Capturing New Revenues: The Opportunity and Challenges

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Opportunity: What’s Hot?

- Ancillaries
- Joint Ventures
  - Upstream JV
  - Provider JV
- Pay for Performance
- Gainsharing
- Provider Speciality Alliances
Ancillary Services

- Expansion of the scope of services
- Lab, imaging, pharma, PT
- Most physicians must find a way to bring these services inside their groups to avoid Stark problems
Ancillary Services

- To fit within in office ancillary services exception:
  - Supervision
  - Location
  - Billing
Ancillary Services

- In office ancillary services exception difficult to satisfy for many smaller groups
- Alternatives . . .
Joint Ventures

- **Upstream**
  - Generally do not involve clinical services—equipment leasing, management, etc

- **Provider JV**
  - Generally venture is involved in providing care
Hypothetical # 1

- Slice PC, a group of orthopedic surgeons, is looking for a way to expand revenues by capturing at least a portion of the technical revenues from the imaging studies (MRIs) ordered by Slice physicians. Slice, however, does not order a sufficient volume of MRI scans to justify buying its own magnet. Vision, a radiology group, offers to open a new site near Slice’s offices and to form a joint venture with Slice to own the MRI and lease it to Vision. Rent would be calculated on a per click basis.
Analysis

- This simple JV raises several regulatory issues:
  - Stark
  - Anti-kickback
  - Reimbursement
  - State law restrictions
Hypo # 1

RAD  RAD

Vision

Surgeon  Surgeon

Slice

JV
Upstream Joint Venture

- An equipment leasing company is a prime example of an “upstream” joint venture
- Key distinction: the joint venture entity is not a provider
- This avoids the Stark prohibition (at least in most cases)
Stark Analysis

- Slice and Vision physicians have ownership interest in joint venture
- Joint venture has compensation arrangement (lease) with Vision, a provider of designated health services
- Analyzed as an indirect financial relationship under Stark
Vision physicians are radiologists – under Stark radiologists don’t refer

Thus, Vision physicians financial relationship with a provider of diagnostic imaging generally not relevant under Stark.
Orthopedic surgeons do refer under the Stark law.

Thus, Slice physicians' ownership interest in the joint venture does create a financial relationship that must be analyzed.
Indirect Compensation Relationship

- 3 part test
- Unbroken chain of financial relationships between physician and DHS entity
- Compensation arrangement closest to the physician varies with the volume or value of referrals
- DHS entity knows
Indirect Compensation

- Slice physicians who are employees and do not have an ownership interest in the group, the closest compensation relationship is their salary from the group.

- Does their salary vary with volume or value of their referrals to the Vision Imaging Center?

- If not—no financial relationship
Indirect Compensation

- For the Slice shareholders, however, the closest compensation arrangement will be the lease payments from Vision to the joint venture.

- Rent is per click and, for purposes of the definition of indirect compensation arrangement is considered to vary with volume or value.

- Thus, Slice shareholders likely have a financial relationship with Vision Imaging.
Indirect Compensation Exception

- This exception requires:
  - Agreement in writing, signed by the parties
  - Describes services covered
  - Payment fair market value and not based on volume or value
  - Arrangement does not violate Anti-kickback statute
Indirect Compensation Exception

- Parties should be able to structure the lease to fit within the exception

- Key distinction: for the indirection exception per click payments are deemed not to be based on volume or value
Anti-kickback

- The joint venture and related lease do raise kickback issues
- No safe harbor protection for either the investment interest or for the lease
- Facts and circumstances analysis
- Hanlester instructive in this analysis
Anti-kickback

- Bottom line: some risk under the kickback law
- Try to structure the transaction to meet as many of the applicable safe harbor criteria as possible
Reimbursement

- Joint venture is upstream, so reimbursement issues are really Vision’s problem
- Lease of equipment should not trigger the purchased diagnostic test rule
State law issues

- **Washington:**
  - Medicaid Stark and Kickback statutes
  - RCW 19.68

- **California:**
  - Speier
  - State Kickback laws
Hypothetical #2

Slice reviews the pro formas for the Joint Venture equipment leasing company and is dissatisfied. Slice wants to operate the imaging center on a part time basis and bill under its group provider number. What are Slice’s options?
Provider Joint Venture

- In Hypo #2 Slice wants to capture at least a portion of the technical reimbursement for imaging studies
- The Stark Law creates significant challenges
What are the options?

- New Joint venture entity: Slice-Vision LLC
- Full time operation of Imaging Center as a part of Slice group practice (purchase or lease from Vision)
- Part time lease of space/equipment by Slice
HYPO # 2

Slice-Vision LLC

Bill to Payors?

Contract with Hospital?
Slice-Vision LLC

- Slice-Vision LLC would be a provider of DHS, if it bills Medicare for diagnostic radiology
- No ownership exception is available for Slice (unless in rural area)
- Vision ok because Radiologist don’t refer
- Under Arrangements? (Slice-Vision would not be “entity” under Stark because it would not bill Medicare)
Slice: Sole provider

- If Slice PC has sufficient volume it could lease MRI from Slice-Vision and provide the diagnostic imaging services through its group practice
- This is not always practical
Slice: Part Time Imaging Arrangements

- Slice-Vision could lease the MRI center to Slice PC on a part time basis
- When leased to Slice, the group would provide the imaging services and bill under its number
- Must fit within Stark Exception
In Office Ancillary Services Exception

To bill for DHS under this exception:

- Supervision
- Location
- Billing
Slice: Part time Provider

- Locational Test
- Centralized location
- Same Building

Fit inside or build inside
Carve Out Option

- Stark applies to referrals of Medicare patients for designated health services
- If Medicare patients are carved out of the joint venture then Stark prohibitions avoided
- Beware: Practical Challenges
Carve Out Option

- Carve outs are not favored by the regulators
- Anti-kickback issues should be carefully considered
- “Swapping” arrangements should be avoided
Pay for Performance

- Over 100 Pay for Performance initiatives currently underway
- Wide variety of criteria used
- Array of goals
- Strong Support
- But, confusion reigns
Pay for Performance

- Traditionally reimbursement based on volume not on quality or outcome
- Perception that the system creates the wrong incentives
- PFP in all of its iterations is an attempt to link payment to quality or to some outcome measure
Pay for Performance

- The Pay for Performance Programs are essential to the emerging concept of consumer driven health care.

- In theory, as patients assume more control and financial responsibility, they will need good cost and quality data to make informed choices.
Pay for Performance

- Pay for Performance also has many advocates among large employers and health plans
  - LeapFrog
- Some of the rhetoric suggests that PFP should be relatively easy to implement
Pay for Performance

- Two types of PFP programs:
  - Programs that focus on process
  - Programs that focus on outcomes
Pay for Performance: Process

- Process focused PFP programs may be based on:
  - Adoption of Clinical Pathways
  - Implementation of EHR systems (i.e. CPOE)
  - Preventive care
  - Performance of screening or tests
Pay for Performance: Outcomes

- Pay for Performance based on clinical outcomes may measure:
  - Morbidity
  - Infection rates
  - Readmission rates
  - Complications
  - Medical Errors
  - Compliance with Best Practices
Pay for Performance

- Problem
- BAD DATA
The Rand Corporation Study

- February ’06 Rand Study found that the methods commonly used to create quality “report cards” generally overstate quality of care provided
Rand Study

- Report Cards typically rely on administrative records collected by insurers because data is computerized and available.
- In Rand Study administrative records indicated patients received 83% of recommended care.
- When Medical Records reviewed, percentage dropped to 55%.
GAO Report on CMS Project

- Under MMA Hospitals required to submit data on 10 quality measures
- Failure to submit the data result in loss of .4% of payment update
- Quality Measures cover 3 conditions: heart attack, heart failure and pneumonia
GAO Report

- CMS has gathered data and launched website “Hospital Compare” to convey the information to consumers
- Congress directed GAO to assess the reliability of the publicly reported information on quality
In January 2006 GAO released report

Data found to be incomplete and “statistically uncertain”
Bottom line:

CMS needs more rigorous methods to ensure reliability of the quality data it is publishing.

Note the limited scope of project—does this bode well?
Data Problems

- The GAO Report and Rand study are not alone in pointing out the foibles of the data used to measure quality.
- Other common problems:
  - Age of data (doesn’t reflect current care provided)
Dated Data

- If the data upon which payment is made (or which consumers rely on to make choices) is not current . . .

- Study in Northeast of Cardiac Bypass Surgery at Several Hospitals over 10 year period
Dated Data

- There was a 2 year delay in publishing data
- Hospital ranked 1st in 1996 was last in 1998
- So when the patient shopped for the highest quality hospital in 1998 relying on 1996 data . . .
Data Problems

- Accuracy of standards
  - If recent improvements not reflected in measurement tool, providing better quality is punished
  - Example: CMS / Premier project requires use of ACE inhibitors despite fact that new evidence suggests that some patients better treated with ARB (angiotensin receptor blockers)
Data Problems

- Acuity adjustments flawed
  - Difficult to adjust for all variables
- Adverse selection can skew data
- Foibles allow providers to game the system
But, the beat goes on

- Despite the data problems Pay for Performance is a growing trend
Physician Consortium for Performance Improvement

- AMA and Specialty Societies collaborating over past several years
- Developed 90 quality measures covering 15 conditions
Ambulatory Care Quality Alliance (AQA)

- New National Pilot Program on quality measurement
- AQA endorsed set of 26 performance criteria that have started gaining acceptance
- Pilot Program will aggregate and report data on physician performance across all public and private programs
- 6 Health care consortiums will participate (CA, IN, MA, AZ, MN, WI)—Data collection begins May 2006
AMA & Congress

- Late February 2006 AMA signed an agreement with Congress to develop 140 performance measures covering 34 clinical areas by end of 2006.

- Specialty Societies unhappy (not at the table).

- No commitment either to pay for voluntary compliance with performance criteria or to revise physician compensation to more accurately reflect costs.
Pay for Performance: Prediction

- PFP Movement will continue
- PFP, however, will continue to be plagued by inaccurate standards, incomplete data and the pace of change in medicine
PFP Prediction

- PFP success is directly tied to development of strong information technology systems
- PFP will improve quality and will affect provider reimbursement
- Current high quality providers will be the biggest winners
- But, the winners in PFP will include those who can game the system as well as those who provide quality care
Gainsharing and its Progeny

*Gainsharing is difficult to precisely define. Most use the term to refer to hospitals sharing cost savings with the physicians who help generate those savings*

*Programs generally intended to align incentives:*
  - Hospitals paid DRGs— at risk
  - Physicians paid FFS— no stake in hospital costs
Gainsharing: Early Programs & Legislation

- In 1980s a Texas Hospital System adopted a program that paid physicians $200 per day for discharging patients early.
- Congress, not amused, enacts Civil Money Penalty Law addressing Physician Incentive Plans (PIPs).
- 1990 PIP statute bifurcated between health plans and hospitals (hospital law much more restrictive).
Gainsharing: Range of Regulatory Issues

In addition to the Physician Incentive Plan (PIP) law, gainsharing programs raise several regulatory issues:

- Stark
- Anti-kickback
- Tax exemption requirements
- State law restrictions
Gainsharing: Stark

- Stark Law prohibits physician from referring Medicare patients to an entity (including a hospital) if the physician has a financial relationship with the entity that does not fit within an exception.

- Gainsharing programs difficult
  - What is fair market compensation?
  - Is cost savings tied to value of referrals?
Gainsharing: Anti-kickback

- Anti-kickback statute also implicated by Gainsharing
- Government worried that programs will influence physician choice of hospital (steering) and distort medical decision making (stinting)
The Gainsharing Bandwagon

- Health care industry in late 1990s began embracing concept
- Focus: Cost per case programs
  - Cardiology leading the way
- IRS Private Letter Ruling approves program
- Advisory Opinion requests submitted: initially mixed signals from OIG
- Cottage Industry created
OIG 1999 Special Advisory Bulletin
OIG Special Advisory Bulletin (SAB)

- SAB indicates that hospital PIP law: clear prohibition on gainsharing
  - SAB equates incentive to reduce cost w/incentive to reduce care
- OIG suggests Gainsharing Advisory Opinions inappropriate (just kidding?)
- Look to Congress for solution?
- Providers instructed to dismantle existing programs expeditiously
2005: Advisory Opinion Wave

- About Face?
- In rapid succession, OIG issues 6 advisory opinions approving specific gainsharing programs
- All opinions address gainsharing between Hospital and cardiac surgeons or cardiologists
- All involve the same consultant
The 2005 Wave

- The OIG drew a distinction between
  - Generalized gainsharing arrangements tied to overall cost savings (not permitted) and
  - Limited gainsharing arrangements tied to specific, identifiable and verifiable cost savings (subject to case by case review)
Keys Elements of Acceptable Gainsharing Programs

1) Transparency
2) Clinical Support for Criteria
3) Non-Discrimination
4) Baseline limits on cost savings
5) Product Standardization Safeguards
6) Limits in Scope and Duration of program
7) Savings distributed to the physicians on a pro rata basis
Gainsharing

- **Bottom Line:** management contract or cost per case gainsharing opportunities are limited
- But MedPac Report endorses concept of gainsharing
- CMS Demonstration Projects in progress
  - Preliminary reports suggest cost savings not as significant as predicted
A New Twist

- If cost per case savings programs are too difficult, what are the other options?
- The New New Thing: Service Line Joint Ventures
- Sometimes call Provider Specialty Organizations
Provider Speciality Organizations (PSO)

- PSO is typically a joint venture between a hospital and a group of subspecialists.
- PSO contracts with health plans to provide specific procedures on a globally priced basis (professional and facility fees combined).
- Most common in Cardiology.
Provider Sponsored Organizations

- PSO members, the hospital and the specialist physicians, share risk.
- Typically hospital and physicians agree to fixed base payments for facility and professional services for a procedure.
- The remaining funds are placed in a risk pool.
Provider Sponsored Organizations

- If over the course of a year the PSO controls costs, the risk pool funds will be available for distribution to the participating physicians and hospital.

- Criteria for distribution of risk pool proceeds set by PSO.
Provider Sponsored Organizations

- This structure gives the member physicians and the hospital both an incentive and the flexibility to structure effective measures to ensure quality and promote efficiency.
Why does this work?

- The structure of the PSO and the sharing of risk mean
  - Health Plan (not Hospital) PIP Law should apply
  - Risk Sharing Exceptions under Stark and Anti-kickback statute available if program structured correctly
What are the Challenges?

- Physicians and hospital must develop sufficient knowledge of practice style and cost structure to be comfortable with risk sharing.
- Payors in Community must be willing to contract with Joint Venture to provide globally priced procedures.
What are the Challenges

- Payor should be involved incentive criteria
- Risk pool funds limited to patients covered by global contracts
- Criteria used to measure quality and efficiency should be applied only to this group of patients (difficult to isolate data; problem of small numbers)
What are the Challenges?

- State Laws may restrict ability of providers to share risk or impose burdensome requirements
- Developing risk pool criteria not as easy as it sounds
- Application probably limited to distinct service lines with procedure driven reimbursement
Prediction: PSOs

Provider Sponsored Organizations will emerge as a viable, but somewhat limited way, to align the incentives of hospitals and physicians.