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BUILDING YOUR HEALTHCARE REFORM TOOLKIT:
Strategies for Delivering Accountable Care

Thursday, May 12, 2011

Hospital / Physician Integration Models

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AFTERNOON AGENDA

- Hospital / Physician Integration Models in Response to Health Reform
- Structural and Regulatory Issues for Integration Transactions
- Valuation and Compensation Perspectives of these Models
- Compliance Implications for Integrated Delivery

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Will Medicare ACOs be successful?

Initially very few. Why?

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CHALLENGES

- Industry reaction to the proposed regulations is lukewarm at best
  - Few healthcare organizations are pioneers – they tend to adopt what works for others
  - Process is complex, uncertain, and costly

- CMS does not expect widespread participation
  - 75-150: CMS estimate of the number of Medicare ACOs formed to participate in the Shared Savings Program during first 3 years.
  - $1.75 Million: CMS estimate of the start-up and first year operating expenditures for each ACO.

- Many organizations are not prepared to be a Medicare ACO
  - Not enough integration between providers (financial / clinical / trust)
  - Don't have data to accurately measure quality or cost
  - Don't have mechanism to share risk

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ARE THERE ALTERNATIVES?

First, understand what the drivers are for integration

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INTEGRATION DRIVERS

- Contain or reduce costs
- Improve quality
- Better coordination of care among providers
- Gaining a competitive edge in the market
  - Physicians are combining to form super groups
  - Hospitals trying to maintain market share
  - Commercial plans (United) are getting into the game

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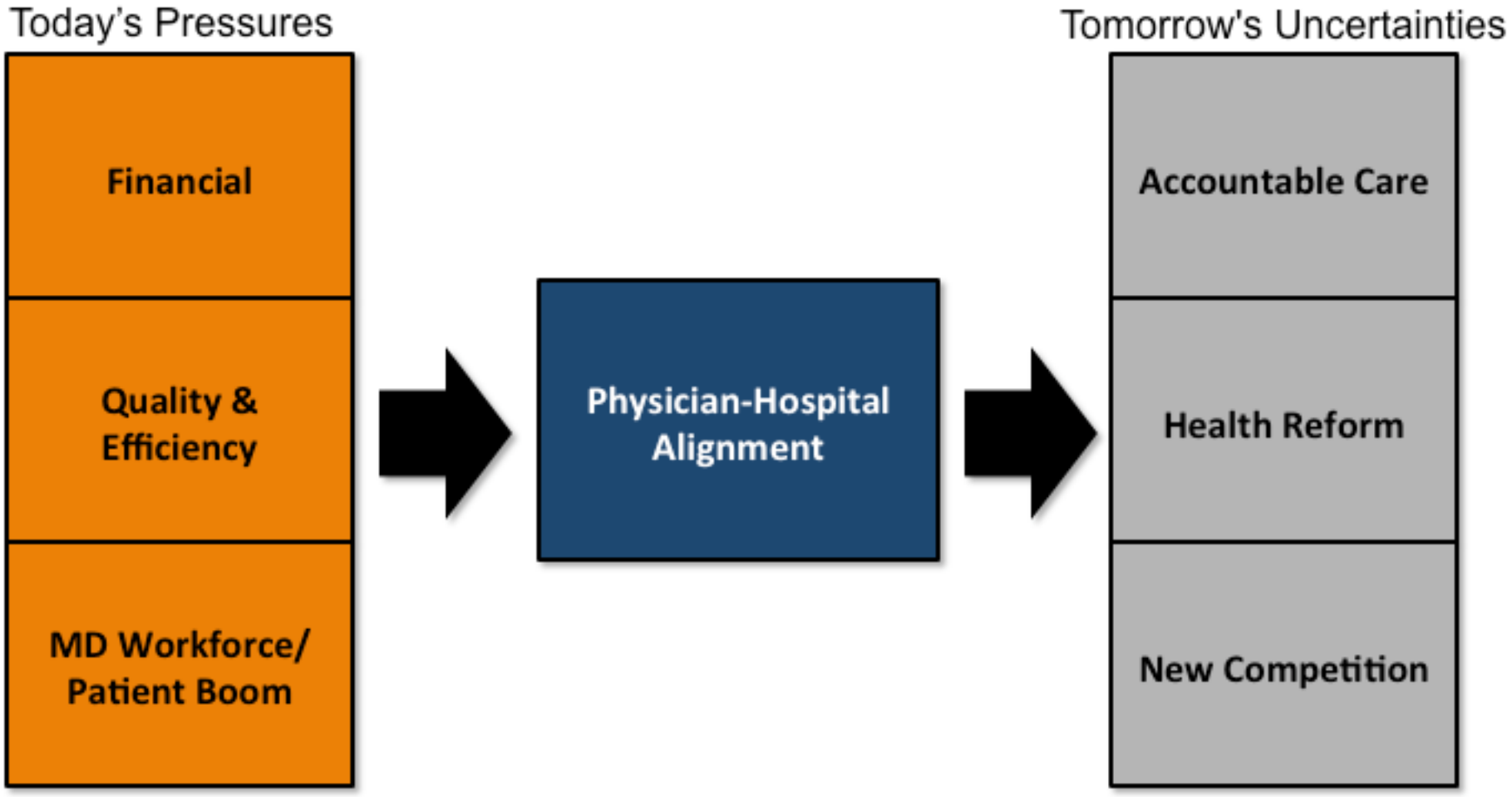
Drivers Impacting Today…and Tomorrow



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ISSUES TO ADDRESS / QUESTIONS

- We have to have an ACO.
- We have to buy and employ our physicians because there won't be any left if we don't.
- Can we have our own ACO?
- How can we compete with the Hospital down the street or across town that is more integrated?
- Should we jump in now or wait and see if this all goes away?
- Will ACOs really take hold or is this all a fad like the PHOs and capitation concepts of the 90's?

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WHAT ALTERNATIVES ARE AVAILABLE?

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ALTERNATIVE MODELS TO A MEDICARE ACO

- Test the waters
  - Choose areas where you can work with partners to reduce costs (service line co-management)
  - Identify a few key areas to measure quality and reward successful participants

- Next Steps
  - Create or refine the infrastructure and operations to financially and clinically integrate with other providers to manage costs, share some risk, and measure outcomes
  - Work with a major commercial plan on a specific initiative to meet these goals for a specific group of patients or service line (ortho, cardiology, transplant)

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MODELS TO CONSIDER

(whether you are a Medicare ACO or choose another form of integration)

3 LEVELS ON THE *SPECTRUM* OF INTEGRATION

Contractual Model

- Hospital, physicians and other providers contract with each other to share payments, monitor quality, reduce costs, manage service-line / patients, etc.

JV Model (PHO)

- Clinically or financially integrated JV to share payments / risk
- Shared governance / control

"Employment" Model

- Various employment models ranging from:
  - full employment of physicians by hospital (most integrated); to
  - "Group Practice Subsidiary" models (where physicians maintain significant level of independence)

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BEFORE CHOOSING A MODEL, CONSIDER:

- Will the ACO be a Medicare ACO?
- Will it be focused on commercial payors?
- Will it be limited to certain service lines, DRGs, etc.?
- What providers are involved (hospital(s), physicians, other providers)?
- Will payors be involved?
- How will services be compensated (global or bundled payments, shared risk, DRG, capitation)?
- How will compensation be split (who takes the risks)?
- Will one party control and contract with others or will it be joint control with multiple parties? How will governance work?

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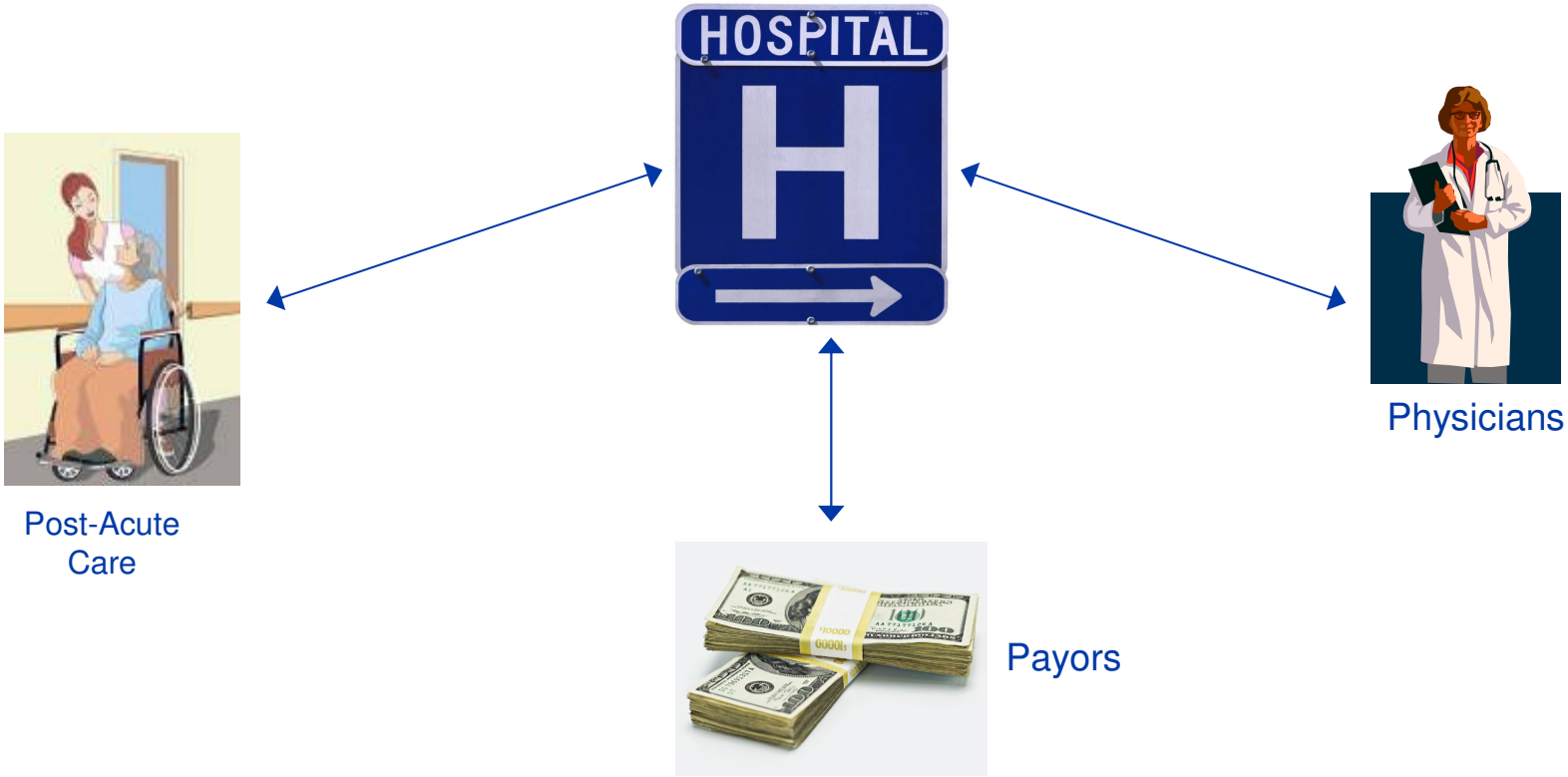
MODELS

CONTRACTUAL MODEL



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CONTRACTUAL MODEL

- Pros
  - Don't have to go through integration headaches
  - Quicker to put together
  - Less capital requirements
  - Produces a walk-before-we run model for multiple groups/hospital partners
  - Established a 'first step' towards alignment
  - Autonomy of parties
- Cons
  - Incentives not as aligned
  - Sometimes integration headaches replaced with migraines
  - More legal hurdles since contractual arrangements less protected (gainsharing restrictions, antitrust, Stark, etc.)
  - More opportunity for misunderstandings – comp/incentive/definitions/goals
  - No incentives to share risk

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“EMPLOYMENT” MODELS

Direct Employment

Employment Agreements

Physicians

Group Practice Subsidiary

Ownership

Subsidiary

Employment Agreements

Physicians

Physician Integration Model

Ownership

Subsidiary

Lease

Physician Practice

Employment Agreements

Physicians

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“EMPLOYMENT” MODEL

- Pros
  - Much more integrated
  - Can more easily share savings (gainsharing) / information
  - Less regulatory issues (Kickback, Stark, Antitrust)
  - Hospitals can direct referrals by employed physicians
  - Can build alignment across specialties – The “In” Crowd
  - More flexibility in distributing global payments, etc.
- Cons
  - More effort to put together
  - Hospitals “lose” money unless appropriate incentives to MDs
  - MDs wont agree to employment unless “kept whole”, putting economic risk on Hospital
  - Majority of models still do not align economic risks
  - MDs may have less autonomy / governance

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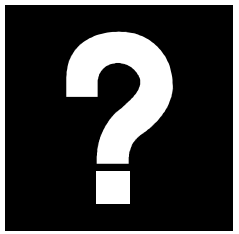
PHO (OR OTHER JV MODEL)

Physicians



Others?

PHO

Payors

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PHO (OR OTHER JV MODEL)

- Who thought PHOs and JVs were dead?
- Pros
  - Forces Hospital and MDs to think through the governance issues up front
  - Gives MDs a real voice
  - Shares risk among providers - consistent incentives
- Cons
  - Lots of skepticism with PHOs based on past history
  - Still have many legal issues to address (particularly antitrust)
  - Governance and control can be very difficult to agree upon
  - Splitting fees can be a difficult issue - administratively difficult to manage

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Structural and Regulatory Issues for Integration Transactions

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With a focus on systems that incentivize quality performance and utilize sharing principles, remember nothing has really changed for ACO-style structures outside of the Medicare shared savings program

- Proposed regulations deal with Medicare ACO's
- Policy changes (e.g., new FTC guidance) not applicable to Purely Private Pay-based "ACOs"
  - Old rules still apply

As hospitals, physician practices and other evaluate their options, it is important to consider:

- Governance and control issues
- Tax issues
- Antitrust Issues
- Stark and Anti-kickback Considerations

Governance/Control Considerations

- Key questions in choosing a structure:
  - What are the principal objectives and concerns of each participant?
    - Mission goals
    - Economic goals
    - Control over future decisions
  - Areas requiring "super majority" approval
    - Admission of new participants
    - Fundamental changes in business plan/budgets
    - Change of Control events
  - Dispute resolution
  - Fiduciary obligations and concerns
  - Conditions for termination of relationship/dissolution of enterprise
- How do these considerations affect each model?

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Governance/Control Considerations – Employment Models

- Direct Employment Model:
  - Terms of employment agreement control--No shared "governance“
  - Written agreements highly recommended
    - Ensure clear understanding of the rights and duties of each party
    - Define conditions for termination of employment

Governance/Control Considerations – Employment Models

- Group Practice and Physician Integration Models:
  - Governance through Practice Subsidiary BOD
  - Key issues:
    - Address Concerns of Physician Employees of Group Practice
      - Control by Physicians over Operation of Group Practice
      - Compensation/terms of employment
      - Selection of Management
    - Address Concerns of Member Hospital through reserved powers:
      - Further Member/Hospital's charitable purposes
      - Protect 501(c)(3) status/Bond compliance/Other tax issues
      - Notice/approval rights with regard to new physician employees

Governance/Control Considerations – Contractual Model

- Not Integrated, so no shared governance
- Controls based 100% on contractual covenants and obligations of the parties

Governance/Control Considerations – PHO/JV Models

- Governance may be a major factor:
  - Considerations include comfort level with "partners"
  - Expectations of the parties--clearly define
- Choice of Entity:
  - Corporation--Governed by Board of Directors
    - More formalities
    - Fiduciary duty issues
  - Limited Liability Company--Governed either by members or managers
    - Significant freedom of contract to structure governance
    - Significant flexibility to structure other arrangements
  - Simple partnership--Governed by partners in accordance with partnership agreement
    - Not likely to be used due to personal liability exposure and availability of other

Tax Considerations

- Hospitals – Generally
  - Tax exemption
  - Intermediate sanctions
  - Tax-exempt bonds
  - UBIT

Tax Considerations

- Providers – Generally
  - Characterization of compensation
    - Provider v. provider group
    - Wages v. non-wages
    - Capital gain v. ordinary income
  - Special considerations when provider group assets/liabilities involved

Tax Considerations

- Hospitals
  - Avoid transaction being so big that private persons get too much benefit and implicate private inurement concerns
  - If disqualified persons involved, invoke rebuttable presumption procedures to minimize risk of onerous excise taxes
  - If arrangement involves private use of tax-exempt financed space, fit term and compensation under IRS safe harbor

Tax Considerations

- Providers
  - Generally, taxes play very minor or no role

Tax Considerations - “Employment” Model

- Hospitals
  - Same tax exemption and intermediate sanctions concerns
  - Tax-exempt bond rules relaxed for employment

Tax Considerations - “Employment” Model

- Providers
  - Employment itself doesn’t raise significant tax issues
  - Disposition of practice assets can raise whole host of tax issues
    - Sale/lease of assets
    - Resolution of liabilities
    - Liquidation/dissolution of practice entity
    - Unfunded retirement plan obligations

Tax Considerations - PHO/JV Model

- Hospital
  - Same concerns regarding tax exemption
  - IRS position on minimum hospital ownership to maintain tax-exempt status
  - UBIT concerns can often arise

Tax Considerations - PHO/JV Model

- Providers
  - Depending on the structure, this model can have many of the same issues raised in the employment model

Antitrust Considerations

- **The Basics:**
- **Agreements between competitors "in restraint of trade" prohibited**
- **Unlawful exercise of monopoly power**
- **Many types of agreements judged under the "Rule of Reason":**
  - **Test: anticompetitive effects vs. precompetitive benefits**
  - **If Rule of Reason applies, likely to withstand antitrust scrutiny**
- **Certain agreements involving competitors are held to be "Per Se" unlawful:**
  - **Price fixing**
  - **Allocation of markets or customers**
- **Sanctions can include:**
  - **Criminal prosecution**
  - **Civil enforcement/injunction**
  - **Private action for treble damages**

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Antitrust Considerations

- ***Copperweld* Doctrine: Actions and decisions of a person that is considered a single party do not constitute "agreements" subject to scrutiny under Section 1.**
- **FTC/DOJ Focus in Healthcare on whether parties are "Integrated" for purposes of negotiating prices, etc.**
  - **Financial Integration through shared economic risk**
  - **Clinical Integration through systems to control costs and ensure quality**

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Antitrust Considerations

- **"Over inclusiveness"**
  - **Exclusive Networks 20% Physician Participation Threshold**
  - **Nonexclusive Networks 30% Physician Participation Threshold**
  - **Shared Savings Program: 30% "Safety Zone"**

Antitrust Considerations

- **Contractual Model**
  - **Integration very difficult**
  - **No sharing of cost and pricing information**
- **Employment Model**
  - **Parties are integrated**
- **PHO/JV Model**
  - **Whether "integrated" depends on degree of financial and or clinical integration**

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Antitrust Considerations

- **FTC/DOJ Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program:**
  - **ACOs that are seeking or have been granted approval to participate in the Medicare Shared Savings Program**
  - **Rule of Reason treatment will be available to ACOs that qualify for and participate in Shared Savings Program:**
    - **"for the duration of [the ACO's] participation in the Shared Savings Program"**
    - **30% Safety Zone**
    - **Review thresholds**

Antitrust Considerations

- **Same treatment for an ACO operating <u>also</u> in the commercial market if it uses the same governance and leadership structure and the same clinical and administrative processes as used to qualify for the Medicare SSP**
- **Comments are due on May 31--Criticism from some panel members at FTC conference on Monday (May 9):**
  - **Practicability**
  - **Expense and time involved in Agency reviews**

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Stark/AKS Considerations

- Stark Law prohibits:
  - Physicians from referring Medicare patients
  - For certain designated health care services ("DHS")
  - To an entity
  - With which the physician or member of immediate family has a financial relationship
  - Unless an exception applies

Stark/AKS Considerations

- Stark Law violation sanctions include:
  - Denial of payment of claims submitted to CMS
  - Refund of amounts improperly billed
  - Civil Monetary Penalties ("CMPs")- $15,000 per item + 2x amount claimed - $100,000 fine for "circumvention schemes"
  - Exclusion from Medicare
  - False Claims Act liability

Stark/AKS Considerations

- Anti-Kickback Statute ("AKS") prohibits:
  - The knowing and willful (but does not require actual knowledge of AKS or specific intent to commit an AKS violation)
  - Offer or payment OR solicitation or receipt
  - Of any remuneration
  - Directly or indirectly, overtly or covertly, in cash or in kind
  - To induce a person to make a referral
  - For any item or service
  - Paid for by a Federal health care program

Stark/AKS Considerations

- Anti-Kickback Statute sanctions:
  - Criminal fines
  - Federal penitentiary
  - CMPs - $50,000 + 3x “illegal remuneration”
  - False Claims Act now specifically actionable after PPACA

Stark/AKS Considerations - Contractual Model

- Stark Personal Service Arrangements Exception
  - Arrangement must be:
    - Set out in writing
    - Signed by the parties
    - Specify the services covered
  - Arrangement(s) must cover all of the services furnished by the physician (through cross references in the contract(s) or maintenance of a master list)
  - Aggregate services must not exceed those that are reasonably necessary
  - Term of at least 1 year (if terminated prior to 1st year, cannot enter into new agreement for remainder of that year)
  - Compensation is:
    - Set in advance
    - Does not exceed FMV
    - Not determined in a manner that takes into account the volume or value of any referrals or other business generated

Stark/AKS Considerations - Contractual Model

- AKS Personal Services and Management Contract Safe Harbor
  - Similar to Stark Personal Service Arrangements Exception, except that “aggregate” compensation must be set in advance

Stark/AKS Considerations - "Employment" Model

- Stark Bona Fide Employment Exception
- Arrangements between hospitals and employed physicians are allowed if:
  - Employment is for identifiable services; and
  - Compensation is:
    - Consistent with FMV;
    - Not determined in a manner that takes into account the volume or value of referrals by the referring physician; and
    - Commercially reasonable even if no referrals were made
- Productivity bonuses are permitted, but ONLY for personally-performed services (no "incident-to" or ancillary services)

Stark/AKS Considerations "Employment" Model – Group Practice Subsidiary

- Stark In-Office Ancillary Services Exception
  - Protects ancillary revenue distribution arrangements within a Group Practice
  - Three elements of exception (all must be satisfied):
    - Who furnishes the DHS
    - Where the DHS is furnished
    - Who bills for the DHS
  - Must satisfy "Group Practice" definition

Stark/AKS Considerations "Employment" Model – Group Practice Subsidiary

- Highlights of the Stark Group Practice Definition
  - Formal, separate legal entity
    - Formed for the primary purpose of being a group practice
    - No loose affiliations
  - Substantial group-level management and operation
    - Centralized decision-making
    - Governing body representative of the group practice
    - Effective control of group's assets, liabilities, budgets, compensation and salaries
  - Unified business having consolidated billing, accounting, & financial reporting

Stark/AKS Considerations "Employment" Model – Group Practice Subsidiary

- Other related financial arrangements must meet applicable Stark exceptions
  - Professional Services Agreement (PSA) – for professional services purchased by hospital from the Group Practice
  - Management Services Agreement (MSA) – for management and administrative services purchased by the Group Practice from hospital
  - Lease Agreements – for equipment and space leases from hospital to Group Practice
- AKS regulations contain safe harbors for each of these arrangements that merit consideration

Stark/AKS Considerations "Employment" Model – Group Practice Subsidiary

- These arrangements should:
  - Be structured to meet an applicable exception (Personal Services Arrangements; Equipment Rental; Space Rental; Indirect Compensation)
  - Clearly define the services needed
  - Structure the compensation to be fair market value

Stark/AKS Considerations "Employment" Model

- AKS Employment Safe Harbor
  - "Remuneration does not include any amount paid by an employer to an employee who has a bona fide employment relationship with the employer for the furnishing of any item/service for which payment may be made in whole or in part under a Federal health care program."

Stark/AKS Considerations
PHO/JV Model

- Post-10/1/09 Stark regulations expand definition of DHS "entity" to include the entity that "performs" the DHS in addition to the entity that receives payment
- Therefore, referring physicians have a direct financial relationship (ownership) with a DHS entity (PHO or JV) - not an indirect compensation relationship like before

Stark/AKS Considerations
PHO/JV Model

- Unless you are located in a rural provider setting, no Stark exception is available for traditional provider-based under arrangements JVs
- This affects:
  - Hospital/physician joint ventures (e.g. cath labs, imaging centers, surgery departments)
  - Other technical services performed by physician-owned entities (e.g. mobile radiology services)
  - Possibly other arrangements not intended to be covered by this change

Stark/AKS Considerations
PHO/JV Model

- Other related financial arrangements must meet applicable Stark exceptions
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Stark/AKS Considerations
PHO/JV Model

- AKS Investment Interest Safe Harbor – if this model becomes popular and provider/referrer ownership becomes widespread, careful consideration should be given to complying with this safe harbor

Valuation and Compensation Perspectives

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Jeremy Peters, The Pinnacle Group

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Models for Discussion

- Contractual Model
- Employment Model
  - Direct
  - Group Practice Subsidiary
  - Physician Integration
- Joint Venture Model

Key Legal/Valuation Issues

- Fair Market Value ("FMV")
- Not based on the volume or value of referrals or other business generated by the referring physician
- Commercially Reasonable

Fair Market Value

- The value in arm's-length transactions, consistent with the general market value
- "General Market Value"—the price / compensation that would be included in an agreement as a 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 agreement.

Commercial Reasonableness

- An arrangement is a sensible, prudent business arrangement from the perspective of the parties involved, even in the absence of potential referrals.

U.S. ex rel. Kosenske, M.D. v. Carlisle HMA, Inc.

- Arm's-length negotiation between a hospital and a physician will not be bona fide bargaining between parties "who are not otherwise in a position to generate business between the parties."

Contractual Model Issues

- Fair Market Value
- Not based on the volume or value of referrals or other business generated

Contractual Model – CV Considerations

- Tried and true approach to integration
  - Compensation valuation models are *generally* well understood within the industry
  - More limited alignment than other forms of integration
- Performance compensation for achievement of quality and/or operational metrics can be included
  - Service line co-management
  - Administrative services arrangements
  - Comprehensive clinical coverage
- How is the achievement of performance metrics valued?

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Value of Performance – Risk Spectrum

Desired outcomes implied within the rate	Desired outcomes support contracting at higher %tiles	Desired outcomes results in additive compensation

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Employment Model Issues

- Fair Market Value
- Not based on the volume or value of referrals or other business generated
- Commercially Reasonable
- Subsidiary/Physician Integration Models—In-Office Ancillary Services Exception
- Impact of Subsidy

Employment Model – BV Considerations

- Will the existing physician practice or practice assets be purchased as part of the employment agreement?
- What will be purchased?
  - Specific assets
  - Leveraged income streams
  - Ancillary businesses
  - Liabilities
- Approach to value – cost vs. income
- Synergies?

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Employment Model – CV Considerations

- Another tried and true approach to integration
  - Compensation valuation models are well understood within the industry
  - Can result in significant alignment and integration
- How to influence behavior to achieve desired outcomes of high quality and low cost care?
  - "Behavior follows incentive" – use of physician compensation plans to achieve desired outcomes
  - Not always easy to design and implement, but physician input can help
  - How are quality and value recognized? Bonuses (still within FMV), withholds, etc.
- Non-physician services (e.g., leased employees, billing services), if present, need to be evaluated ➔ FMV & commercial reasonableness

Joint Venture Model Issues

- Impact of the definition of “Entity”
- Fair Market Value
- Tax Exempt Entity Issues

Joint Venture Model – BV Considerations

- Type of entity – revenue contracting vs. standalone business
- Ownership
  - Assets / capital contributed – ownership percentages negotiated on the front end
    - Level of control
    - Economic income split desired
    - Capital available to contribute
  - Income split based on FMV of services provided, e.g., global billing

Joint Venture Model – CV Considerations

- Single contracting entity results in the merger of 2 revenue streams (hospital and physician)
- Contracting entity – how to split the revenue stream *-and-* document a FMV / commercially reasonable relationship?
  a) Market Approach – how are other organizations doing it? Challenges?
  b) Cost Approach – what are the parties' costs to furnish the service (allocate the revenue)? Challenges?
  c) Income Approach – what are the current, separate payments for the services (allocate the revenue)? Challenges?
  - Standalone business entity – contracts for services / leases (e.g., providers, technical and support staff, facilities, equipment) need to be evaluated to ensure FMV and commercially reasonable arrangement.

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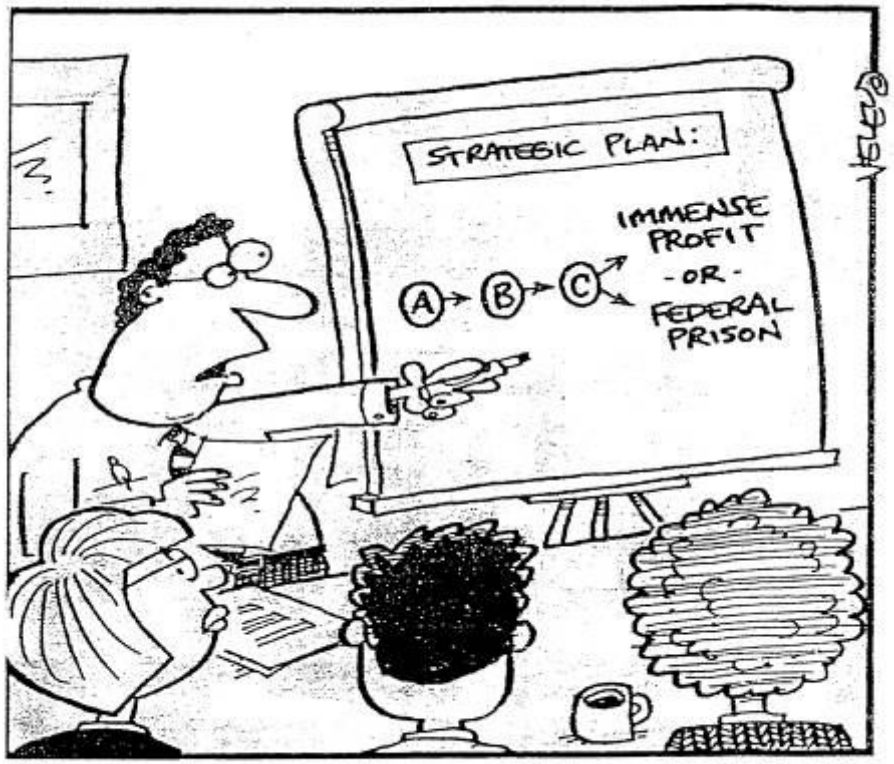
Final Thoughts



"Stay with me now, people, because in step C, things get a bit delicate."

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Compliance Implications for Integrated Delivery

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Compliance Implications

- Unique compliance issues often times overlooked
  - Not as commonly discussed in the industry
  - Do not result in less liability
- Identify and assess pre-transaction
  - Audit considerations
- Address in implementation phase
  - Operationalization considerations
- Follow-up review and monitoring
  - Audit and monitoring considerations

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Compliance Implications: Compensation Considerations

- Personally Performed Services
  - Stark Law requirement for employment relationships
  - No credit for midlevel providers or ancillary services
  - Increased risk with productivity-based compensation models
- Supervision of Midlevel Providers
  - Appropriate to pay for personally performed supervision (employment)
  - Consider state law supervision requirements
  - Consider impact on physician's practice
- Quality Payments
  - Define quality metrics
  - Ensure appropriate measurement tools

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Compliance Implications: Coding and Documentation

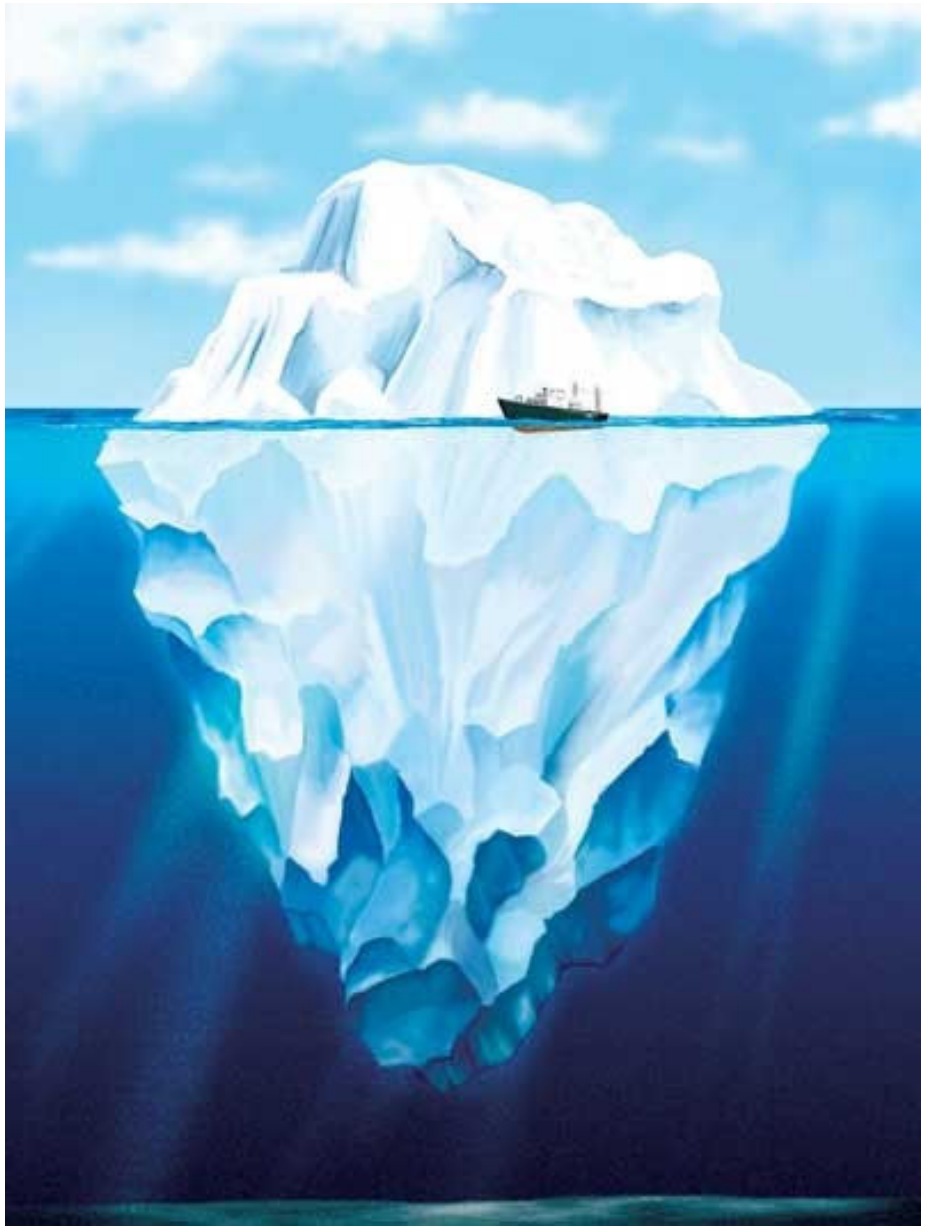
- Coding and Documentation Practices
  - Far reaching
    - Compliance
    - Revenue Opportunities
    - Liability
  - Increased risk for hospitals under new integration models

Compliance Implications: Contractual Payments

- Satisfying Contract Requirements – Payment Provisions
  - Risk of technical Stark violation
  - Inadvertent errors can create substantial liability
    - Accounting department payment practices / processes
  - Reconciliation paragraph

Compliance Implications: Joint Marketing Activities

- Joint Marketing Pitfalls
  - Relates to independent groups with whom the hospital may collaborate
  - Requires appropriate allocation of costs for joint marketing activities
    - Consider allocation based on content dedicated to each party
  - Educate marketing departments and related personnel



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All Physician Integration Models

- Compliance Risk
  - Documentation
  - Business Process
- Revenue Risk
  - Coding
  - Accounts Receivable

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Compliance and Revenue Risk

- Pre-Transaction
  - Coding Trends
  - Documentation Habits
  - Problem Procedures
  - Problem Providers
  - Coding/Billing Process

Compliance and Revenue Risk

- Post Transaction
  - Coding Trends
  - Documentation Habits
  - Problem Procedures
  - Problem Providers
  - Liability
  - Compliance Plan
  - Contract Management

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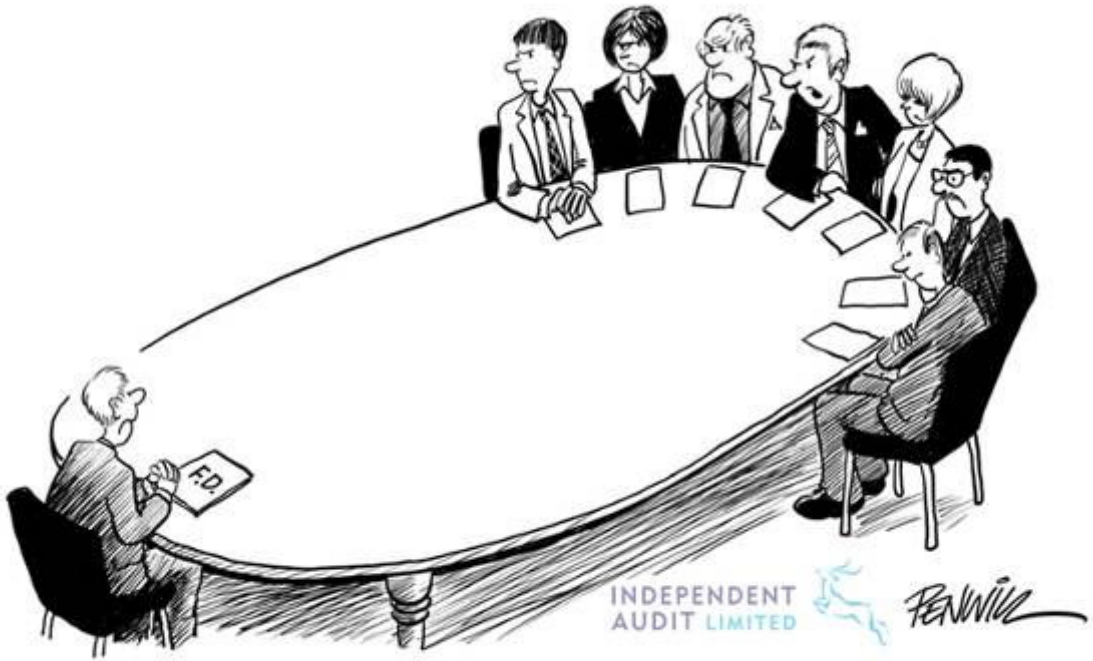
Audit



"WE DON'T WANT YOU TO VIEW THIS AUDIT COMMITTEE AS BEING IN ANY WAY CONFRONTATIONAL"

PARAGON HEALTH

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PINNACLE

Objectives

- Discover Improper Coding and Documentation
- Identify Specific Problem Codes or Providers
- Focus your Resources to Address Issues
- Promote Organizational Compliance

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Types

- Data Only
- Full Documentation
- Accounts Receivable Audit

Perspectives

- Prospective
- Retrospective
- In-House
- Independent Auditor

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PINNACLE

Common Questions and Concerns

- Should every physician acquisition require an audit?
- What is typically found as a result of an audit?
- What is the hospitals liability if improper coding/billing is discovered?
- What is the best risk management strategy going forward?