Akerman

Physician - Hospital Co-Management Arrangements

September 26, 2011

By Marshall R. Burack

In recent years, a number of regulatory and economic factors have driven hospitals and physicians to find ways to work together in a more coordinated manner in order to improve the quality and reduce the cost of patient care. Factors causing hospitals and physicians to work together include, among other things, bundled payments for services, the imminent introduction of Accountable Care Organizations and other shared savings arrangements, and reduced reimbursements from both private and governmental payers.

Direct employment of physicians is one means by which hospitals can assure a cooperative relationship with physicians. An ever-increasing number of physicians are becoming employed by hospital-owned practices.[1] Many hospitals, however, either do not wish to employ physicians directly, or do not have the financial resources necessary to acquire and operate medical practices. Moreover, although more physicians are electing to become employed by hospitals, many physicians do not want to become employees of a hospital or other institutional provider and wish to continue to provide patient services through an independent, physician-owned practice.

Co-Management Arrangements

For those hospitals which do not wish to establish and operate a hospital-owned medical practice, and for those physicians who wish to practice independently rather than as a hospital employee, the physician-hospital co-management arrangement offers an alternative arrangement for aligning financial incentives and encouraging physicians to work cooperatively with the hospital to which they admit patients to improve the quality and reduce the cost of hospital care.

A co-management arrangement typically involves the formation of a management company which is jointly owned by a hospital and independent physician members of the medical staff. The purpose of the jointly-owned company is to manage one or more service lines offered by the hospital. The management company may be formed to manage a specific, narrowly defined service line (e.g., the cardiac cath lab) and include only a limited number of specialist

physicians. Alternatively, the management company could be formed to manage a broadly defined service line (e.g., surgical services, or inpatient medical services) and include a substantial portion of the hospital's medical staff. In either event, the general objective of the management company in managing a particular service offered by the hospital is to improve the quality of that service, while reducing the cost of providing the service to patients.

In order to achieve this objective, the management company and the hospital would enter into a written management agreement, setting forth the specific tasks to be performed by the management company and the specific goals or objectives to be achieved. The management agreement also sets forth the compensation to be paid to the management company for providing the management services and for achieving specified goals and objectives. The management compensation is often structured to include both a fixed fee, for general management services, and incentive fees, for achieving specified benchmarks or targets. For example, a management agreement relating to management of surgical services might provide for incentive fees payable for beginning surgical cases on a timely basis, or for standardizing utilization of certain implantable devices. A management agreement relating to management of inpatient medical (non-surgical) services might provide for incentive fees for increasing patient satisfaction rates, or for reducing readmissions for certain conditions.

The fees received for by the management company, after payment of operating expenses, are generally allocated and paid to the equity owners of the company, including physicians, in accordance with their respective ownership interests. If structured properly, the co-management arrangement can provide strong financial incentives for physicians to take certain actions which are designed to improve the quality and increase the efficiency of patient care provided by the hospital. Without the co-management arrangement and the financial incentives it presents, the physicians might not otherwise be inclined to take the actions necessary to achieve the desired results.

Regulatory Concerns

Because a physician-hospital co-management arrangement involves a payment arrangement between a hospital and physicians who refer patients to the hospital, the arrangement must be evaluated for potential abuse under applicable health care statutes and regulations.

Stark Law

The Stark Law[2] prohibits a physician from making referrals for certain designated health services (DHS) payable by federal health care programs to an entity with which the referring physician (or an immediate family member) has a financial relationship, unless an exception applies. Inpatient and outpatient hospital services are included within the definition of DHS. The physicians who are members of the management company and who receive distributions from the management company have a financial relationship with the hospital, which pays fees to the management company for the services provided by the company. Thus the compensation arrangement provided for in the management agreement must satisfy a Stark law exception.

If the compensation paid by the hospital to the management company, and ultimately to the physician owners of the management company, does not vary with, or otherwise reflect, the volume or value of referrals by the physicians to the hospital, and if the compensation reflects the fair market value of the management services provided by the management company, the compensation arrangement should not be deemed to be in violation of the Stark Law.

Accordingly, it is essential that, when establishing the compensation arrangement, including, in particular, the details of any incentive fee arrangement, where the amount of the fee will vary depending upon achievement of certain benchmarks, the management fee must not vary based upon the volume or value of referrals to the hospital. It is advisable to engage an independent third-party consultant to structure the incentive fee arrangements, to assure that the fees will not vary based upon referral volume, but, rather, will be based entirely upon achieving the specified benchmarks. The consultant would also monitor the operations of the management company in order to verify whether the stated benchmarks have been achieved, thus entitling the management company to receive incentive compensation.

Finally, an independent third party who is experienced in providing healthcare valuation services should review the compensation arrangement and confirm that the projected compensation amounts reflect the fair market value of the management services to be provided.

Anti-Kickback Statute

The federal Anti-Kickback Statute[3] prohibits the payment or receipt, directly or indirectly, of remuneration in return for, or to induce, referrals for items or services reimbursable under most federal health care programs. A hospital's offering physicians on its medical staff the opportunity

to acquire an ownership interest in the management company, and the payment of management fees to the management company by the hospital, could potentially implicate the Anti-Kickback Statute.

The Department of Health and Human Services has published "safe harbor" regulations that define practices which are not subject to prosecution under the Anti-Kickback Statute because such practices would be unlikely to result in fraud and abuse.[4] The safe harbors set forth specific conditions which, if met, assure the entities participating in a qualifying arrangement will not be prosecuted for violation of the Anti-Kickback Statute.

Many arrangements which are not likely to result in fraud or abuse will not satisfy all of the requirements of a potentially applicable safe harbor. The Office of the Inspector General of the Department of Health and Human Services has acknowledged on numerous occasions that an arrangement which fails to meet all of the requirements of a particular safe harbor may, because of the presence of certain safeguards, be a lawful arrangement under the Anti-Kickback Statute.

The safe harbor regulations include a safe harbor for "investment interests," which could potentially be applicable to the cash distributions which physician members of a management company receive from the company. This safe harbor requires, among other conditions, that: (i) no more than 40% of the value of the investment interests may be held by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for, the entity; and (ii) no more than 40% of the gross revenue of the entity may come from referrals, items or services furnished by, or business otherwise generated from, investors.

It is unlikely a typical co-management arrangement would satisfy this so-called 40/40 requirement, because physicians who provide services for the management company may hold more than 40% of the management company's ownership interests, and the gross revenues generated by the management company will be derived principally from management services furnished by physician owners. Notwithstanding the failure of a co-management arrangement to comply with the investment interest safe harbor, if the hospital offers investment interests to physicians without regard to the volume of referrals made by such physicians, distributions to investors are proportional to their invested capital, and not tied to the volume or value of referrals to the hospital, and certain other conditions are satisfied, it is unlikely the co-management arrangement would be deemed to violate the Anti-Kickback Statute.

The Personal Services and Management Contracts safe harbor is potentially applicable to the management services provided by the management company and its physician members on behalf of the hospital. A carefully structured arrangement, which is set forth in writing and provides for compensation which reflects the fair market value of the management services provided and does not take into account the volume or value of referrals or other business generated between the parties, should fall within the Personal Services and Management Contract safe harbor, and thus be protected from prosecution under the Anti-Kickback Statute.

Civil Monetary Penalties Statute

The Civil Monetary Penalties Statute[5] ("CMP") prohibits a hospital from knowingly making a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided to patients who are entitled to benefits under federal health care programs.

Although the purpose of a co-management arrangement is to improve the quality and efficiency of patient care, the compensation paid by a hospital to a management company which is partially owned by physicians could implicate the CMP by inducing the physicians to reduce or limit the level of certain items or services provided to patients at the hospital, in order to achieve certain efficiency benchmarks.

The OIG has issued favorable advisory opinions on several proposed co-management arrangements. In order for a co-management arrangement to be regarded as not inducing a reduction or limitation of services to patients, the arrangement should contain certain safeguards.

These safeguards include:[6]

- physicians are compensated for specific actions which have been recognized as improving patient care;
- there is no incentive for a physician to apply a specific standard in medically inappropriate circumstances;
- the performance measures which could result in payment of incentive compensation to the management company are clearly identified, and affected patients are notified of the arrangement;

Akerman

• an independent consultant monitors the operation of the arrangement with respect to achievement of the benchmarks for incentive compensation to ensure that inappropriate reductions in patient care or services do not occur, and advises the hospital to take appropriate actions if problems arise.

If a co-management arrangement is structured so as to include these safeguards, it should not violate the CMP Statute.

Conclusion

A physician-hospital co-management arrangement permits a hospital to provide financial incentives for physician members of the medical staff to assist the hospital in improving the quality and reducing the cost of providing patient care. A co-management arrangement can be an attractive alternative to direct hospital employment of physicians, both for hospitals which do not want to assume the financial and administrative burden of owning and operating a large physician practice, and for physicians who wish to maintain their independence rather than becoming hospital employees.

Because a co-management arrangement involves the payment of compensation to physicians who refer patients to the hospital, the arrangement must be structured properly in order to avoid violation of applicable health care statutes and regulations. Hospitals which are considering entering into a co-management arrangement with members of the hospital's medical staff should engage knowledgeable health care counsel, as well as experienced consultants who will help structure and monitor the arrangement and who will confirm that compensation amounts reflect the fair market value of the management services provided. If a hospital ensures that the co-management arrangement is structured properly, the arrangement should prove to be beneficial for the hospital, the physicians, and most significantly, for hospital patients who will receive higher quality care.

1. According to the Medical Group Management Association, 40% of doctors hired out of residency or fellowship in 2009 were placed in hospital-owned practices.
2. 42 U.S.C §1395nn.
3. 42 U.S.C §1395nn.
4. 42 CFR §1001.952.
5. 42 U.S.C §1320a-7a.

Akerman

6. *See, e.g.*, OIG Advisory Opinion 08-16, issued Oct. 7, 2008.

This Akerman Practice Update is intended to inform firm clients and friends about legal developments, including recent decisions of various courts and administrative bodies. Nothing in this Practice Update should be construed as legal advice or a legal opinion, and readers should not act upon the information contained in this Update without seeking the advice of legal counsel.

©2011 Akerman Senterfitt, Akerman Senterfitt LLP. All rights reserved.