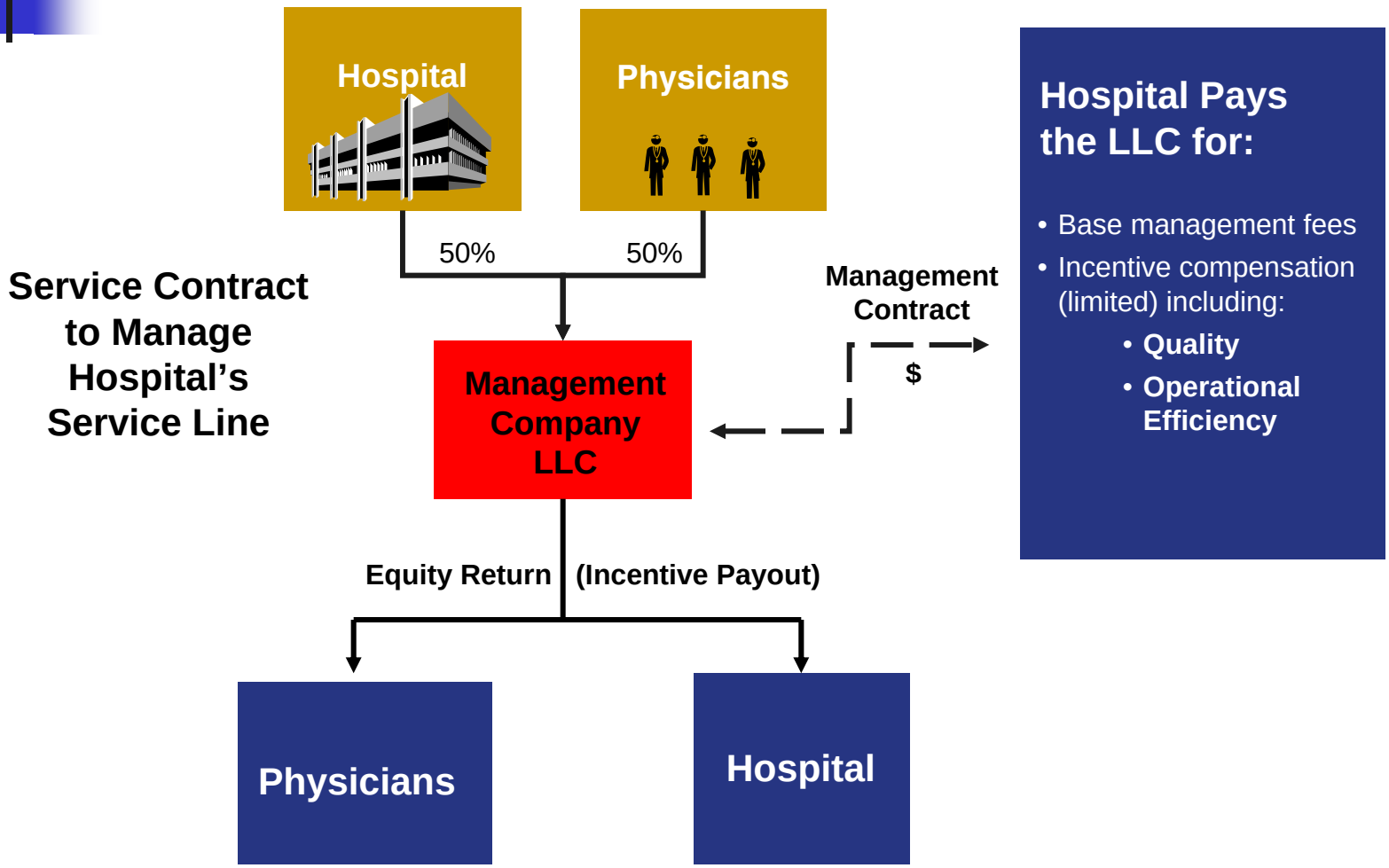
Co-Management

- Activities (continued):
  - Medical technology evaluation, use management, vendor selection and relationship management
  - Drug formulary assessment and management
  - Management time spent in capital and operating budget formation, review and evaluation
  - Physician recruiting, mentoring, specialized training
  - Referral source development and management

Co-Management Structure

- Physicians and potentially the Hospital form a limited liability company (LLC) management entity to provide specific management services for the managed service line
- The LLC is motivated to drive organizational outcomes based on performance
- The LLC links financial incentives to the achievement of specific outcomes related to people, service, quality, resources and growth goals e.g.:
  - Patient safety improvement and satisfaction
  - Complication and infection rate benchmarks
  - Implementation of clinical pathways
  - Efficiency and standardization

Example: Co-Management Structure



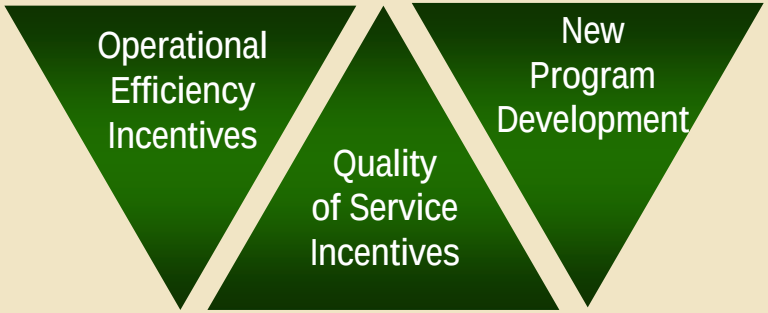
Co-Management: Compensation

- The contract will specify a base management fee
- Bonus is tied to achievement of the pre-established identified performance results
  - First year – Incentives paid on achievement of the baseline measures for each outcome
  - Second year – improvement from year one baseline at specified target levels
- Compensation must be reasonable, based on:
  - Defined work effort
  - Fair Market Value

Co-Management Compensation

Base Management Fee
(Services Provided)

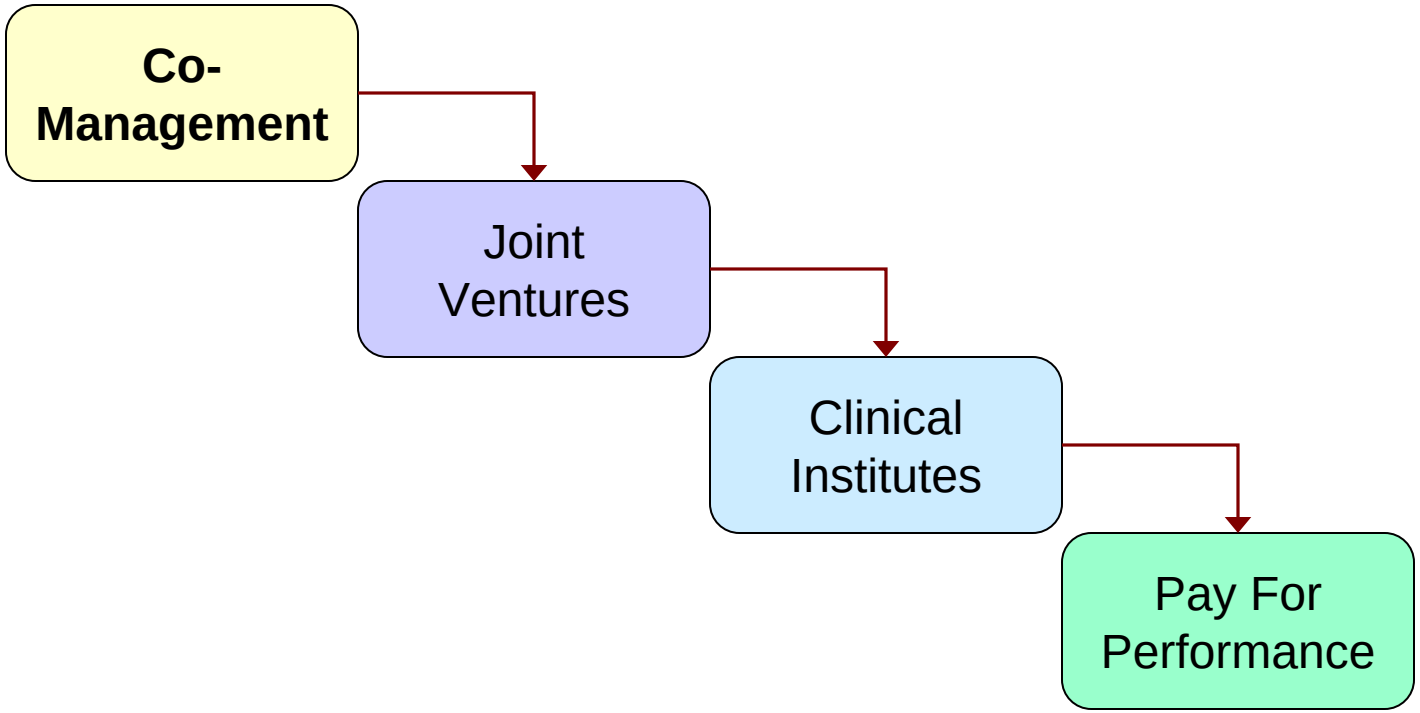
Incentive Compensation
(Goals Achieved)



Co-Management Utilization

- Service lines, i.e.:
  - Cardiac
  - Gastroenterology
  - Imaging
  - Oncology
  - Orthopedics
  - Plastics
- Primary care
- Outpatient surgery services

Proactive Approach



Example: Outpatient Surgery Co-Management at Midwest Hospital

- A 710-bed JCAHO accredited hospital located in the Midwest
- Long term, the hospital wanted to develop a joint venture (JV) ambulatory surgery center (ASC), but due to CON restrictions did not have the immediate outpatient volume to move forward with the initiative
- In an effort to build volume for the future JV ASC and align with physicians in the short term, the hospital implemented a co-management outpatient surgery services strategy at its existing hospital
  - The hospital and 30 physicians from various groups and specialties created a LLC management company
  - The LLC was then contracted to manage operations for the hospital's outpatient surgery services

Case Study: Orthopaedic and NeuroSpine Co-Management

Background

- At the initiation of this project, Providence Hospital Northeast (Providence):
  - Had fewer than five surgeons operating regularly
  - Utilized two of its four OR suites, five days a week
- Most surgeons had left the hospital, not willing to cover ED call at multiple locations
- **Providence initially developed a co-management strategy to:**
  - Build orthopaedic and simple spine neurosurgery business due to declining overall surgical volumes
  - Diversify from its predominate focus on cardiovascular services
  - **Utilize as a platform to develop an Orthopaedic and NeuroSpine Institute**

Achievements to Date

- With the co-management agreement in place, in less than twelve months, the hospital:
  - Increased OR usage from two to six ORs with volume at 141% of budget
  - Went from no neurosurgery and orthopaedic Emergency Department coverage to 24/7 call coverage with dedicated specialty medical direction
  - Developed clinical programs and system changes linking physicians' offices to the hospital for scheduling and registering patients electronically
  - Implemented a Sports Health Division with ATC support and training at two high schools and a public health facility
  - Completely changed the hospital culture to a "can do" organization

A Legal Perspective

Mission Impossible?

In the Beginning…. Gainsharing Defined

- Any arrangement in which a hospital gives physicians a share of the reductions in the cost for patient care that are attributable, in part, to the physicians' efforts

Civil Monetary Penalty Statute

- Prohibits a hospital from knowingly making a payment (directly or indirectly) to induce a physician to reduce or limit services (items) to Medicare/Medicaid beneficiaries under the physician's direct care
- A hospital that makes, and a physician who receives, such a payment are each subject to civil penalties of up to $2,000 for each beneficiary with respect to whom such payment is made

Anti-Kickback Statute

- Criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program.
- Remuneration includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
- Violation is a felony subject to a maximum fine of $25,000 and/or five years imprisonment. Automatic exclusion from Federal health care programs.

1999 Special Advisory Bulletin

- "Black box" arrangement with no transparency
- OIG recognized that properly structured gainsharing arrangements may offer significant benefits
- OIG concluded that the CMP Statute clearly prohibits gainsharing arrangements
- OIG said it will take into consideration in exercising its enforcement discretion whether the gainsharing arrangement was terminated expeditiously

Advisory Opinion No. 01-01 (January 2001)

- Favorable opinion
- NFP hospital agreed to share with CV surgeons 50% of the hospital's cost-savings arising from group's implementation of 19 cost reduction measures during a one-year period
- Group distributed savings on a per capita basis
- No savings shared for an increase in volume over the base year
- Changes in case mix could lead to termination of physician from the arrangement

Advisory Opinions 05-01 – 05-06, 06-22 January/February 2005, November 2006

- Similar to facts of Advisory Opinion 01-01
  - Acute care hospital
  - Groups of either cardiologists or cardiac surgeons
  - Outside program administrator to monitor
  - One-year program
  - 50% of cost-savings paid to group
  - Physicians paid on per capita basis

Advisory Opinion 05-01 – 05-06

- Five categories of cost-savings –
  1. Open packaged items only as needed
  2. Perform blood cross-matching only as needed
  3. Use surgical supplies only as needed
  4. Substitute less costly items for items currently being used
  5. Standardize certain cardiac devices and supplies unless medically inappropriate for a particular patient

Advisory Opinions 05-01 – 05-06, 06-22

- Arrangement violated CMP and potentially violated Anti-Kickback Statute but no sanctions because sufficient safeguards to protect against program abuse and a reduction in patient care
- OIG approved, for the first time, recommendations related to product standardization of high-cost clinical preference items
- OIG appears to be comfortable with the inclusion of cardiologists in gainsharing arrangements

Conditions Relevant to Approval

1. Specificity and transparency
   - Specific cost-saving actions and resulting savings were clearly and separately identified allowing for public scrutiny and physician accountability
2. Written disclosure to patients prior to the procedure being performed
3. Payments based on all surgeries regardless of insurance coverage and a ceiling that limits the effect on federally-funded programs

Conditions Relevant to Approval

4. Payments based on actual costs calculated from the hospital's actual out-of-pocket acquisition
5. Preservation of quality patient care
   - Credible medical support that implementation of recommendation would not adversely affect patient care
6. Financial thresholds based on objective historical clinical measures that reduce incentive to underutilize by capping savings

Conditions Relevant to Approval

7. Product standardization
   - Must protect against inappropriate reductions in services by ensuring that physicians still have available the same selection of devices as before
8. Volume controls
   - No sharing of savings on any volume that exceeds previous year's
9. Short-term duration (one year) to limit sharing of financial benefits

Conditions Relevant to Approval

10. Controlled distribution to physicians of profits on a per capita basis
11. Ongoing monitoring by independent clinical expert to evaluate the impact of program on quality of care

OIG Opinions Are A Significant Regulatory Development

- OIG recognition that:
  - Hospital cost savings are an ever-important policy objective
  - Achieving such savings requires the active cooperation of physicians on the hospitals' medical staff
  - Such savings may be achieved through product standardization programs (esp. high-cost, clinical preference products)
  - Physicians may need to be paid for their cooperation
  - All this may be achieved in a controlled fashion that would reduce the likelihood of program abuse and avoid a negative effect on the quality of patient care

Anti-Kickback Statute

- Personal Services and Management Contracts Safe Harbor
  - Aggregate compensation must be set in advance
  - Consistent with fair market value
  - Arms' length transaction
- Percentage compensation does not meet first element

Stark Law

- Prohibits a physician who has a financial relationship (either directly or through an immediate family member) with an entity from referring patients to that entity for the furnishing of Medicare-covered DHS
- Violations require refunding amounts collected, and may include civil penalty up to $15,000 per self-referred service and exclusion from Federal health care programs

Possible Stark Exceptions

- Personal Service Arrangements – can't have comp based on volume or value
- Fair Market Compensation of the physician's effort
- Indirect Compensation Arrangements

CMS

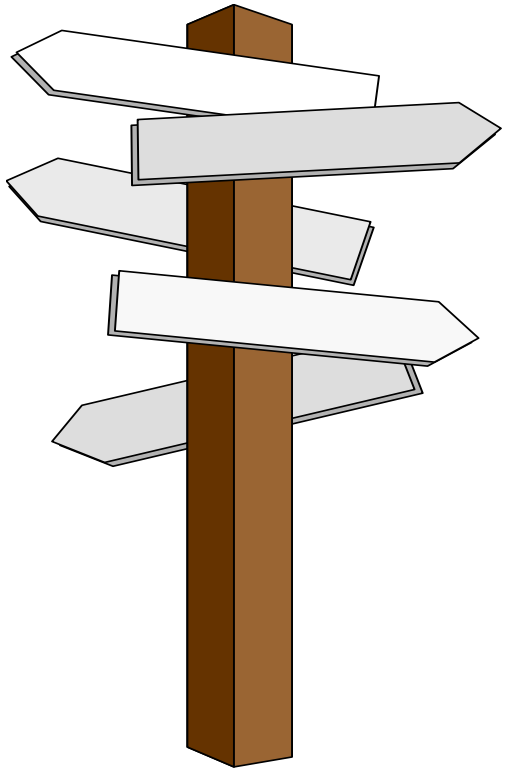
- CMS stated that Stark prohibits hospitals from paying physicians incentives for meeting hospital or drug utilization targets (Preamble 2004 Stark II, Phase II Interim Final Rules)

Tax-Exemption Issues

- Incentive Compensation for Services permitted under long-standing IRS precedent (e.g., General Counsel Memorandum 36918)
  - Arms' length relationship
  - Payment advances a purpose of the organization
  - Results not abusive
  - Ceiling on payout
- How should services be valued (in terms of results or effort taken by MD?)
- Intermediate Sanctions issues arise when MDs are employees of institution (highly compensated persons)

Where Do We Go From Here?

- Any gainsharing arrangement has to have a component ensuring quality of care is not compromised
- Gainsharing should be applicable to entire range of medical services, not just cardiac



Co-Management Legal Issues

- Each of the agreements created as part of the contractual integration should conform to the requirements of the Stark personal services exception and the personal services safe harbor under the Anti-Kickback Law
- Each agreement must be in writing, for a term of a least one year and the compensation must:
  - Be set in the advance in the aggregate
  - Be reasonable and consistent with FMV
  - Not vary with the volume or value of the referrals

Legal Structure of a Typical Co-Management Arrangement

- One-year term with automatic renewals with mutual consent
- Confidentiality and non-compete covenants
- Physician fees
  - Hourly fees set at FMV and subject to documentation and annual cap
  - Performance bonus based on percentage of hourly fees, related to improvement in quality (e.g., clinical quality, stakeholder satisfaction, compliance with regulations) and annual cap
- Total compensation must be reasonable and consistent with FMV

Legal Advantages to Co-Management

- Non-equity model
- Rewards physicians for achieving certain pre-determined clinical outcomes
- Focuses on quality and standards of care, not costs
- Compensates physicians for jointly managing clinical service line
- Physicians maintain their group identity and remain independent of the hospital
- Does not require hospital to deploy scarce capital to purchase a physician practice
- Arrangement is reversible if it doesn't achieve results

Co-Management – Pros and Cons

- Pros:
  - Allows physicians to participate with a minimal up-front capital investment
  - Physicians and potentially the hospital share capital costs for the LLC
  - Physicians are more engaged re: quality, cost, operations
- Cons:
  - ROI is less than other models
  - Contract has a definite life span
  - Requires physician's time to support co-management initiatives

When Should Co-Management Be Utilized?

- To develop trust and collaboration with physicians in a short time frame in support of long term alignment objectives
- To address physician and/or operational issues within a service line or area of operations
- When capital dollars are limited for both the physicians and hospital
- To align physician practice goals with hospital strategic initiatives

Collaboration

1. You have to give up power to get power
2. Reach agreement on assumptions for the future at the outset
3. Trust is a must
4. Establish a strong case for collaboration
5. Recognize the “deal breakers”
6. Let form follow function

Veni

Vidi

Vici

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