Greeley Medical Staff Institute Symposium

Solutions to top medical staff challenges

Health Laws, Bylaws, and Regulatory Issues Track

Stark, Anti-kickback, and Private Inurement

Finding flexibility in what hospitals are allowed to do and how they can do it

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Stark Act

- The federal self-referral statute, commonly referred to as the “Stark Law,” provides that a physician cannot:
  - Refer Medicare patients to an entity
  - For the furnishing of designated health services (DHS)
  - If there is a financial relationship between the referring physician or an immediate family member and the entity
    - Unless an exception applies
  - Stark prohibits an entity from presenting a Medicare claim for a DHS that has been rendered pursuant to a prohibited referral

Stark Act (cont'd)

- Penalties for violating Stark include:
  - Denial of claims
  - Monetary penalties of up to $15,000 for each claim submitted as a result of a prohibited referral
  - A fine of up to twice the amount paid for the service
  - Exclusion from Medicare/Medicaid programs

Stark Act (cont'd)

- "Financial relationship" includes four different types of relationships between a physician and an entity furnishing DHS:
  - Direct ownership or investment interest
  - Indirect ownership or investment interest
  - Direct compensation arrangement
  - Indirect compensation arrangement
- A physician who has any of the foregoing relationships with a DHS provider cannot refer Medicare or Medicaid patients unless an exception applies

Designated Health Services

- Clinical laboratory services
- Physical therapy, occupational therapy, and speech/language pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics and prosthetic devices, and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

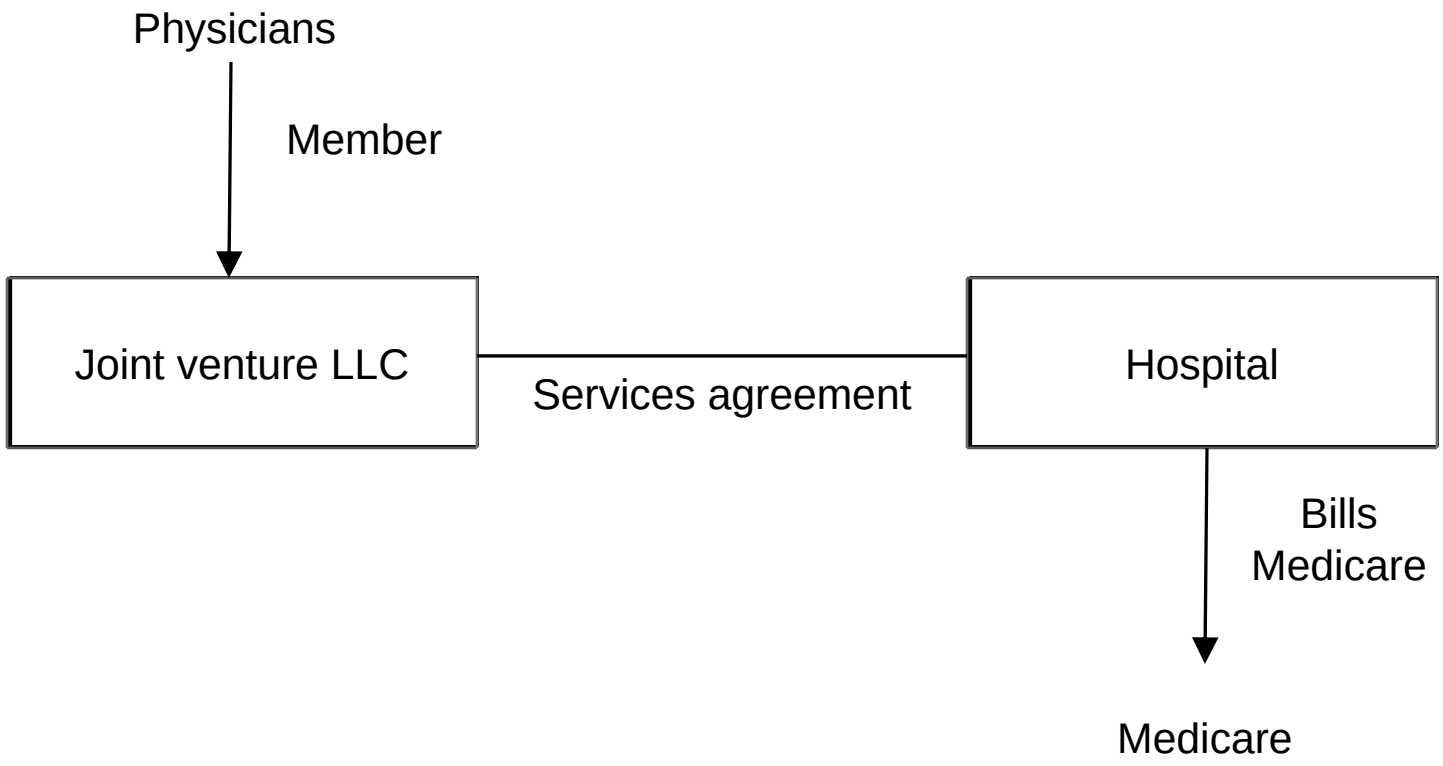
New CMS Stark Regulations

- CMS goal:
  - Close perceived “loopholes” that permit allegedly abusive financial relationships between hospitals and physicians
    - August 19, 2008: CMS publishes final Stark rules (73 Fed. Reg. 48434, 48688-48752)
    - Effective Dates:
      - October 1, 2008
      - October 1, 2009
- Practical effect:
  - Will require restructuring of many hospital-physician transactions

Definition of DHS Entity

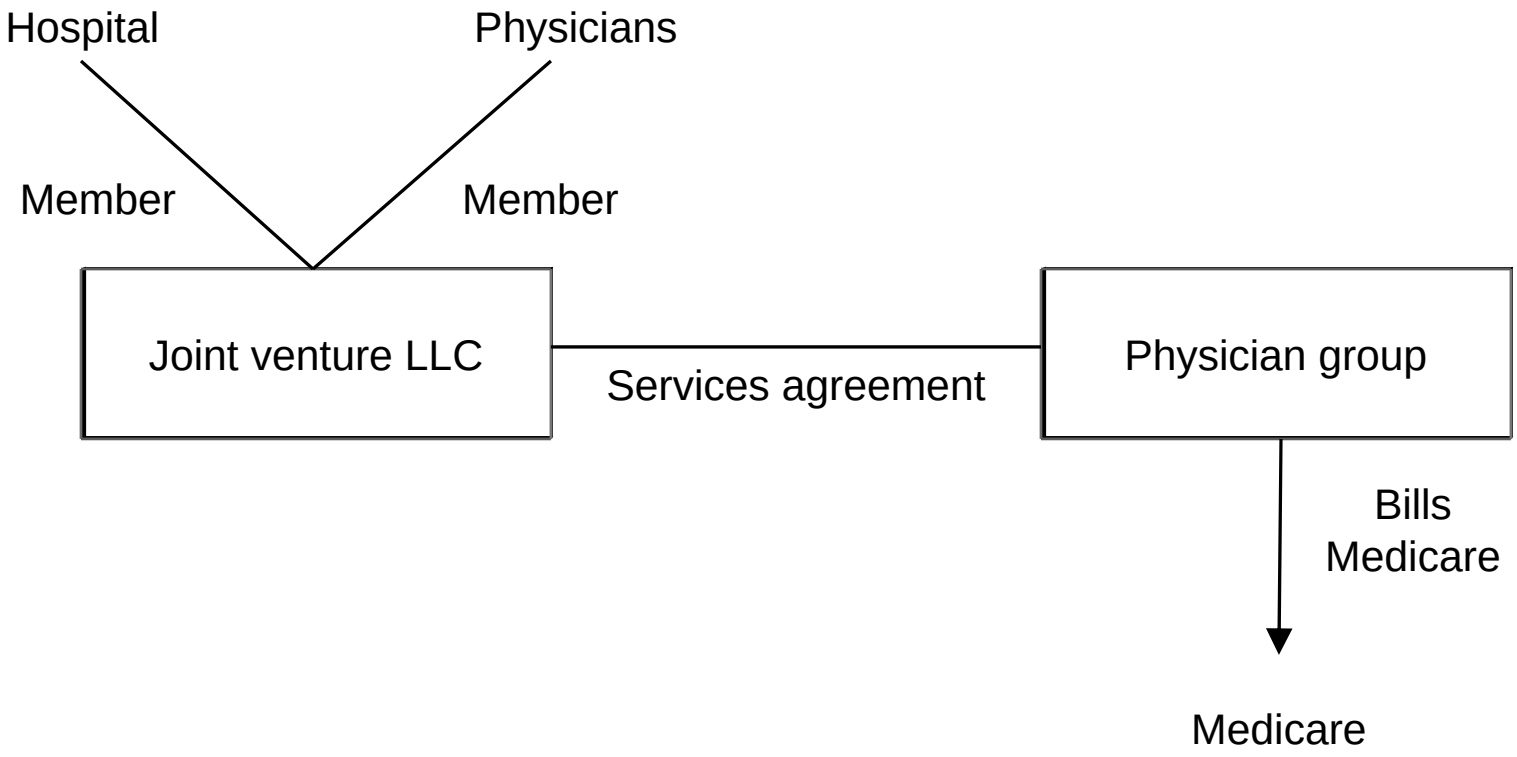
- Current definition:
  - DHS Entity is the entity that bills Medicare for DHS
- New definition:
  - Effective October 1, 2009
  - DHS Entity is the entity that bills Medicare for DHS and the entity that has performed the services that are billed as DHS
- Practical effect:
  - Will limit referring physician investments in entities that do not themselves bill for DHS services, but provide them to hospitals “under arrangements”
- Problem:
  - CMS has declined to define the word “performs”
- CMS indication:
  - “Performs” has its “common meaning”
  - Permissible: Entities that solely lease equipment, provide management, provide billing services or provide personnel to the entity performing the service

Example 1



Source: The Katten Muchin Rosenman LLP, Chicago.

Example 2



Source: The Katten Muchin Rosenman LLP, Chicago.

Physician Owners "Stand in the Shoes" of Their Physician Organizations in Relation to DHS Entities

- CMS concern:
  - Stark law prohibition circumvented by routing compensation through other entities between the physician and the DHS entity
- New Rule Effective October 1, 2008
  - Owners of a physician organization "stand in the shoes" of that organization
  - However, physicians who are only employees of the physician organization and physicians with only a "titular ownership interest" (i.e., without the ability to receive the financial benefits of ownership) are not required to stand in the shoes of their physician organization

Physician Owners "Stand in the Shoes" of their Physician Organizations in Relation to DHS Entities (cont'd)

- Effect:
  - Compensation provided by a DHS entity, such as a hospital, to a physician group likely to be "direct compensation" to the referring physician and will need to meet a Stark exception for a direct financial relationship
  - Previously such compensation could qualify for "indirect compensation" treatment and avoid the more rigid rules applicable to direct compensation
  - NOTE: Change not as expansive as originally proposed and is subject to a grandfather provision for pre-existing situations

Prohibition Against Unit-of-Service or "Per Click" Payments

- Prior Law
  - Unit-of-Service or "Per Click" payments were generally permitted
- New rule effective October 1, 2009:
  - "Per Click" payment methodologies are prohibited for leasing arrangements under the space and equipment lease exceptions, fair market value exception, and the exception for indirect compensation arrangements to the extent that these charges reflect services provided to patients referred between the parties
- Effect:
  - For example, prohibits a physician from leasing a CT scanner to a hospital on a "per click" basis if that physician refers patients to the hospital for CT services

Prohibition Against Unit-of-Service or “Per Click” Payments (cont’d)

- NOTE: Block time leases are not prohibited
- Must meet requirements for space and equipment lease exception, including that the arrangements be fair market value and commercially reasonable
- Abuse concerns
  - Small blocks of time and extended blocks of time

Prohibition Against Percentage-Based Compensation for Rental of Office Space and Equipment

- New rule effective October 1, 2009
  - Prohibits the use of compensation methodologies based upon a percentage of revenue raised, earned, billed, collected, or otherwise attributable to the services performed or business generated in the office space leased or by use of the leased equipment
- NOTE: Prohibition does not apply to management or billing services
- Lessor can charge lessee pro rata share of expenses attributable to leased portion
- CMS will monitor and may further restrict percentage-based methodologies in future

"Set in Advance" and Amendments to Agreements

- Stark law exceptions for rental of office space and equipment and personal services require that rental charges/compensation be "set in advance"
- CMS original "set in advance" position:
  - Multi-year agreement for rental of office space or equipment or personal services could not be amended during its term without violating the "set in advance" requirement

"Set in Advance" and Amendments to Agreements (cont'd)

- CMS new "set in advance" position:
  - An agreement can be amended as long as:
    - All requirements of the applicable exception are satisfied;
    - The amended rental charges/compensation are determined before the amendment is implemented and the formula is sufficiently detailed that it can be verified objectively;
    - The formula for amended rates does not take into account the volume or value of referrals generated by the referring physician; and
    - The amended charges (or formula) remain in place for at least one year from the date of amendment
  - Amendment rule applies to all compensation exceptions that include a one-year term requirement

The Anti-Kickback Statute

- The Federal Anti-kickback Statute generally makes it illegal to knowingly and willfully offer, pay, solicit, or receive any remuneration, directly or indirectly, in return for the referral of a patient or in exchange for arranging for an item or service payable, in whole or in part, under a federal healthcare program
- Can be remuneration in cash or in kind
- Intent to induce or pay for referrals must be proven
- Violations are punishable by imprisonment, treble damages and fines of up to $50,000

Private Inurement

- Section 501(c)(3) of the Internal Revenue Code (the "Code" or "I.R.C.") provides tax-exempt status for "[c]orporations . . . organized and operated exclusively for . . . charitable purposes"
- An organization is not operated exclusively for charitable purposes if any part of its net earnings inures to the benefit of any private shareholder or individual
- The prohibition on private inurement is absolute and, therefore, the incidence of any private inurement will result in the loss of tax-exempt status
- The Code and its regulations do not define private inurement. As a result, whether private inurement occurs depends upon the facts and circumstances surrounding a transaction or arrangement

Private Inurement (cont'd)

- The private inurement prohibition applies to an organization's "net earnings." The concept of net earnings permits an organization to pay or receive "reasonable compensation" for a good or service
- If, however, a transaction results in a hospital paying more than reasonable compensation for an item or service it purchases, or receiving less than reasonable compensation for an item or service it sells, the transaction may result in private inurement

Private Inurement (cont'd)

- The IRS Audit Guidelines for Hospitals, Manual Transmittal 7(10) 69-38, Exempt Organizations Guidelines Handbook (Mar. 27, 1992) (hereinafter the "Hospital Audit Guidelines") list the following examples of private inurement:
  - Excessive compensation
  - Receipt of less than fair market value in sales or exchanges of property
  - Inadequately secured loans
  - Other questionable loans
  - Payment of personal expenses of an insider that the organization did not characterize as compensation, even if later added to compensation and not in excess of reasonable total compensation

Private Inurement (cont'd)

- The private inurement prohibition applies only to private shareholders or individuals. Private shareholders or individuals are commonly referred to as "insiders," and include officers and directors.
- At times, the IRS has taken the position that all financial relationships between a tax-exempt hospital and members of its medical staff are subject to the Code's private inurement proscription
- Such as department heads, medical staff officers, or physicians with exclusive provider contracts
- The IRS also has stated that all persons performing services for an organization may possess the requisite relationship to find private inurement. Despite this, most newly recruited physicians are unlikely to be deemed insiders for the private inurement proscription.

Private Benefit

- In addition to the proscription on private inurement, an exempt organization must serve public rather than private interests and cannot be operated for the benefit of individuals with private interests in the organization
- Unlike private inurement, the private benefit prohibition applies to all persons, not just insiders. On the other hand, the prohibition against private benefit is not absolute. An activity is permitted if the private benefit is merely incidental to the public benefit. The private benefit must be incidental in both a qualitative and a quantitative sense.

Physician Recruitment and Retention – General Rule Under Stark

- The Stark II, Phase III recruitment exception protects remuneration provided by a hospital to recruit a physician that is paid directly to the physician or through the group and that is intended to induce the physician to relocate his or her medical practice (or for new physicians to locate) to the geographic area served by the hospital in order to become a member of the hospital's medical staff
- General requirements:
  - The arrangement is set out in writing and signed by all parties, which may need to include the physician group and the physician

Physician Recruitment and Retention – General Rule Under Stark (cont'd)

- The arrangement is not conditioned on the physician's referral of patients to the hospital
- The amount of remuneration under the arrangement is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician

Physician Recruitment and Retention – New, Revised and Additional Standards

- Relocation
  - Physician must relocate his or her practice to the geographic area served by the hospital
    - Physician must move medical practice at least 25 miles; or
    - Must establish that at least 75% of the physician revenues from services provided by physician to patients, including inpatients, are derived from services provided to new patients not seen or treated at prior medical practice site during the preceding three years measured on an annual basis (fiscal or calendar year)

Physician Recruitment and Retention – New, Revised and Additional Standards

- For initial “start up” year, 75% test is satisfied if there is a reasonable expectation the practice will derive 75% of revenues from new patients not treated at prior practice during preceding three years

- Medical Staff Membership
  - Recruited physician cannot already be a member of the hospital’s medical staff
  - The fact that a physician may have been a courtesy or locum tenens member who had little or no activity is irrelevant

Physician Recruitment and Retention – New, Revised and Additional Standards

- Recruited physicians cannot be prohibited from establishing staff privileges at other hospitals or from referring to other hospitals, even if these hospitals are competitors
  - "The exception does not prevent hospitals from imposing reasonable credentialing restrictions on physicians when they compete with the recruiting hospital. Such restrictions must not take into account the volume or value of referrals"
    - Statement is somewhat vague but suggests that restrictions can be imposed that would preclude ownership in a competing surgi center, for example. Need to see if this point is further clarified

Physician Recruitment and Retention – New, Revised and Additional Standards

- Geographic area served by the hospital
  - Geographic area served by the hospital is defined as the area comprised of all of the contiguous ZIP codes from which hospital draws fewer than 75% of its in-patients (see discussion on rural hospital below)
    - Use to be the lowest number of contiguous zip codes
  - The term “contiguous ZIP codes” does not mean only ZIP codes that are contiguous to a ZIP code in which the hospital is located, but ZIP codes that are next to or contiguous to each other

Physician Recruitment and Retention – New, Revised and Additional Standards

- Hospital should look at in-patient data to determine where patients live and then calculate lowest number of ZIP codes that touch at least one other ZIP code in which the inpatients reside
- If all of the contiguous ZIP code areas account for less than 75% of the hospital's inpatients, the hospital is limited to recruitment into those areas
- If a ZIP code area has, for example, only large office buildings or commercial district and has no patients, a hospital may recruit into this "hole" ZIP code

Physician Recruitment and Retention – New, Revised and Additional Standards

- If multiple configurations containing the same number of ZIP codes permit the hospital to meet the 75% (or 90% for rural hospitals), hospital is entitled to use any of the configurations
- The date on which the 75% (or 90%) standard applies is the date on which the parties have signed the written recruitment agreement – recognizes that service areas may change with different recruitment arrangements
- Even if a hospital is part of a health system, the standard is hospital and not health system specific

Physician Recruitment and Retention – New, Revised and Additional Standards

- Payment guarantee by group practice
  - A hospital may seek to have a physician group guarantee repayment of any monies advanced to the group on behalf of the recruited physician if, for example, physician does not fulfill community service requirement
  - It does not let the hospital off the hook from its obligation to go after the physician for breach of contract or other claims or failing to meet community service or other related obligations under the recruitment arrangement

Physician Recruitment and Retention – New, Revised and Additional Standards

- Comments make the particular point that hospitals are obligated to collect any amounts owed by the physician or the physician practice making the guarantee because if collections are not sought, this would be viewed as remuneration to the group practice or the recruited physician and would need to be analyzed under the Anti-kickback Statute

Physician Recruitment and Retention – New, Revised and Additional Standards

- Allocation of group practice costs to recruited physician
  - General rule is that a group practice may only take into account the "actual costs incurred by the . . . physician practice in recruiting a new physician . . ." when determining payment to the referred physician under an income guarantee
  - Stated differently, the group is not permitted to divide expenses on a pro rata basis among all physicians, including newly recruited physicians, if no additional expenses have been incurred

Physician Recruitment and Retention – New, Revised and Additional Standards

- For example, if a physician joins a four-person practice with but no additional employees are hired, no new employee expenses have been incurred and therefore cannot be considered an incurred cost

– Actual costs incurred for recruitment efforts by the group such as head hunter fees, airfare, hotel, meals, costs associated with visits, moving expenses, telephone calls, tail insurance and other related expenses, can be included in the cost allocation assessment

Physician Recruitment and Retention – New, Revised and Additional Standards

- A hospital may pay a physician group for time spent in the recruitment of a physician as long as the requirements of the reasonable compensation exception have been met
  - It is irrelevant whether the recruited physician did or did not join the group for purposes of this exception
- Where recruited physician is replacing "a deceased, retiring, or relocating physician in an underserved area" the practice may, when calculating an income guarantee, use a per capita allocation of the practice's aggregate overhead and other expenses as long as it does not exceed 20% of the practice's aggregate cost or use the alternative method of allocating the actual additional incremental costs to the practice

Physician Recruitment and Retention – New, Revised and Additional Standards

- Physician must join group practice
  - For the exception to apply, the recruited physician must be a physician in the group practice or a member of the group. The exception does not apply to a physician who simply leases space and equipment from the group at the same location. As a practical matter, the hospital cannot provide support to the group practice for this arrangement, including the use of income guarantees.

Physician Recruitment and Retention – New, Revised and Additional Standards

- Practice Restrictions
  - In a major reversal, Stark II, Phase III now permits reasonable restrictions on a recruited physician's ability to practice medicine in the geographic area served by the hospital
  - Although not completely deferring to state and local laws regarding noncompete agreements, the commentary states that "we believe that any practice restrictions or conditions that do not comply with applicable State and local law run a significant risk of being considered unreasonable"

Physician Recruitment and Retention – New, Revised and Additional Standards

- The result of this reversal is that hospitals and group practices may utilize different but reasonable practice restrictions including, but not limited to:
  - Restrictive covenants and non-compete clauses
  - Reasonable liquidated damages clauses
  - Restrictions on moonlighting
  - Prohibitions on soliciting patients and/or employees of the physician practice

Physician Recruitment and Retention – New, Revised and Additional Standards

- Requiring that the recruited physicians treat Medicaid and indigent care patients
- Requiring that a recruited physician not use confidential or proprietary information of the physician practice
- Requiring that recruited physicians repay losses of his or her practice that are absorbed by the physician practice in excess of any hospital recruitment practice

Other Changes Under Stark II, Phase III

- Rural Hospitals
  - The “geographic area served by the hospital” as applied to rural hospitals, meaning hospitals not included in an MSMA, is composed of the lowest number of contiguous ZIP codes from which the hospital draws at least 90% of its inpatients. If the hospital draws fewer than 90% of its inpatients from this area, the geographic area may also include non-contiguous ZIP codes beginning with the non-contiguous ZIP code in which the highest percentage of the hospital’s inpatients resides and continuing to add non-contiguous ZIP codes in decreasing order of percentage of inpatients.

Other Changes Under Stark II, Phase III (cont'd)

- Recruited physicians not subject to relocation requirement
  - A resident or a physician who has been in practice for one year or less
  - Where is has been determined through an advisory opinion that the physician does not have an established medical practice that serves or could serve a significant number of patients who are or could become patients or the recruiting hospital
  - A physician who was employed on a full-time basis for at least two years immediately prior to the recruitment arrangement by one of the following, as long as the physician did not have a private practice in addition to the full-time employment:

Other Changes Under Stark II, Phase III (cont'd)

- A Federal or State bureau of prisons or other similar entity, to serve the prison population
- The Department of Defense or Department of Veteran Affairs to serve active or veteran military personnel and their families
- An Indian Health Service facility
- Recruitment of a physician outside the geographic area of a rural hospital is permitted if an advisory opinion is issued by the secretary demonstrating a need

- Recruitment exception extended to apply to federally qualified health centers and rural health clinics

Physician Recruitment – General Rule Under the Anti-Kickback Statute (cont'd)

- Although the Anti-kickback Statute has a safe harbor for physician recruitment, it is very narrowly drawn and only applies to a physician who has been practicing within his or her specialty for less than a year and relocates a primarily practice within a defined health professional shortage area

Physician Recruitment – General Rule Under Anti-Kickback Statute (cont'd)

- The relevant safe harbors criteria include many of the same standards under Stark III.
- Additional requirements include the following:
  - Benefits which are provided cannot be in excess of a three-year period and should not be renegotiated during the three year period in any substantial aspect
  - Physician should not be restricted from obtaining medical staff privileges at or referring services to or otherwise generate any business from a competing entity, including a hospital
  - The physician should agree to treat Medicare/Medicaid and in-patients from other federal health programs in a non-discriminatory manner

Physician Recruitment – IRS Standards

- Where possible, hospital should engage in a community need/community benefit analysis to determine whether there is a specific need in the community, versus a specific need for hospital, which will be served by the recruited physician in his or her specialty
- This analysis should be supported by hard statistical information, use of physician-patient ratios and other factors sometimes utilized in a needs assessment policy which can take into account factors such as splitters, age of physicians, waiting times, out migration patterns, underserved indigent, Medicaid and other patient populations, etc.
- All payment and support arrangements should always take into consideration prevailing fair market value standards in the area

Physician Recruitment – IRS Standard (cont'd)

- Any recruitment expenses paid, whether to the group or directly to the physician, should require bills, invoices and the like, where possible, these costs should be determined in advance to make sure that they are reasonable
- Any loans which are made should be consistent with bank industry standards, particularly as it relates to the use of promissory notes, security interests and other protections in the event that the physician defaults on a loan
- Where income guarantees are utilized, again, fair market value should prevail and hospital should be looking to such groups as MGMA, Sullivan Cotter or other similar industry standards
- Guarantee should not exceed two years

Physician Recruitment – IRS Standard (cont'd)

- Should have a ceiling on total outlays
- Guarantee, if paid out, should be converted to loans at prime plus 1 or 2%. Can be forgiven if physician agrees to stay in the community if need still exists or can be worked off at FMV
  - Must be documented
- Local pay scales obviously can be taken into consideration but should be documented. It is also important to make sure that the allocated cost standards under Stark III are factored into this analysis

Call Compensation: Two OIG Advisory Opinions

- Different fact patterns, same guidance
  - Carefully tailored payment structure
  - Tangible responsibilities
  - Uniform administration
  - Circumstances giving rise to arrangement
- Take-away: There is more than one way to structure call compensation

09-05 Does Not Trump 07-10

- Advisory Opinions are not regulatory models
  - Each advisory opinion is responsive to the facts presented
  - Neither says hospitals should or shouldn't pay for call coverage
- Per-diem payment model is still viable

Lost Opportunity Payments

- NEITHER Advisory Opinion says lost opportunity payments are good or bad
- BOTH Advisory Opinions caution that such payments can be used to disguise payments for referrals
- Each opinion's treatment of lost opportunity is fact-specific:
  - 07-10: Variable per diem payment reflects logical difference between weekday vs. weekend call burden
  - 09-05: No lost opportunity payments in the proposed arrangement, thus no risk that payments for referrals are hidden there

A Few Words on FMV

- OIG is not authorized to opine on whether fair market value shall be, or was, paid
- BUT, OIG can and does look to see
  - Are logical inputs going into the payment formula?
  - Are referrals being factored into the payment formula?

Take Comfort...

- OIG analyzes different fact patterns using the same, consistent principles
- Our call coverage payment analysis boils down to this:
  - What is the level of risk that one party is paying another for its referrals?

...Also Use Caution

- These opinions are based on the totality of each arrangement's facts and circumstances
  - If your arrangement has different facts, it could yield a different result

Background on 07-10

- Scope of the program – almost all specialties
- Drivers/market conditions that lead to the program:
  - Increased costs for physician, particularly malpractice premiums
  - Lack of tort reform
  - Specialties refusing to take call at all hospitals in community
  - Increasing number of indigent/uninsured patients in ED
- Response to specific market situation and breadth
- Not a response to a single group or specialty
- Cooperative development of program

Hospital's Key Structural Considerations

- Securing scope of services beyond just call:
  - ED call coverage and timely response
  - Consultations while on-call, including for indigents/uninsured
  - ED care and follow-up care through discharge for indigent/uninsured
  - Participate in quality initiatives
- Securing agreement of all needed specialties – avoiding diversion
- Consistent treatment and approach for specialties (not same payment, but consistent treatment)
- Creating system that did not exceed financial viability
- Shared commitment to indigent care (18 days of uncompensated call)

Design of Payment Methodology

- Per diem – weekday rate and weekend/holiday rate
- Based on:
  - Severity of illness typically encountered
  - Likelihood of having to respond when on-call
  - Likelihood of request for consult
  - Likelihood and degree of follow-up care in hospital for patients presenting at ED
- Hospital & physicians jointly rejected response pay or subsidy payment for indigent/uninsured

Rationale for Advisory Opinion

- Mutual commitment to transparency by hospital and physicians
- Breadth of the program (i.e., covering nearly all specialties)
- Concern over response of competitors

Background on 09-05

- Hospital is a 400-bed facility in the county but serves patients in five counties in which there are nine other hospitals
- All members of active staff provide ED coverage
- Medical staff complaining of needing to respond at all hours, taking on additional medical liability for treating patients they have never seen and sometimes rendering services beyond the scope of their capability
- As a result of these factors and a number of groups reducing their coverage obligations to the minimums required under the current hospital policy because they are not being paid, the hospital, at times, does not have the needed specialists on call and is forced to out source emergency care pursuant to transfer agreements with other hospitals

Patient Covered by the Proposed Arrangement

- Patients presenting to the ED will be covered if deemed as an “eligible patient”
- Eligible patient must have no sponsoring insurance plan, such as Medicare, Medicaid, workers comp, private commercial insurance, and other insurance policy

Physician Eligibility for the Proposed Arrangement

- First, physician must be an active member of the medical staff
- Second, physician must sign a letter of agreement with the hospital that provides that the physician agrees to participate in the arrangement and required policies
  - Must respond within 30 minutes of an ED request when consulted
  - Must provide additional evaluation and care as are deemed clinically appropriate by the physician with input from the patient's family or guardian
  - The letter agreement binds the physician to follow the proposed arrangements claim request process

Physician Eligibility for the Proposed Arrangement (cont'd)

- Third, physician must provide on-call coverage as part of the organized on-call schedule prepared by the relevant medical staff department or specialty
  - In departments of four or more active medical staff members, each physician is required to provide at least one week of ED call coverage on a rotating basis
  - In departments of less than four active staff members, the department prepares its own call schedule so that each physician is required to provide not more than one week of ED call coverage. Members can ask for additional days or weeks of coverage

Physician Compensation Under Proposed Arrangement

- After treating an eligible patient, physician submits a completed claim request form to hospital's Patient Financial Services Office
- Physicians receiving compensation agree to waive all billing or collection rights, or claims against any third-party payer or the eligible patient for services rendered
- Claims must include a date of service, description of service, dollar amount, patient's full name and patient's social security number
- The hospital's patient accounting department reviews each claim to determine whether the state program has deemed the patient eligible for reimbursement. Eligible claims will be processed for payment.

Physician Compensation Under Proposed Arrangement (cont'd)

- If the hospital determines that another payor source, including Medicaid, is available to the patient for the billed service, the hospital will return the claim to the physician's office so that the physician may pursue to the alternative payer source
- Physicians are compensated according to the following plan:
  - Emergency consultations on an eligible patient presenting and receiving face-to-face services - $100 flat fee
  - Care of eligible patients admitted as inpatients from the ED and provides inpatient care and management, H&P, daily rounds, discharge summary, etc. - $300 per admission

Physician Compensation Under Proposed Arrangement (cont'd)

  - Surgical procedure or procedures performed on eligible patient admitted from the ED – a $350 flat fee for the primary surgeon of record
  - Endoscopy procedure for procedures performed on eligible patient admitted from the ED - $150 flat fee for the physician performing the endoscopy procedure
- Hospital states that payments will be made solely on the basis of services actually needed and provided and without regard to referrals or any other business generated between the hospital and the physicians
- Hospital has further certified that payments are within the fair market value for services rendered

Physician Compensation Under Proposed Arrangement (cont'd)

- Compensation amounts described previously are based on evaluation methodology that looked at the following factors:
  - Patient acuity levels for ED patients
  - A blended fee incorporating fees across public, private, and self-payors
  - An overall average length of stay based on actual average lengths of stay for public, private, and self-payers
  - Payer mix
  - Physicians' likely time commitment for the service

OIG Analysis

- Although there is a safe harbor for personal services and management contracts, this arrangement does not fit squarely within the safe harbor because compensation is not set in advance and therefore does not meet all of the elements of the safe harbor
- That being said, OIG viewed the arrangement as presenting "a low risk of fraud and abuse" for the following reasons:
  - The hospital certified that the payment amounts are within the range of fair market value for services rendered without regard to referrals or other business generated between the parties. Payments are made only for services rendered and not for any "lost opportunity" if physician is on call but is never requested to provide patient care services.

OIG Analysis (cont'd)

- Physician only obtains payments for uninsured patients and therefore cannot double bill
- Hospital has a legitimate rationale for providing compensation based on gaps in ED coverage and its obligation to outsource ED services to other hospitals
- The program is designed to minimize risk of fraud and abuse because it is offered uniformly to all physicians pursuant to an ED call schedule prepared by each respective department and governed under the medical staff bylaws
- The program provides an obvious public benefit by facilitating better emergency on-call and related uncompensated care for physician services at the hospital which is the sole provider within its county

Other Acceptable Hospital/Physician Arrangements

- Physician employment
- Independent contractor arrangements
- Joint venture arrangements
- Equipment and space leases
- Gain sharing arrangements
- Acquisition of physician practices

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Refer to Resources portion of your workbook for information on the NPDB.