Hospital and Physician Relationships in Health Reform Era

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What's Going On?
The Environment

Health care in the U.S. as we know it is financially unsustainable:

• Projected that approximately 32 million newly insured patients will be entering the market over the next few years:
  – More patients and more total $$$; however, there will be fewer $$$ per patient

• Finances will drive change for both providers and hospitals:
  – Shift risk for $$$ from traditional payors to providers, patients and government

• Reimbursement methodologies will impact physician compensation approaches:
  – Bundled payments
  – Episodic payments
  – Shift from pay for providing unit of care to pay for value
The Environment

- **Reimbursement**
  - Reimbursement Rate
  - CPT Code
  - Volume

- **Physician Compensation**
  - Efficiency
  - Quality
  - Productivity

**Today**

- CPT Code
- Pay for Performance

**Tomorrow**

- CPT Code
- Nonpayment for Preventable Complications

**The Environment**

- Reimbursement Physician Compensation
- Volume
- Reimbursement Rate
- Quality
- Productivity
- Efficiency
- Pay for Performance
- Nonpayment for Preventable Complications
The Environment

Down the Road

Value
Quality
Productivity
The Environment

• Clinical transformation will occur across all facets of care delivery
• Integration and alignment will be necessary to weather the change
• Physician leadership is key
• Integrated HCOs are in the best position to guide this transformation
The Environment

We cannot forget about the regulatory environment…

• Increased number and $$ amounts of False Claims Act settlements
• Increased focus on accountability for individual executives and officers
• OIG considering ways to enforce the Responsible Corporate Officer Doctrine:
  – Permits criminal prosecution of corporate officers and executives using a liability theory-based assumption that an officer has the responsibility to prevent or correct misconduct
• Increased funding for and use of Strike Forces
• On March 2, 2011, Senator Grassley introduced the “Strengthening Program Integrity and Accountability in Health Care Act of 2011”:
  – Strengthens exclusion authority of the OIG
  – Testimony of Lewis Morris, OIG Chief Counsel (see Attachment for summary of testimony)
The Environment

Regulatory Concerns

Current and evolving physician compensation models present legal challenges under fraud and abuse and other laws

- Anti-kickback law
- Stark law
- Civil monetary penalties (CMP) law (prohibiting payments to reduce services)
- Antitrust laws
- False Claims Acts
- Tax exempt IRS laws
- Insurance laws
The Environment

> Stark, Anti-kickback and tax exempt laws **ALL** require physician compensation arrangements to be fair market value (FMV)

> Enforcement climate is increasingly focused on FMV and commercial reasonableness
The Environment

Stark Law and FMV:

>Stark Law Definition of FMV:
- Value in arm’s length transactions, consistent with the general market value
- General market value means the 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, at the time of the service agreement
- Fair market price is generally based on bona fide comparable services agreements, where the compensation has not taken into account the volume or value of anticipated or actual referrals
The Environment

IRS 501(c)(3) Requirements:

> IRC 501(c)(3) tax exempt entities are prohibited from operating other than for charitable purposes and no part of net earnings can inure to the benefit of private individuals:

- Prohibits payments in excess of FMV
- Total physician compensation package for actual physician services rendered must be reasonable for geographic market and physician specialty; use compensation studies:

> Base salary
> Bonus
> Fringe benefits
> Deferred compensation
The Environment

IRS and FMV:

> Price expressed as price at which property would change hands between a hypothetical willing and able buyer and hypothetical willing and able seller acting at arms’ length in an open and unrestricted market when neither is under compulsion to buy or sell and when both parties have reasonable knowledge of relevant facts (Rev Rule 59-60)

> Reasonable compensation is the amount that would ordinarily be paid for like services by like enterprises under like circumstances (IRC Section 162)
The Environment

IRS Intermediate Sanctions (IRS 4958):
> If payment is to “disqualified person” may be “excess benefit” transaction:
  - Excise tax if payment exceeds FMV
  - “Disqualified persons” **can include physicians** if they have actual substantial influence or control over decisions (e.g., key medical director/department chair, voting board member)
  - Requires board/delegated committee to approve arrangement following “rebuttable presumption” procedure:
> Approved in advance by board/committee excluding anyone with conflict of interest
> Received and relied on appropriate comparability data
> Adequately documented basis for decision concurrently

“Not take into account the volume or value of referrals or other business generated”
The Environment

Commercial Reasonableness:

> Stark requires compensation arrangement to be commercially reasonable even if no referrals to the DHS entity:

- An arrangement will be considered “commercially reasonable” in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of like type and size and a reasonable physician … of similar scope and specialty even if there were no potential DHS referrals 69 Fed Reg 16093, 16107 (Mar 26, 2004)

> Commercial reasonableness applies to broader business issues related to the arrangement:

- Community need to retain or add service/specialty; ability to increase indigent care; patient care benefits such as quality, continuum of care

- Documentation should attest to the existence of relevant commercial reasonableness factors:

> Especially arrangements providing compensation for administrative and other non-clinical services
The Environment

Enforcement atmosphere is heightened:

• Stark is payment prohibition
• Violations of Stark and Anti-kickback statute = False Claims
• FCA can be brought by whistleblowers
• DOJ taking increasingly aggressive stance on FMV
• Courts are equally at sea
The Environment

Consequences if payments are not FMV:

> Penalties under Stark, Anti-kickback and Tax Exempt laws include:
  - Fines and penalties, including $11,000 per claim and treble damages for false claims
  - Exclusion from Medicare/Medicaid programs
  - Imprisonment
  - IRS intermediate sanctions excise taxes on “disqualified persons” and management

> Reputational risk

> Diversion of organizational resources to addressing investigations, prosecutions, and resolution of non-compliance
The Environment

Nor can we ignore the physician labor market…

• According to the AAMC, the nation is facing a shortage of over 100,000 physicians within the next 15 years:
  – The greatest demand will be for primary care physicians
  – The U.S. has 352,908 primary care doctors now, and the AAMC estimates that 45,000 more will be needed by 2020
  – However, there are fewer medical school students entering family medicine

• In 2009, increase in number of medical students to U.S. medical schools by 18,000:
  – However, no corresponding increase in the number of residency slots
  – U.S. is ranked 23rd in number of physicians per 1,000 by the World Health Organization

<table>
<thead>
<tr>
<th>Year</th>
<th>Supply</th>
<th>Demand</th>
<th>Shortage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>709,700</td>
<td>723,400</td>
<td>13,700</td>
</tr>
<tr>
<td>2015</td>
<td>735,600</td>
<td>798,500</td>
<td>62,900</td>
</tr>
<tr>
<td>2020</td>
<td>759,800</td>
<td>851,300</td>
<td>91,500</td>
</tr>
<tr>
<td>2025</td>
<td>785,400</td>
<td>916,000</td>
<td>130,600</td>
</tr>
</tbody>
</table>

Source: AAMC Center for Workforce Studies, June 2010 Analysis
According to SullivanCotter’s *Physician Compensation and Productivity Surveys*, the relative total cash compensation (TCC) relationships for 10 specialty areas shows that the gaps in TCC paid between primary care physicians and specialists have increased.

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**The Environment**

Range of Ratios:
- **2000**: 0.76 - 1.27
- **2010**: 0.73 - 1.53

**2000**

- General Pediatrics: 0.76
- Family Practice: 0.79
- Psychiatry: 0.81
- Internal Medicine: 0.81
- Pathology: 0.96
- Overall: 1.00
- Emergency Medicine: 1.09
- Obstetrics/Gynecology: 1.15
- Anesthesiology: 1.17
- Radiology: 1.19
- Surgery: 1.27

**2010**

- Psychiatry: 0.73
- Family Practice: 0.73
- Internal Medicine: 0.76
- General Pediatrics: 0.77
- Emergency Medicine: 0.96
- Obstetrics/Gynecology: 0.98
- Pathology: 1.00
- Overall: 1.00
- Surgery: 1.22
- Anesthesiology: 1.31
- Radiology: 1.53
The Environment

• Large health system physician groups pay less than private group practices:
  – But the gap is rapidly narrowing

• We are seeing high demand for:
  – Primary care physicians
  – Oncologists (all types)
  – Pediatric surgical specialists
  – Stroke neurologists

The Market

> **Today**, compensation for clinical work typically consists of:
  
  - Pay for work effort (volume, time)
  - Limited compensation for quality, patient satisfaction, compliance and citizenship
  - Not value-based compensation

> Most physician employers (84%) use incentive-based pay:
  
  - Mix is generally 80% to 85% salary and 15% to 20% incentive

> Salary only model is used by selected large and prestigious physician groups

<table>
<thead>
<tr>
<th>Most Common Incentive Measures Today</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Productivity</strong></td>
<td><strong>Non-Productivity</strong></td>
</tr>
<tr>
<td>wRVUs (71%)</td>
<td>Quality (74%)</td>
</tr>
<tr>
<td>Collections (33%)</td>
<td>Patient Satisfaction (70%)</td>
</tr>
<tr>
<td>Net Income (29%)</td>
<td>Alignment with Org. Objs. (33%)</td>
</tr>
<tr>
<td>Patient Visits (17%)</td>
<td>Citizenship (25%)</td>
</tr>
</tbody>
</table>

Source for market statistics: Sullivan, Cotter and Associates, Inc.’s 2010 *Physician Compensation and Productivity Survey*
The Market

- Use of **alignment incentives** is emerging:
  - Used by about one-third (36%) of physician groups today\(^1\)
  - In addition, about two-thirds of those who are not currently utilizing alignment incentives anticipate doing so within the next two years
  - Alignment Metrics: financial measures, patient satisfaction and quality
  - May include mid-level providers (MLPs)
  - Common objective is to improve quality and reduce/limit growth in costs by encouraging patient-centered care

<table>
<thead>
<tr>
<th>Target Incentive</th>
<th>Maximum Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% of Base Salary</td>
</tr>
<tr>
<td></td>
<td>11.3%</td>
</tr>
<tr>
<td></td>
<td>10.0%</td>
</tr>
</tbody>
</table>

\(^1\)Source for market statistics: Sullivan, Cotter and Associates, Inc.’s 2010 *Physician Compensation in Medical Groups Survey*
The Market

• Mid-Level Provider Supervision:
  – Use of physician compensation for MLP supervision is increasing:
    • Used by 31% of HCOs:
      – Typical stipend paid ranges from $6,000 to $15,000 per year
    • The form of compensation for MLP supervision can range from simple (stipend) to complex formulas (net revenue per incident to wRVU):
      – Must be included in physician’s FMV assessments

• Non-qualified deferred compensation:
  – Use of NQDC for physicians is increasing:
    • Used by 31% of HCOs
    • Average HCO contribution is 5% of salary
The Market

• High demand by HCOs for:
  – MDs with leadership talent
  – Non-MDs with group practice management skills
  – New positions are emerging:
    • Chief Clinical Integration Officer/Chief Physician Integration Officer
    • Chief Information/Clinical Transformation Officer
    • Chief Clinical Officer
  – Medical Director compensation is changing:
    • More MDs to manage
    • Multi-site and/or system-wide responsibilities
    • Financial responsibilities
    • Compensation may begin to mimic executive compensation approaches:
      – Potential use of scope measures such as number of facilities managed, number of physicians supervised, departmental operating budget
Market Strategy

Today
- CPT Code
- Quality
- Volume

Tomorrow
- CPT Code
- Nonpayment for Preventable Complications
- Pay for Performance

Down the Road?
- Quality Improvement
- Patient Population
- Consumer Value

Reimbursement
- Value
- Quality
- Productivity

Physician Compensation
- Value
- Quality
- Productivity

- ?
The Strategy

• The “right” compensation approach is a function of:
  – Culture and values
  – Aligned objectives
  – Business strategy and environment
  – Legal compliance
  – Sharing of quality and outcomes data
  – Effective measurement systems
  – Physician preferences
• Motivation is only one component of performance:
  – Effective goal setting
  – Feedback
  – Helpful systems
• Every model has advantages and disadvantages
• Every model requires the physician leader to manage some aspect of physician performance
• No compensation model is capable of replacing strong physician leadership

“All systems are perfectly designed to produce the outcomes they produce”
Compensation Today
Compensation Tomorrow
Is this the Long-Term Future?

High Value
Low Quality

Low Value
Low Quality

Low Value
High Quality

High Value
High Quality

Quality/Efficiency

TCC, Quality and Value Alignment

Performance corridor

5% 5%
Emerging Compensation Approaches

- Emerging trend: HCOs are moving towards having a physician compensation plan with guiding principles, however, the pay delivery may vary. A common theme includes three compensation pay delivery models:
  - Primary care plan:
    - Net revenue or collections model
    - wRVUs
    - Panel size
    - Quality component
    - Challenges: creating efficiency and access though use of MLPs, efficient management of employee population
  - Hospital/shift based work plan (Critical Care, ED, Hospitalists, Urgent Care):
    - Shift based pay
    - Hourly based pay
    - Group based incentives
    - Challenges: desire to pay for improved efficiencies
  - Specialist plan – volume driven:
    - wRVUs
    - Quality components
    - Challenges: desire to pay for improved efficiencies
Regulatory Compliance

• Net revenue/collections:
  – wRVUs
  – Quality
  – Benefits
  – Other cash compensation

• Productivity compensation (wRVUs and collections):
  – Under Stark Employment Exception can use productivity compensation only for personally performed services
  – Cannot reward physician for volume of work of others but can pay for effort in supervising

• Quality metrics:
  – Difficult to determine FMV for performance related to quality
  – Challenge in measuring/tracking outcomes
  – More time/effort at outset of achieving quality
  – Reset over time; may reduce quality component
  – Physician role in quality achievement

• TOTAL compensation must be FMV
• TOTAL compensation/arrangement must be “commercially reasonable”
Co-Management Agreements

- Reward physicians for effort in developing, managing and improving quality and efficiency of a particular hospital service line

- Enhanced Medical directorship

Base Fee – Fixed
Bonus – At risk for meeting pre-established outcomes/goals
Co-Management Agreements

• Co-management agreements are designed to:
  – Further integrate physicians into the management of HCO services
  – Provide opportunity for physicians to directly impact quality and efficiency
• Key issues to consider/define:
  – What are the duties and responsibilities?
  – Do the duties overlap with other services that are already paid for?
  – How much time is required for each of the duties?
  – Are they necessary for the operation of the service line?
  – What are the expected outcomes?:
    • Efficiency
    • Quality
    • Can these outcomes be measured today? If not, when?
    • Will the required outcomes vary from year to year?
  – Is the compensation reasonable and within FMV?
Co-Management Agreements

- Regulatory challenges include:
  - Must be commercially reasonable
  - The services must be performed
  - At-risk compensation fails the anti-kickback safe harbor
  - Difficult to determine FMV for achievement of efficiency goals
  - Difficult to determine FMV for achievement of quality goals
  - Does the physician effort required to achieve initial goals decline over time thus impacting the value of their total work effort?
  - Once key efficiency and operating goals are achieved, should they be sustained? Or measure continuous improvement?
Co-Management Agreements

- Co-Management Duties:
  - Department chair
  - Medical director
  - Program director
  - Committee chair
  - EMR implementation/review
  - Quality management and improvement
  - Operational efficiency improvement
  - Credentialing
  - Physician recruitment
  - Training of hospital staff
## Co-Management Agreements

### Base Compensation for Administrative Services

<table>
<thead>
<tr>
<th>Base Compensation for Administrative Services</th>
<th>Proposed Rate</th>
<th>Amount (Low Hour Range)</th>
<th>Amount (High Hour Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on Blended Average Hourly Rate</td>
<td>$150.00</td>
<td>$750,000</td>
<td>$1,050,000</td>
</tr>
</tbody>
</table>

### Projected Performance Incentive Compensation

<table>
<thead>
<tr>
<th>Equivalent Rate</th>
<th>Amount (Low Hour Range)</th>
<th>Amount (High Hour Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve 1 of 5 Incentive Measures (+5%)</td>
<td>$7.50</td>
<td>$37,500</td>
</tr>
<tr>
<td>Achieve 2 of 5 Incentive Measures (+10%)</td>
<td>$15.00</td>
<td>$75,000</td>
</tr>
<tr>
<td>Achieve 3 of 5 Incentive Measures (+15%)</td>
<td>$22.50</td>
<td>$112,500</td>
</tr>
<tr>
<td>Achieve 4 of 5 Incentive Measures (+20%)</td>
<td>$30.00</td>
<td>$150,000</td>
</tr>
<tr>
<td>Achieve 5 of 5 Incentive Measures (+25%)</td>
<td>$37.50</td>
<td>$187,500</td>
</tr>
</tbody>
</table>

### Total Compensation for All Services Based on Range of Performance Incentives

<table>
<thead>
<tr>
<th>Equivalent Rate</th>
<th>Amount (Low Hour Range)</th>
<th>Amount (High Hour Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve 1 of 5 Incentive Measures</td>
<td>$157.50</td>
<td>$787,500</td>
</tr>
<tr>
<td>Achieve 2 of 5 Incentive Measures</td>
<td>$165.00</td>
<td>$825,000</td>
</tr>
<tr>
<td>Achieve 3 of 5 Incentive Measures</td>
<td>$172.50</td>
<td>$862,500</td>
</tr>
<tr>
<td>Achieve 4 of 5 Incentive Measures</td>
<td>$180.00</td>
<td>$900,000</td>
</tr>
<tr>
<td>Achieve 5 of 5 Incentive Measures</td>
<td>$187.50</td>
<td>$937,500</td>
</tr>
</tbody>
</table>

1. Total base compensation for administrative services calculated using the low hour range of 5,000 annual hours and high hour range of 7,000 annual hours.
Example Compensation Models

Example: Co-Management Incentive Compensation

<table>
<thead>
<tr>
<th>Incentive</th>
<th>Measure</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Efficiency Improvement Incentive</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost per Case</td>
<td>TBD</td>
<td>$0</td>
<td>$100,000</td>
</tr>
<tr>
<td><strong>Quality Incentive</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection Rate</td>
<td>TBD (e.g., Actual vs Expected)</td>
<td>$0</td>
<td>$100,000</td>
</tr>
<tr>
<td>Mortality Rate</td>
<td>TBD (e.g., Actual vs Expected)</td>
<td>$0</td>
<td>$25,000</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>90 - 92%: $10,000</td>
<td>$0</td>
<td>$25,000</td>
</tr>
<tr>
<td></td>
<td>93 - 95%: $15,000</td>
<td>$0</td>
<td>$25,000</td>
</tr>
<tr>
<td></td>
<td>96% or higher: $25,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Hours: Range from 3,000 - 3,200 per year

Total Maximum Compensation: $1,000,000

Hourly Rates: Range from $234.38 - $333.33 per hour
What is Accountable Care?

- Healthcare Delivery Model focused on:
  - Evidence-Based Medicine
  - Greater Provider Accountability for Patient Outcomes
  - Provider Cooperation and Collaboration Across the Entire Care Spectrum
  - Greater Patient Involvement
  - Improving Overall Quality of Care
  - Reducing Health Care Costs
  - Using Healthcare IT for Better Care Coordination and Outcomes
Principal Drivers Behind Growth of Accountable Care

– Cuts in Professional and Ancillary Reimbursements
– Increasing Care Delivery Costs & Overhead
– Aging Population with More Acute and Chronic Care Needs
– Health Care Reform Payment Initiatives, e.g. Bundled Payments, Shared Savings
– Uncertainty of Health Care Reform
Metrics

**Fee-For-Service Medicine**
- Reactive
- Episodic/Fragmented
- Rewards Volume
- Independent Providers

**Accountable Care**
- Proactive/Preventative
- Integrated/Coordinated
- Rewards Quality
- Interdependent Providers
Managed Care

- PCP = Gatekeeper
- Reduce Utilization
- Care “Silos”
- Health IT Still Nascent
- Independent Practice Model Still Viable Option
- Market Driven

Accountable Care

- PCP = Care Coordinator
- Improve Quality
- Care Collaboration Across Entire Continuum
- Heavily IT Dependent
- Independent Practitioner Becoming Extinct
- Law Driven (Medicare Shared Savings Program)
Accountable Care Organizations

• What is an ACO?
• An organization engaged in the delivery and financing of “Accountable Care”:
  – Organized enterprise of healthcare providers (e.g. physicians, hospitals, ancillary providers, etc.)
  – Collaboratively providing care
  – Evidence-based, outcomes/quality measured
  – Specific populations of patients
  – Providers share in savings/losses in the healthcare costs of that population, as a result of such collaboration
History of ACO Model

• Based Largely on Medicare Physician Group Practice (PGP) Demonstration:

• PGP Demonstration Designed to:
  – Improve quality and decrease costs
  – Encourage Part A and Part B Provider Cooperation

• 5 Year Project: 2005-2010

• 10 Participants, including Physician Group Practices, IDS, IPAs
  – Geisinger, Marshfield Clinic, Billings Clinic, Dartmouth Hitchcock, etc.
History of ACO Model

• Shared Savings with CMS if quality/cost measures met (No Downside Risk)
• 32 QI Metrics
• 2% Savings Threshold, before PGP providers share in savings
Medicare’s Version of ACOs

• Shared Savings Program
  – Established under Health Care Reform Act
  – Starts in 2012

• Medicare Definition of ACO:
  – Organization of providers and suppliers that work together to manage and coordinate care for Medicare Fee-For-Service beneficiaries.
Medicare Shared Savings Program (MSSP) ACO Participation Requirements

In order to Qualify as a Medicare ACO under MSSP:

– Must be accountable for the quality and cost of care of Medicare enrollees
– Participate for at least 3 years
– Have a legal structure that can receive and distribute payments
– Sufficient number of PCP’s to support ≥ 5,000 enrollees
– Include a sufficient number of other types of providers
Medicare Shared Savings Program (MSSP)
ACO Participation Requirements

In order to Qualify as a Medicare ACO under MSSP:

– Capable of sharing data with Medicare
– Maintain appropriate clinical and administrative management systems
– Provide patient centered, evidence based medicine and coordination of care
Medicare Shared Savings Program (MSSP) ACO Participation Requirements

• ACOs eligible to share in savings, only if:
  – ACO meets 65 Medicare determined quality measures; and
  – ACO achieves savings in excess of Medicare determined benchmarks:
    • Benchmark based on each beneficiary’s prior 3-year medical costs;
    • Benchmark is risk adjusted to reflect to overall health status of population enrolled in ACO;
    • Benchmark will be updated annually based on total projected growth in per capita costs for both Part A and Part B Services.
Medicare Shared Savings Program (MSSP)
ACO Participation Requirements

• ACO shares portion of any savings with Medicare: Track 2 ACOs share losses with Medicare
• ACO Prohibited from “cherry picking”
New ACO Draft Regulations: First Impressions

• Primary care bias
• Heavily favor large, well-integrated, well-capitalized, established providers
• Favor developed markets
• High barriers of entry for mid-level providers—quality measures (65), IT investment (EHR), high-savings benchmarks, start-up/operating costs
• Large integrated system bias may lead to further market alignment/consolidation, upward commercial pricing pressure
New ACO Draft Regulations: First Impressions

- CMS expecting:
  - 75-100 ACO applications accepted
  - 1M-4M enrollees
  Projected 3 year savings: $170M-$960M
ACO Proposed Rules: 10 Key Provisions

• Two-sided risk sharing (Tracks 1 and 2)
• Retrospective assignment of beneficiaries
• PCP exclusivity
• Beneficiary representation on governing body
• Proportional representation of ACO providers on governing body
• 25% limit of non-ACO provider representation on governing body
ACO Proposed Rules: 10 Key Provisions

• 5 quality domains/65 sliding scale quality measures
  Significant CMS monitoring/oversight with significant penalties for non-compliance
  No separate entity required for Integrated Delivery System ACOs
• 50% PCP EHR “meaningful user” requirement by Yr 2
Goals

1. Triple aim (better care, better health, lower costs)
2. ACO should put the beneficiary and his/her family at the center of all activities; honor individual preferences, value, and culture; or engage in shared-decision making
3. Ensure coordination of care, regardless of time/place
4. Carefully attend to care transitions, especially from one part of a health care system to another
5. Manage resources carefully and respectfully
6. Continually reduce dependence on in-patient care (*hospitals take note)
7. Be proactive, reach out to patients with reminders.
8. Use data to measure processes and outcomes over time
9. Be innovative in achieving triple aim
10. Continually invest in ACO workforce/clinicians
Who Can Become An ACO

- Physician group practice
- Network of Independent Physicians (IPA)
- Joint Ventures Between Hospitals and Physicians (PHO)
- Hospital with Employed Physicians (IDS)
- Method II Critical Access Hospitals (CAH)
- Others approved by CMS
- No FQHCs or RHCs, but shared savings incentive available for including in network
Physician Group Practice

CMS

- FFS Reimbursement
- ACO Participation Agreement
- 3-Year Agreement

- Group Practice ACO
- FFS Reimbursement
- ACO Participation Agreement

- Hospital
- Specialists

- Post-Acute Providers
Joint Venture (PHO)

ACO, LLC (PHO)

CMS

Hospital

Physicians (IPA)

Hospital

Hospital-Affiliated MD Group

Ancillary Providers

Community-Based (IPA) Providers

Participation Agreements

ACO 3-Year Agreement
Integrated Delivery System

CMS

ACO  3-Year Agreement

Health System IDS ACO

FFS Reimbursement

Hospital  Physician Enterprise  SNF  HHA

FFS Reimbursement
ACO Risk-Sharing Rules

Overview

• Fee-for-service payments continue
• ACOs entitled to share in savings in excess of CMS determined cost target (benchmark)
• Two-track risk-sharing option:
  – Track 1:
    • No-downside risk until year 3
    • 50%-52.5% shared savings
    • Tiered minimum savings rate (MSR) based on population size
    • 2% net savings threshold before shared savings if MSR met
  – Track 2:
    • Day one downside risk
    • 60-65% shared savings
    • MSR fixed at 2%
    • First dollar shared savings if MSR met
    • Shared loss rate inverse to shared savings rate
ACO Risk-Sharing Rules

Overview (cont’d)

• Cap on ACO savings
  – Track 1: 7.5% of benchmark
  – Track 2: 10% of benchmark

• Caps on ACO losses
  – Track 1: 5% of benchmark (year 3 only)
  – Track 2: yr. 1: 5%; yr. 2: 7.5%; yr. 3: 10%

• 25% withhold to cover losses

• Other “cost recoupment mechanisms” to cover up to 1% of annual FFS population expenditures
Process For Determining Potential
Shared Savings/Loss

1. Establish the benchmark (including adjusters)
2. Compare benchmark vs. actual costs
3. Compare savings/loss to minimum savings rate (MSR)
4. If MSR met, determine the sharing rate (based on quality scores)
5. Apply sharing cap to savings/loss
Shared Savings Illustrations

TRACK 2 ILLUSTRATION: IPA Model ACO

ACO Enrollment: 20,000 Members
Benchmark (incl. Adj.): $10,000/Member

Aggregate Benchmark: $200,000,000
Actual FFS Expenditures: $150,000,000
Total Savings: $50,000,000

MSR Flat 2%: 4,000,000
ACO Sharing Rate (Assumes Highest Scores on All Quality Measures): 60.0%

ACO Share of Savings: $30,000,000

Apply Cap (10%): 20,000,000
Deduct 25% Withhold: (5,000,000)
Net Distributable ACO Savings: $15,000,000
Hospital Implications

• Shrinking top line revenue growth
• Episode management will be key
• Decreased avoidable admissions
• Reduced profitability for specialty care
• Physician alignment never more important
• IT critical to success
• Profitability increasingly tied to cost controls/efficiency
ALIGNING INTERESTS AND INCENTIVES UNDER ACCOUNTABLE CARE
Hospital Implications

- Rise of the CMO and CIO
- Need to re-evaluate productivity based compensation models for physicians
- “Right Sizing” of hospital specialty physician panel vs. PCP panel
- Realign CEO/COO compensation packages with accountable care “values”
- Revisit C-suite executive job descriptions for better compatibility with value based healthcare
Now What?

Large, integrated, risk-experienced systems =
Now What?

Mid-sized, community hospitals with affiliated physician enterprise, but limited risk experience:
• Continue physician integration strategy
• Accelerate IT/EHR investments
• Develop evidence-based clinical protocols focused on decreased inpatient utilization
Now What?

• Implement “toe-in-the-water” mini ACO pilot:
  – Collaborate with commercial payors on PCHM:
    • Patient data sharing
    • Seed money
    • Care management fees
    • Jointly developed clinical protocols
  – Focus on hospital employee self-funded plan
  – Target chronic disease employees initially
  – Limit to hospital-affiliated physician network
  – Start with upside risk (shared savings) only
Building an ACO

Assemble Physician Network

Develop Quality Measures and Care Management/Coordination Models

Establish and Test IT Infrastructure for Data Sharing and Reporting

Collaborate with Payors and Negotiate Payment/Bonus Models

TIMELINE
ACO PREPAREDNESS ASSESSMENT

A. DO WE WANT TO BE AN ACO?

- Financial/Cost Considerations
  - $1M+ start-up costs
  - Many years before ROI
  - Many ACOs see no ROI

- Market Factors
  - What are competing hospitals doing?
  - What are local physicians groups doing?
  - Are local commercial payors clamoring for ACO pilots?
  - Will “ship sail without us”?
  - How long will ACOs be around?

- Practical Considerations
  - Major transformation in delivery model/mindset
  - Interruptions in Operations
  - Need for Physicians Leaders
  - Failure to take lead may lead to physician groups leveraging competing hospitals against one another to compete for role in physician-owned ACO
ACO PREPAREDNESS ASSESSMENT

B. ARE WE READY TO BE AN ACO?

– Do We Have Critical Mass?
  • PCP Panel
  • 15,000+ ACO Patient Panel

– Do We have Appropriate Technology?
  • Electronic Medical Records
  • Disease Registry
  • Data Collecting, Reporting and Submission Capabilities
  • Ability to Measure/Report Quality/Performance Metrics
  • Capacity to Identify and Correct Gaps in Care Delivery

– DNA
  • Are we ready to be measured/compared against our peers?
  • Cooperative spirit between Hospital and Physicians
  • Team approach between PCPs, Specialists, Mid-Levels

– Care Management
  • Team-based approach
  • Monitoring and intervention capabilities
  • Transitioning to Post-Acute Care
KEY STRUCTURAL ELEMENTS IN PLACE?

- Complete and timely information about patients and the care they are receiving
  - EMR, registries, etc.
- Technology and skills for population management and care coordination
- Resources for patient education and self-management support
  - Telemedicine, email, telephonic nursing
- Team Approach/Culture
- Coordination between specialists and PCPs
  - Do we need specialists in the ACO?
- Ability to measure and report on quality
- Infrastructure to accept and manage financial risk
  - Global payments, capitation
  - Allocation of profits/losses among risk pools
  - Organization Financial Stability
- Top-Down Organizational Commitment to Value Improvement and Accountability
What Lies Ahead in 2011 & Beyond?

- Consolidation of resources
- Hospitals employing primary care and specialty physicians
- Employed physicians’ compensation plans becoming *highly* productivity-based
- Increased government involvement (Federal)
- Increased burden on providers
- Continued reduction in reimbursement
- Increased backlog of non-emergent cases
- Continued emphasis on quality and clinical outcomes
Continued Consolidation of Resources

• The “strength in numbers” initiative will continue as providers band together to deliver clinical services
• These collaborations provide a common ground to reduce costs and provide benefits from economies of scale
• Consolidations
  • Increase ability to achieve better performance
  • Potentially reduces risk
• Greater opportunity to obtain a return on investment (ROI) if physicians and hospitals work together
Continued Consolidation of Resources/Alignment

Provider to Hospital Structure

- Managed care networks (IPAs, PHOs)
- Mergers/group formations
- Equity model group assimilation (jointly-owned practice)
- Clinic model
- Management services
- Provider equity (i.e., joint ventures, investments)
- Employment/professional services agreements (PSAs)
Implications of ACOs re: Physician Compensation

• Eventual impact on compensation:
  – Shifts emphasis away from compensation based on production (wRVU or collections)
    • Need to incent physicians to produce **better**, not **more**
    • Especially true in primary care setting
  – To achieve financial incentives for hospital/ system, physicians must:
    • Understand objectives of ACO model
    • Participate in establishing and implementing clinical protocols by specialty
    • Recognize how, when and why their performance will be measured
Implications of ACOs re: Physician Compensation

• For now:
  – Details of ACO model remain unclear, pending further guidance from CMS
  – Until we know how reimbursement will work, hard to identify exactly how to incentivize employed physicians
Implications of ACOs re: Physician Compensation

• Alternatives for interim:
  – Continue with production-driven models, or
  – Commence gradual shift toward models more compatible with ACO world of future?

• Both approaches have their merits
Implications of ACOs: Physician Compensation

• Reasons to continue with production-driven models during interim:
  – Known commodity
  – Stability, continuity and familiarity for physicians
  – Processes already in place for administering
  – Generally not disruptive
  – Permits a one-time change if and when CMS defines parameters
Implications of ACOs: Physician Compensation

• Reasons to move to alternative interim model:
  – Commercial payors *already* shifting toward payment for quality and outcomes, ahead of CMS
  – Greater lead time for employers and physicians to identify and become comfortable with appropriate quality and outcomes measures
  – May soften impact of cultural/economic shifts associated with future ACO implementation
Implications of ACOs: Physician Compensation

—Anecdotally:

• Large physician entities are modifying primary care physician compensation for 5%, 20% or even 50% to be at risk based on factors other than production
Interim Models During ACO Transition

• What remains the same:
  – Compensation tied solely to services personally performed by physician or those under physician’s direct supervision (no compensation for ancillaries)
  – Annual adjustments to ensure FMV
  – Stipend for administrative services and/or supervision of extenders
  – Cap on total compensation
Interim Models During ACO Transition

• What changes – the key question:
  – How to reward physicians for individual performance
Interim Models During ACO Transition

• Objectives of compensation plan:
  – Reward physicians at FMV
  – Encourage diligent work efforts
  – Provide reasonable income stability/continuity during transition to “reformed” healthcare industry
  – Promote quality
Interim Models During ACO Transition

– Reward collaboration with other providers and caregivers
– Encourage better communication with patients
– Promote care in the “right” setting
– Reward effective/efficient use of limited hospital/system resources
Interim Models During ACO Transition

• Potential components of compensation (“building blocks”)
  – Fixed guaranteed salary
  – Production-based compensation (wRVUS, collections, etc.)
  – Quality incentives
  – Patient satisfaction incentives
  – Incentives tied to other individual performance considerations
  – Incentives tied to other group or hospital/system performance considerations
Interim Models During ACO Transition

• Maybe not a one-size fits all proposition (e.g., primary care vs. specialists)?
  – Consider how compensation plan objectives vary between specialty areas
  – If objectives vary, may need to also differentiate the specific building blocks accordingly
Interim Models During ACO Transition

• **Model A**
  – 100% fixed, guaranteed salary, established at start of each year during term of employment
  – Adjust annually based on review of prior-year’s performance
    • Adjustments may be subjective or objective/formulaic
    • Considerations would include:
      – Production (work effort)
      – Participation in process initiatives
      – Quality/outcomes
Interim Models During ACO Transition

• **Model B**
  - Base compensation (50% of maximum total compensation)
    • Production-driven, measured by wRVUs actually produced (current year, prior year, or multi-year period)
  - Process incentive (25%)
    • May include circuit-breaker tied to group, service line, or hospital/system performance criteria
    • Individual payment tied to participation in development and implementation of clinical protocols for that specialty
Interim Models During ACO Transition

• Model B (cont’d)
  – Outcomes incentive (25%)
    • Individual payment tied to achievement of predefined quality and outcomes measures for that specialty
Interim Models During ACO Transition

• **Model C**
  – Compensation calculated 100% with regard to production (wRVUs)
  – Adjust conversion factors (applied to wRVUs) based on individual physician performance
    • **Production**
      – CF increases associated with higher production (e.g., may use CF of $50 for first 5,000 wRVUs, $52 for next 2,500 wRVUs, and $55 above that)
    • **Process**
      – CF increases for demonstrated participation in development and implementation of clinical protocols (e.g., may add another $2 to CF on all wRVUs produced)
Interim Models During ACO Transition

• **Model C (cont’d)**
  • Outcomes
    – CF increases for achievement of predefined quality and outcomes measures (e.g., may add another $3 to CF on all wRVUs produced)
Interim Models During ACO Transition

- **Model D**
  - Starting with primary care only, establish fixed dollar amount *(e.g., $10-20k)* available for achievement of non-production goals
    - Patient satisfaction (1/3)
    - Access (1/3)
    - Quality (1/3)
  - To ensure consistency with fair market value (FMV), need to carve out from existing production-based formula
    - Should not simply add onto amounts already being paid
Interim Models During ACO Transition

• Key to all models:
  – Physicians must be engaged in the development of measures for process and outcomes incentives
  – May need to shift weights/amounts between primary care and specialists, or between specialties
  – Allow sufficient lead time for internal and external FMV analysis, dialogue, feedback, and necessary approvals
Interim Models During ACO Transition

• Key to all models (cont’d):
  – Careful advance modeling required to:
    • Protect employer financially (can we afford this?)
    • Ensure that hospital/system interests are aligned with those of individual physicians
    • Provide physicians with clear understanding of financial impact (and opportunities) of individual, group, service line and/or hospital/system performance
    • Reduce compliance risks
Interim Models During ACO Transition

• Key to all models (cont’d):
  – Must control expectations
    • Dealing with an uncertain future state of healthcare reimbursement and regulation
    • What works now (during interim) may not work 2, 5 or 10 years from now
    • Essential premise: Providers are in this together, and collective success requires alignment of objectives, incentives and performance standards
Valuation Challenges

Today

90th Percentile TCC and Productivity
75th Percentile TCC and Productivity
50th Percentile TCC and Productivity

Total Cash Compensation (TCC)

Productivity (wRVUs or Collections)

Quality, Patient Satisfaction

Typical Compensation Plan
- Base salary
- wRVU productivity incentive
- Quality incentive
Valuation Challenges

Typical Compensation Plan
- Base salary
- Productivity bands
- Quality incentive
- Efficiency incentive
Valuation Challenges

Down the Road

Total Cash Compensation (TCC)

90th Percentile TCC and Productivity
75th Percentile TCC and Productivity
50th Percentile TCC and Productivity

Productivity (wRVUs or Collections)

Value Based Compensation

FMV?

Typical Compensation Plan
- Base Salary
- Value-Based Incentives
- Productivity Incentives?
Evolving Regulatory Concerns Payment for Quality Metrics-Independent Contract

– Fails Anti-kickback safe harbor if aggregate compensation not “set in advance” (RISK?)
– May meet Stark exception “set in advance” if formula can be set forth in agreement
– Both require FMV compensation and not take into account volume or value of referrals or other business
– Both require overall arrangement to be “commercially reasonable”
Evolving Regulatory Concerns Payment for Quality Metrics-Independent Contract

– Measuring/tracking performance outcomes
– Compensation for time spent developing benchmarks, clinical protocols, materials at FMV at outset
– Readjust compensation for time as services completed
– Relevance/evolution of quality metrics over time and FMV as program matures
– Need to “reset” or advance type and measure for time-based performance based metrics
Evolving Regulatory Concerns Payment for Quality Metrics-Employment

– Growing trend to add quality achievement duties
– Recall total compensation package must remain at FMV
– Adding or including performance-based quality compensation cannot increase total beyond FMV
– Consider both quality and clinical duties together:
  » Can all be achieved or impossible day?
  » Salaried versus shift employee
Evolving Regulatory Concerns
Payment for Efficiency/Shared Savings

– Implicates CMP to extent could be viewed as incentive to reduce or limit services to beneficiaries
– See OIG Special Advisory Board and Advisory Opinions on gain sharing, suggesting program standards:
  » Avoid “cherry picking” patients
  » Avoid “stinting” on care, “steering” patient and early discharge
  » Maintain clinician choice of treatment options/supplies
  » Look to recognized, objective clinical guidelines/protocols
  » Transparency
  » Payments per capita and limited duration

– Waiver/new exception from CMP
Evolving Regulatory Concerns
Payment for Efficiency/Shared Savings

– Stark compliance uncertain:
  » Historically, no Stark exception for gainsharing
– 2009 MDFS proposed Stark exception for incentive payment and shared savings programs (gainsharing, PAP, value-based purchasing), not finalized
– Indirect compensation option
– Waiver/new exception for Stark law?
• No anti-kickback safe harbor; not “set in advance”
Evolving Regulatory Concerns Waivers Allow Flexibility in Developing New Compensation Models (e.g., HHS ACO Waiver PPACA §3022(f))

- Case-by-case waiver for payment model (ACO)
- Develop safeguards under existing laws that if met allow model to qualify for waiver from law
Market Trend

• Continued increase in use of on-call pay:
  – Used by 54% of HCOs

2010 Physician On-Call Pay Survey
Comparison of Expenditures 2007-2010

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<th>Year</th>
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<th>Trauma Center Median</th>
<th>Non-Trauma Center Average</th>
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<td>$1,459,804</td>
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</table>
Valuation Challenges

- Valuation of physician on-call pay must take into consideration a number of factors including the:
  - Frequency of call provided
  - Likelihood of being called in
  - Intensity of services when called in and
  - The total compensation provided for the services

The fourth variable is often overlooked when designing a physician on-call pay approach, especially for employed physicians.
Physician Compensation Oversight

Action 1: Educate the Board

• Update the Board on trends in physician compensation models and options management is considering

• Educate the Board on its role and responsibility in ensuring compliance

• In carrying out duties, Board members must make prudent business judgments in the best interest of the organization involving a transparent, deliberate and informed process
Physician Compensation Oversight

Action 2: Establish and Delegate to Board Committee

- Consider establishing a committee of disinterested Board members and/or officers to oversee MD compensation:
  - Current regulatory climate and increased scrutiny of MD compensation arrangements
  - Increasing emphasis on the Board’s compliance oversight obligations
  - Committee members MUST be disinterested

*Existing Board compensation committee often used but many are opting to create a unique Physician Compensation Committee*
Physician Compensation Oversight

Action 2: Establish and Delegate to Board Committee (cont’d)

• In considering whether to use an existing Board committee or creating a new committee, consider:
  – Volume of physician compensation arrangements
  – Synergy with other work of committee
  – Differences in appropriate composition of committee
  – Available skill sets
  – Actual and potential conflicts of interest
  – External and internal scrutiny of committee activities and members
Physician Compensation Oversight

Action 3: Develop Governance Documents and Process

- Define the physician compensation philosophy
- Establish pre-approved ranges/thresholds and parameters
- Limit numbers/types personnel handling physician
Physician Compensation Oversight

Action 3: Develop Governance Documents and Process (cont’d)

- Develop a review schedule:
  - Annual assessment:
    » Leadership positions, integrate with executives
  - Quarterly review of specified number of contracts or other periodic ad hoc requests (new hires, practice acquisitions, contract renewals)
  - Annual or bi-annual review of employed physician compensation arrangements
Physician Compensation Oversight

Action 4: Determine Which Physicians Will be Reviewed

• Develop, review and approve overall compensation plan
• Develop policies for determining which arrangements require Committee-level review. For example:
  – All MD Chair positions
  – Any MD with the title of Chief with pay > $350,000
  – Any MD pay arrangement > $500,000
  – Any MD who has a family member in a key leadership position
Physician Compensation Oversight

Action 5: Conduct Program Audit

- Conduct FMV review of arrangements
- Develop “risk matrix” of current compensation levels by tiering potential exposure based on pay and productivity
- Document business factors to support current positioning
Physician Compensation Oversight

Action 5: Conduct Program Audit (cont’d)

• Review features of compensation plans

• Potential “high risk” issues:
  – Pay misaligned with productivity; productivity paid on first dollar collected
  – Lack of specific, documented job duties for Medical Director:
    » Overlap of duties with other Medical Director positions
    » Time spent on actual services not documented
    » Recommend measuring outcomes and document time spent
Physician Compensation Oversight

Action 5: Conduct Program Audit (cont’d)

• Potential “high risk” issues, continued:
  – Pay for others’ productivity (for example, mid-level providers)
  – The “impossible day” – concurrent pay for on-call, clinical services, Medical Director responsibilities
  – On-call pay arrangements that result in “double-payment” for services (e.g., on-call pay stipend plus guaranteed compensation for services when called in or high professional fees earned when called in)
Physician Compensation Oversight

Action 6: Get Engaged with Transactions Early in Process

• Compensation issues frequently are critical aspects of physician acquisitions
• Committee should be engaged in oversight from the outset of the transaction
• Review key issues and risks
• Assure proposed compensation is consistent with FMV and build appropriate business case; Do NOT back into desired compensation
Physician Compensation Oversight

Action 7: Document Findings

• Ensure that documentation of analysis and outcomes is comprehensive to support Stark, Anti-Kickback and tax exempt compliance
Physician Compensation Oversight

Action 7: Document Findings (cont’d)

• Include:
  – Scope and methodology of analysis
  – Market positioning and productivity results
  – Business case particularly for high risk arrangements
  – Conclusion of FMV analyses
  – Advisor reports
Physician Compensation Oversight

Action 8: Update the Board

• Inform full Board of Committee agenda and actions
• Update the Board on any “high risk” issues or unusual activity that could have implications for the organization
• Prepare talking points, as needed (community benefit, market standards)
Physician Compensation Review Process

- Board Committee comprised of Board members and corporate officers
- Approves compensation and contract parameters/templates on annual basis
- Reviews and approves individual contracts if outside contract parameters/templates
- Committee members must be free of conflict of interest
- Follow IRS “rebuttable presumption” for physician contracts with “disqualified persons”

Hospital Board

- Delegates authority to review physician compensation to Board committee

Physician Compensation Review Committee

- “Rebuttable Presumption”
  - Approve in advance
  - Receive and rely on appropriate comparability date
  - Document decision
ATTACHMENT A: LEGAL SUPPLEMENT
Stark Law Basic Prohibition

- Prohibits physician from referring to an entity for “designated health services” (DHS) if physician has a “financial relationship” with DHS entity UNLESS:
  - Arrangement satisfies ALL requirements of a Stark exception
  - Key Stark exceptions require that compensation is “FMV” and commercially reasonable
- Employment
- Personal services
- FMV
- Indirect compensation
- DHS include ALL inpatient and outpatient hospital services
  - If entity furnishes DHS based on a tainted referral, it cannot bill Medicare or any third party
Stark Law Example

- UNLESS, satisfies Employment Exception
Stark “Bona Fide” Employment Exception (42 CFR 411.357(c))

- Excepts amount paid by employer to bona fide employee physician for services if:
  - Employment for identifiable services
  - Payment is consistent with FMV of the services and;
  - Payment is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician
  - Payment is under an agreement that would be commercially reasonable even if no referrals were made to the employer
  - Payment can take form of a productivity bonus based on services personally performed by the physician
Stark “Bona Fide” Employment Exception (42 CFR 411.357(c))

- Key terms to consider:
  - Commercially reasonable:
    » Without any Medicare or Medicaid referrals for DHS to employer
    » But see “special rules on compensation” (42 CFR 411.354(d)(4)) hospital employers can require “bona fide” employee physicians to refer to hospital facilities if:
      - Compensation is FMV and set in advance for the term
      - Employment arrangement complies with employment exception
      - Requirement to refer to specified provider, practitioner or supplier is in written agreement signed by the parties
Stark “Bona Fide” Employment Exception (42 CFR 411.357(c))

- Key terms to consider:
  - Commercially reasonable (cont’d):
    » Requirement does not apply if patient expresses a preference for another provider, patient’s insurer determines another provider, or referral to specified provider would not be in the patient’s best interest
    » Requirement relates solely to physician’s services under employment agreement, and is reasonably necessary to effectuate the legitimate business purpose of the compensation arrangement
    » Employee physician cannot be required to make referrals that relate to services that are not provided by physician under employment
Stark Personal Services Exception (42 CFR 411.357(d))

- Excepts payment to physician (or group practice) if:
  - Written agreement signed by the parties, specifying the services
  - Agreement covers all services to be furnished by physician (or cross references other service arrangements or references master list)
  - Aggregate services do not exceed reasonable and necessary for the legitimate business purpose
  - Term is for at least one year and if terminated with or without cause parties may not enter into similar arrangement during first year of original term
  - Compensation is “set in advance” and does not exceed FMV and is not determined in manner that takes into account the volume or value of referrals or other business generated between the parties
  - Services do not involve counseling or promotion of arrangements that violate federal or state laws
  - 6 month holdover permitted after expiration if all above are met
Stark Personal Services Exception (42 CFR 411.357(d))

- Key terms to consider:
  - “Set in advance” requires compensation (including per-unit of service based amount or specific formula for calculation compensation) to be stated in agreement BEFORE the services are performed. 42 CFR 411.354(d)(1)
- Percentage-based, per-click, per time period, or other formulas are “set in advance”
- Stark II Phase I commentary clarifies that:
  - Formula must be “set forth in sufficient detail” to allow “objectively verified”, and
  - Cannot be changed during term in manner that takes into account the volume or value of referrals
  - Single fee schedule (or percentage of fee schedule) uniformly applied to all services is “set in advance”; percentage of revenues, collections, or expenses is “set in advance” (66 Fed. Reg. at 856, 877 (January 4, 2001))
Stark Indirect Compensation Exception
(42 CFR 411.357(p); 411.354(c))

• Protects compensation under an “indirect compensation arrangement” if:
  – Compensation is FMV for items or services actually provided and is not
determined in a manner that takes into account the volume or value of
referrals or other business generated by the physician for the DHS entity
  – Compensation for rental of office space or equipment cannot be
percentage-based or per unit based for services to patients referred by
lessor to lessee
  – Arrangement is set out in writing signed by the parties and specifying the
services (except if bona fide employment does not require written
agreement but must be for identifiable services and commercially
reasonable even if no referrals made to the employer)
  – Arrangement does not violate the anti-kickback statute or any federal or
state law governing billing
Stark FMV Exception (42 CFR 411.357(l))

- Protects payment by DHS entity to physician for services if:
  - Written agreement signed by parties identifying all services
  - Agreement specifies time frame (which can be any time frame and can include a termination clause so long as parties enter into only one arrangement per year)
  - Agreement specifies compensation which is “set in advance” and FMV, and not determined in manner that takes into account the volume or value of referrals or other business generated by the referring physician
  - Arrangement is commercially reasonable and furthers the legitimate business purpose of the parties
  - Arrangement does not violate the anti-kickback statute or federal or state laws governing billing
  - Services do not involve the counseling or promotion of a business arrangement or activity that violates federal or state law
Stark Definition of Fair Market Value

- Fair Market Value (FMV) means:
  - Value in arm’s length transactions, consistent with the general market value
  - General market value means the 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, at the time of the service agreement.
  - Fair market price is generally based on bona fide comparable services agreements, where the compensation has not taken into account the volume or value of anticipated or actual referrals.
Stark and FMV (42 CFR 411.351)

- FMV history:
  - Stark II, Phase II
- Clarified CMS will consider range of methods to determine FMV
- Appropriate method varies based on nature and location of transaction and other factors 69 Fed Reg 16054, 16107 (Mar. 26, 2004)
- Established voluntary safe harbors for FMV consisting of two methodologies for determining hourly rates for personal services (average hourly rates for ER physicians and average 50th % salary for specialty using 4 of 6 specified salary surveys) 69 Fed Reg 16054, 16092 (Mar. 26, 2004)
Stark and FMV (42 CFR 411.351)

- FMV history:
  - Stark II, Phase III eliminated “FMV” safe harbors but noted “reference to multiple, objective, independently published salary surveys remains a prudent practice” and FMV may vary based on nature of transaction, location, and other factors 72 Fed Reg 51012, 51015 (Sept. 5, 2007)
  - Stark II, Phase III discussed administrative versus clinical services, stating:

  *FMV hourly rate may be used to compensate physicians for both administrative and clinical work, provided that both are FMC for the type of services, and FMV for administrative services may be different than for clinical services* 72 Fed Reg 51012, 51016 (Sept. 5, 2007)
Anti-Kickback Statute (42 USC 1320a-7b(b))

- Criminal law prohibits the offer, payment, solicitation or receipt of remuneration (i.e., anything of value) to induce or reward, referrals of items or services payable by federal health care programs
- Statutory exception for employment
- Regulatory safe harbors protect qualifying arrangements from prosecution; ALL safe harbor requirements must be met
- Some safe harbors require payment at FMV
Anti-Kickback Employment Exception and Safe Harbor (42 USC 1320a-7b(b); (42 CFR1001.952(i))

> Anti-kickback statute allows “any amount paid by an employer to an employee” for employment in provision of covered items or services covered by Medicare or Medicaid

> Employee must be “bona fide” (meet IRS test at 26 USC 3121(d)(2)), which requires:
  - Behavioral control
  - Financial control
  - Specified relationship factors
  - DOES NOT REQUIRE FMV

> Personal services safe harbor similar to Stark personal services exception (42 CFR 1001.952(d))
Civil Monetary Penalties (CMP) Law (42 USC 1320a-7(b)(1) and (2))

> Prohibits a hospital from paying a physician to induce reductions or limitations of patient care services to Medicare or Medicaid beneficiaries under the physician’s direct care
> Both hospitals and physicians can be liable for CMPs of up to $2,000 per patient involved in the payments
> OIG has said gainsharing arrangements violate CMP but has issued fourteen favorable Advisory Opinions* where safeguards are in place

*See OIG Special Advisory Bulletin on Gainsharing (July 1999); Advisory Opinions 01-01, 05-01, 05-02, 05-03, 05-04, 05-05, 05-06, 06-22, 07-21, 07-22, 08-09, 08-15, 08-16, 08-21
Anti-Kickback Personal Services Safe Harbor (42 CFR 1001.952(d))

- Similar requirements to Stark personal services exception
- Except requires “aggregate” compensation to be “set in advance” and consistent with FMV and not based on referrals
- Aggregate services cannot exceed those reasonably necessary to accomplish commercially reasonable business purpose
- Disallows percentage-based or per-click compensation or other methods where total amount cannot be determined from terms of agreement
IRS Tax Exempt Status (IRC 501(c)(3))

IRC 501(c)(3) entities prohibited from operating other than for charitable purposes and no part of net earnings can inure to the benefit of private individuals:
- Private benefit/private inurement prohibits payments in excess of FMV
- Total physician compensation package for actual physician services rendered must be reasonable for geographic market and physician specialty; use compensation studies
- Total compensation includes base salary, bonus, fringe benefits, and deferred compensation
- See also IRS Health Care Provider Reference Guide (2003) at p.18; Rev Proc 2001-4
IRS Intermediate Sanctions (IRC 4958)

> If payment is to “disqualified person” may be “excess benefit” transaction:
  - Excise tax if payment exceeds FMV
  - “Disqualified persons” can include physicians if they have actual substantial influence or control over decisions (e.g., key medical director/department chair, voting board member)
  - Requires board/delegated committee to approve arrangement following “rebuttable presumption” procedure

> Approved in advance by board/committee excluding anyone with conflict of interest

> Received and relied on appropriate comparability data

> Adequately documented basis for decision concurrently
IRS and FMV

> IRS View of FMV:

– Price expressed as price at which property would change hands between a **hypothetical willing and able buyer and hypothetical willing and able seller acting at arms’ length** in an open and unrestricted market when neither is under compulsion to buy or sell and when both parties have reasonable knowledge of relevant facts (Rev Rule 59-60)

– Reasonable compensation is the amount that would ordinarily be paid for like services by like enterprises under like circumstances (IRC Section 162)
If you have any questions or comments, please contact:

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