

Compliance in Physician Employment and Hospital- Physician Integration

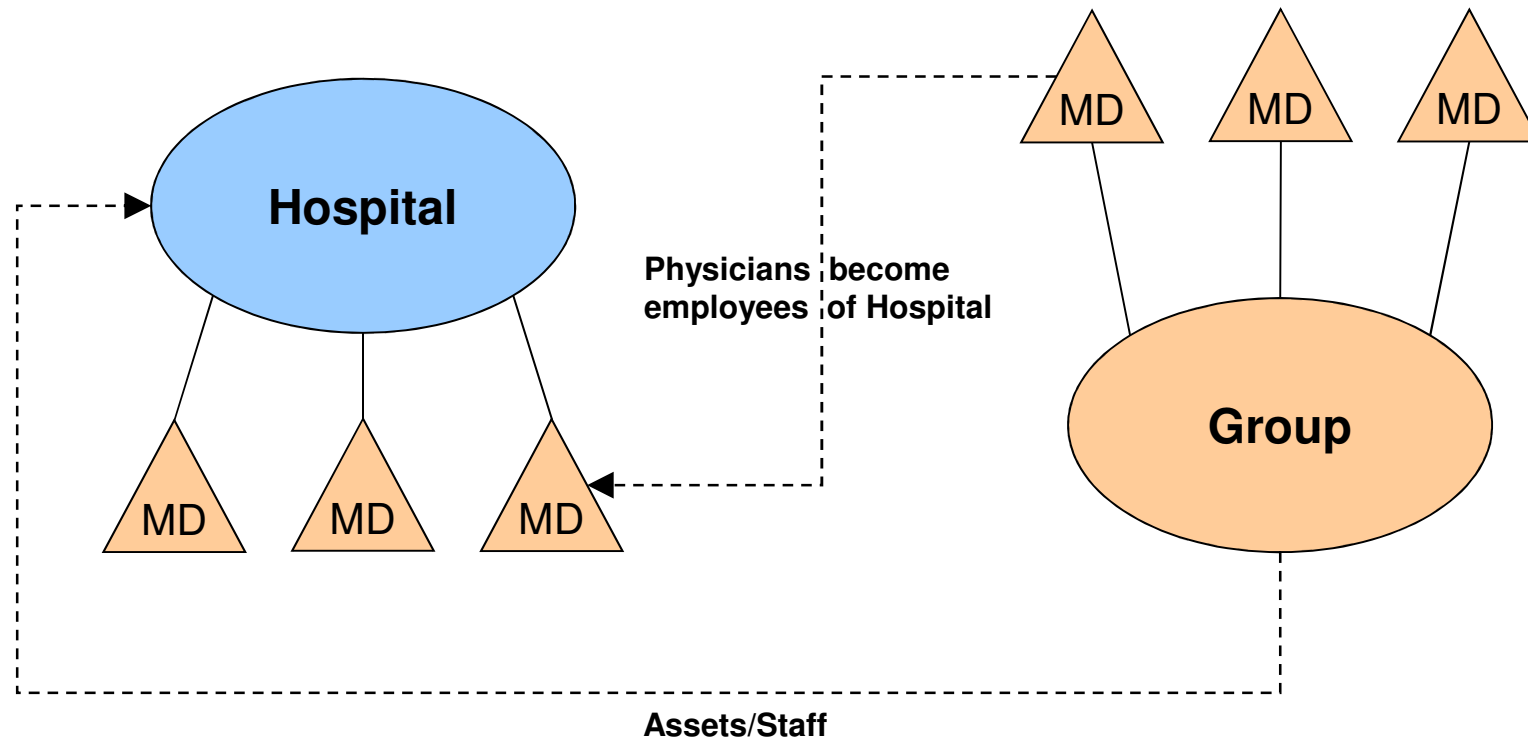
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Current Integration Structures

- Employment
 - Traditional
 - Group Practice Subsidiary
- Recruitment / Seating Arrangements
- Clinical Co-Management
- Management Services Arrangements
- Professional Services Arrangements

Traditional Practice Acquisition and Employment Model



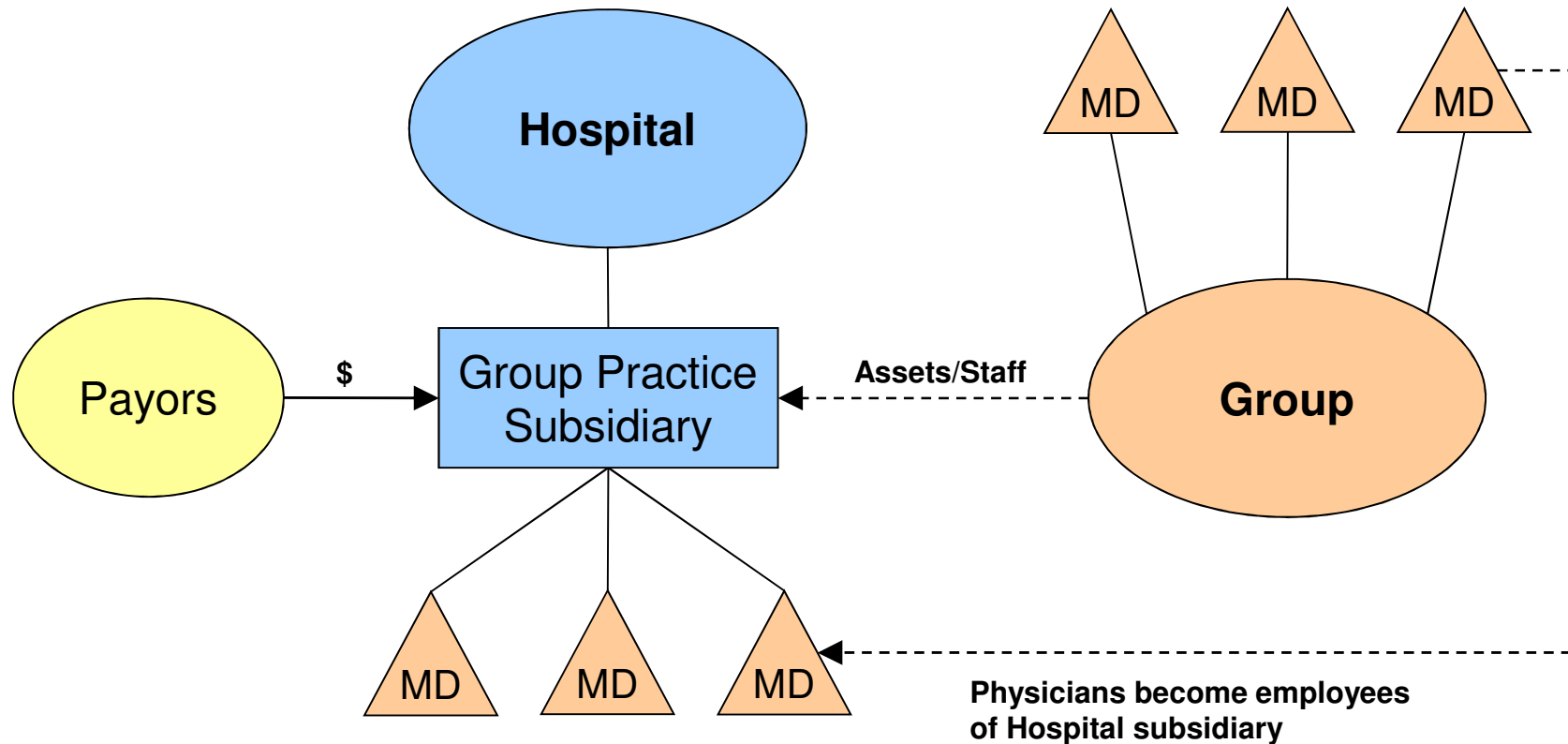
Traditional Practice Acquisition and Employment Model

- Structure:
 - Group sells hard assets to hospital at FMV
 - Physicians become employees of hospital
 - Staff become employees of hospital
- Agreements:
 - Asset purchase agreement
 - Physician employment agreements
 - Lease / sublease for space
 - Lease / sublease of equipment

Traditional Practice Acquisition and Employment Model

- Advantages:
 - Highest level of integration with physicians
- Disadvantages:
 - Hospital has to come up with capital to buy practice
 - MDs nervous about selling & losing “control”
 - No physician sharing of ancillary revenues
 - Difficult to “unwind” if unhappy later
 - Hospitals have traditionally lost money on employed physicians

Group Practice Subsidiary Model



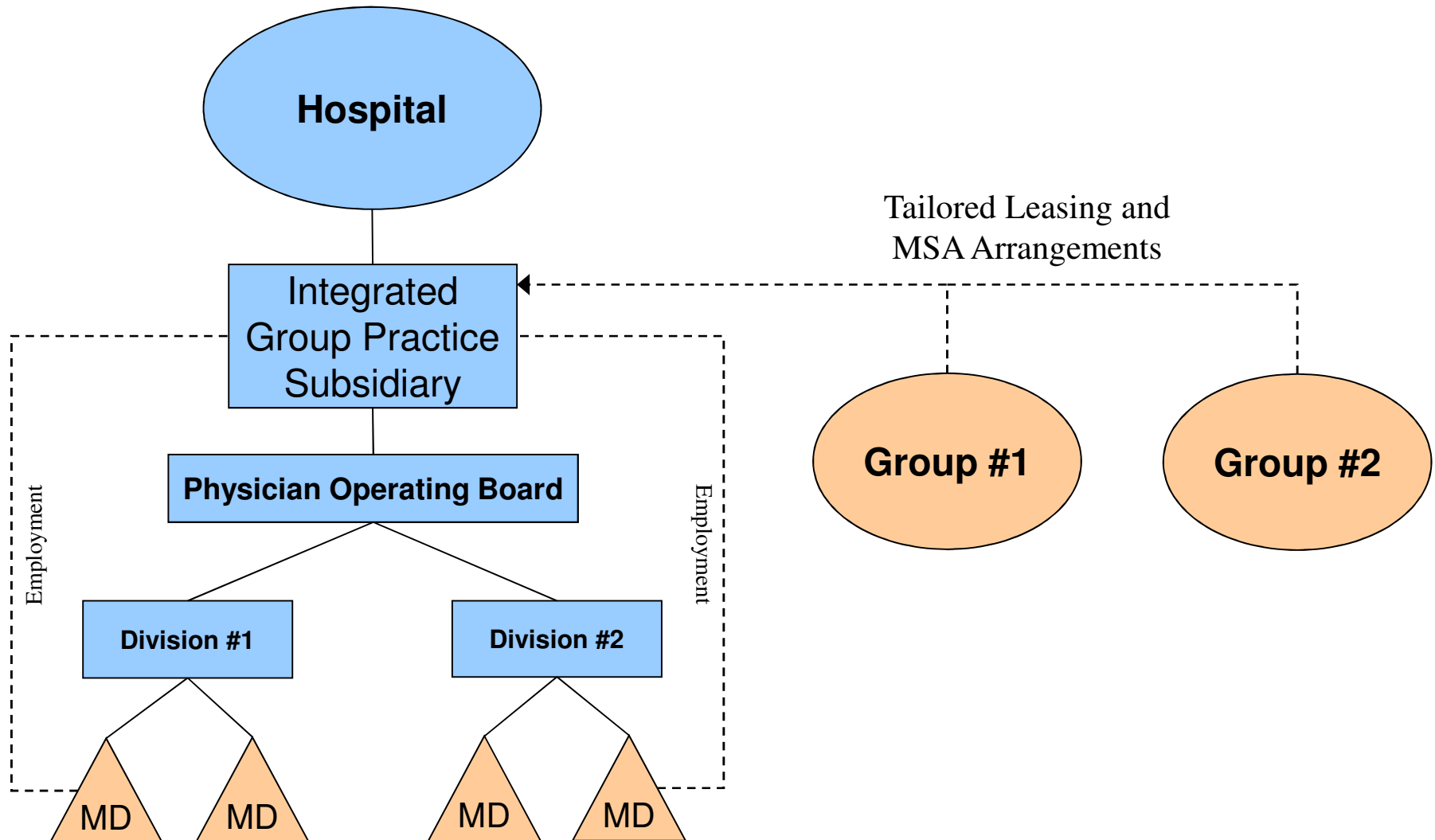
Group Practice Subsidiary Model

- Structure:
 - New entity that is a subsidiary of Hospital
 - Physicians become employed by new entity
 - Operations board is controlled by MDs
- Agreements:
 - Employment agreements between Hospital subsidiary and physicians
 - Asset purchase agreement
 - Organizational / governance documents for new entity including operational and governance policies

Group Practice Subsidiary Model

- Advantages:
 - Gives physicians ability to manage the Group Practice Subsidiary like their own private practice
 - Allows physicians to share in ancillary revenue
- Disadvantages:
 - Must meet “group practice” requirements under Stark which has many requirements
 - Hospital cannot subsidize subsidiary / physicians

Physician Integration Model



Employment Model

Common Compensation Options

Straight salary

- Often used with hospital-based physicians or with physicians that need some type of fixed protection in their compensation

Production options

- WRVU production
- % of collections
- % of charges

Employment Model Compensation Options

WRVU Production Model:

Summary:

- Physicians paid base salary and production bonus if physician exceeds WRVU threshold

Pros:

- Good indicator of productivity – rewards and incentivizes physicians that are productive
- WRVUs are set by Medicare for most CPT codes - not arbitrary
- \$/WRVU is reported data in MGMA
- Payor mix and actual collections does not affect physician

Cons:

- Does not incentivize physician to control overhead costs unless built into formula
- Physician's compensation is not reflective of actual revenue generated
- Hospital assumes all the risk of collecting

Employment Model Compensation Options

WRVU Production Model:

Challenges/Considerations:

- The main challenge in structuring a WRVU model is setting:
 - Base salary
 - WRVU Threshold
 - \$/WRVU as the bonus factor
- Keeping aggregate compensation within FMV range – consider cap on compensation
- Adequately consider overhead in setting formula
- Do not inadvertently take ancillaries into account

Questions:

- How will formula work after 1st year?
- How should decreased production (*i.e.*, vacation, sick time, decreased effort) affect formula in current year's calculation and in subsequent years?
- How are physicians held accountable for keeping overhead costs low?
- How much of the compensation does hospital want to be variable vs. fixed?
- When is the bonus paid (yearly; quarterly)? Is it prorated for partial contract years?

Employment Model Compensation Options

% of Collections Model:

Summary:

- Typically physician paid based on a fixed percentage of the actual revenue collected by hospital for physician's professional services

Pros:

- Relatively easy to administer
- Physician's compensation is reflective of actual revenue generated and realized
- Aligns hospital's and physician's incentives to generate revenue and stay productive

Cons:

- Does not incentivize physician to control overhead costs
- Physicians often concerned about hospital's ability to collect revenue
- Payor mix/charity care may be a concern
- Collection cycle will impact the physician's income and any bonus in the first year
- Impact of collection lag in first and last years of physician employment

Employment Model Compensation Options

% of Collections Model:

Challenges/Considerations:

- Setting the percentage to reflect compensation that is FMV
- Formula must result in aggregate compensation that is within FMV range – consider cap on compensation
- Adequately consider overhead in setting formula
- Do not inadvertently take ancillaries into account

Questions:

- How is the physician held accountable for keeping overhead costs low?
- Will there be a fixed base component or will entire compensation be variable?

Employment Model Compensation Options

% of Charges Model:

Summary:

- Typically physician paid based on a fixed percentage of the actual charges for physician's professional services

Pros:

- Relatively easy to administer
- Aligns hospital's and physician's incentives to stay productive
- Payor mix is not a concern for the physician because compensation is tied to charges, not collections

Cons:

- Does not incentivize physician to control overhead costs
- Physician's compensation is not reflective of actual revenue generated
- Hospital assumes all the risk of collecting the charges
- Physician incentivized to upcode – need to audit regularly

Employment Model Compensation Options

% of Charges Model:

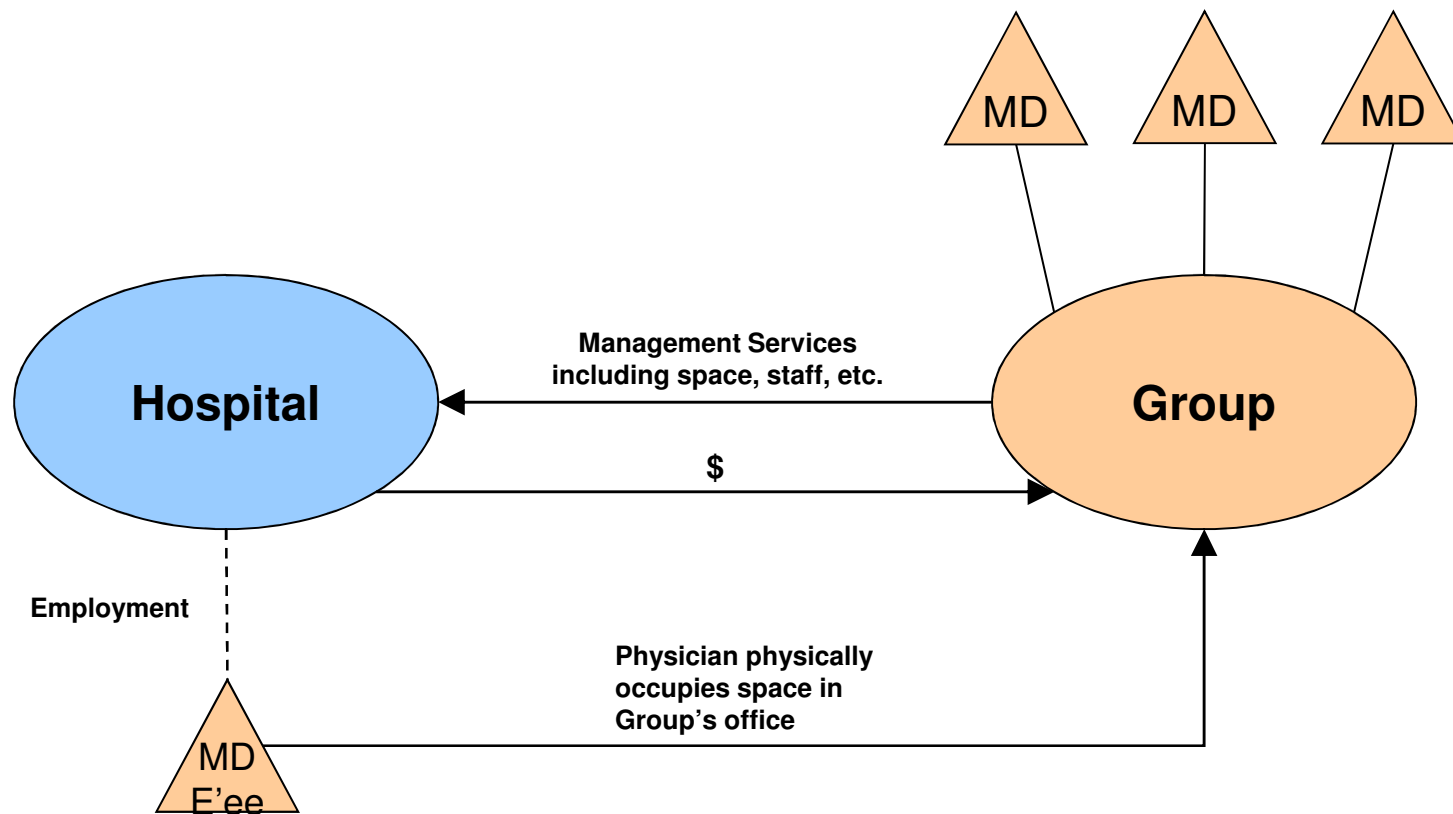
Challenges/Considerations:

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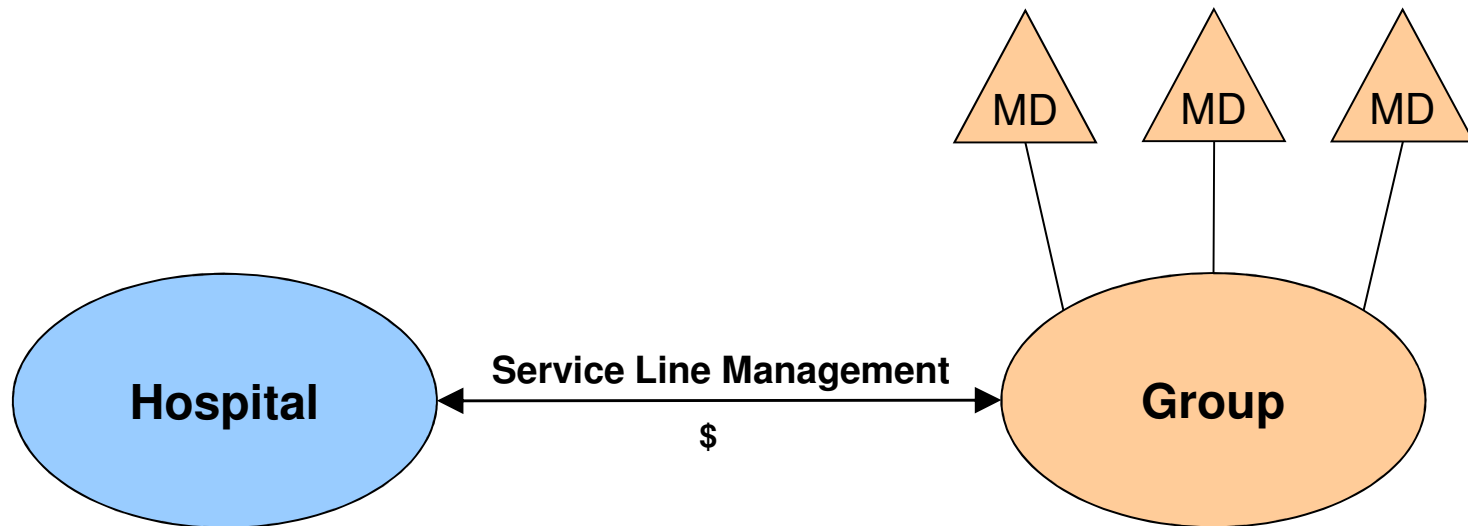
Recruitment ("Seating") Model - Alternative to Traditional Recruitment



Recruitment (“Seating”) Model – Alternative to Traditional Recruitment

- Structure:
 - Hospital employs new recruit and collects for all professional services provided by recruited physician.
 - Group provides management services, space, staff, etc. to Hospital for recruit in exchange for FMV compensation.
- Agreements:
 - Employment Agreement between Hospital and recruited physician
 - Management Services Agreement between Hospital and Group
- Advantages:
 - Avoids cumbersome and restrictive recruitment rules (Income guarantee/incremental expense allocation provisions of recruitment exception are not applicable)
- Disadvantages:
 - Recent Stark law changes make equipment and space leases in an office-sharing arrangement more difficult.

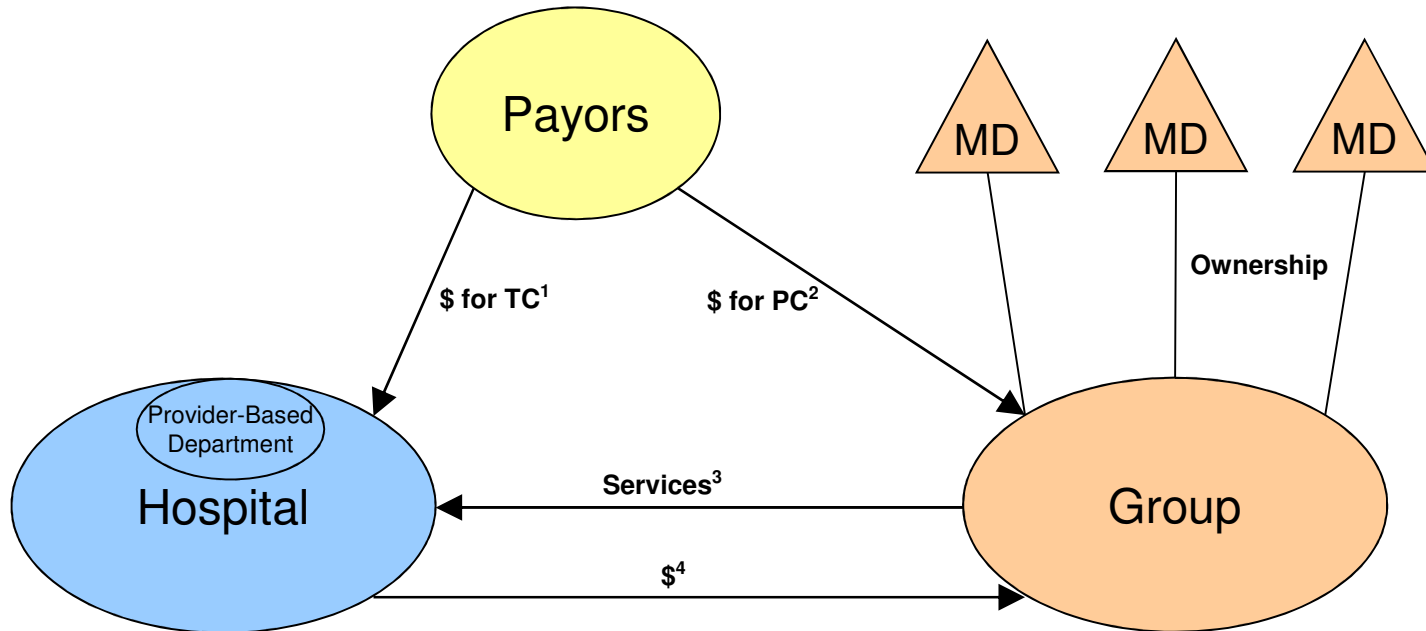
Clinical Co-Management Model



Clinical Co-Management Model

- Structure:
 - No new structure
 - Group provides comprehensive management services to Hospital for service line
- Agreements:
 - Management services agreement
- Advantages:
 - Simple way to integrate with Group and work toward common goals for service line
- Disadvantages:
 - Does not give entrepreneurial group the ability to share in the revenue stream of the technical services

Management Services Agreements – The “New” Under Arrangements



1. Hospital bills for the non-professional services (facility or technical charge) at hospital rates
2. Physician Group bills for the professional services
3. Group provides a variety of services (i.e., equipment or staff; supplies; management services)
4. Hospital pays Group a FMV rate for each service

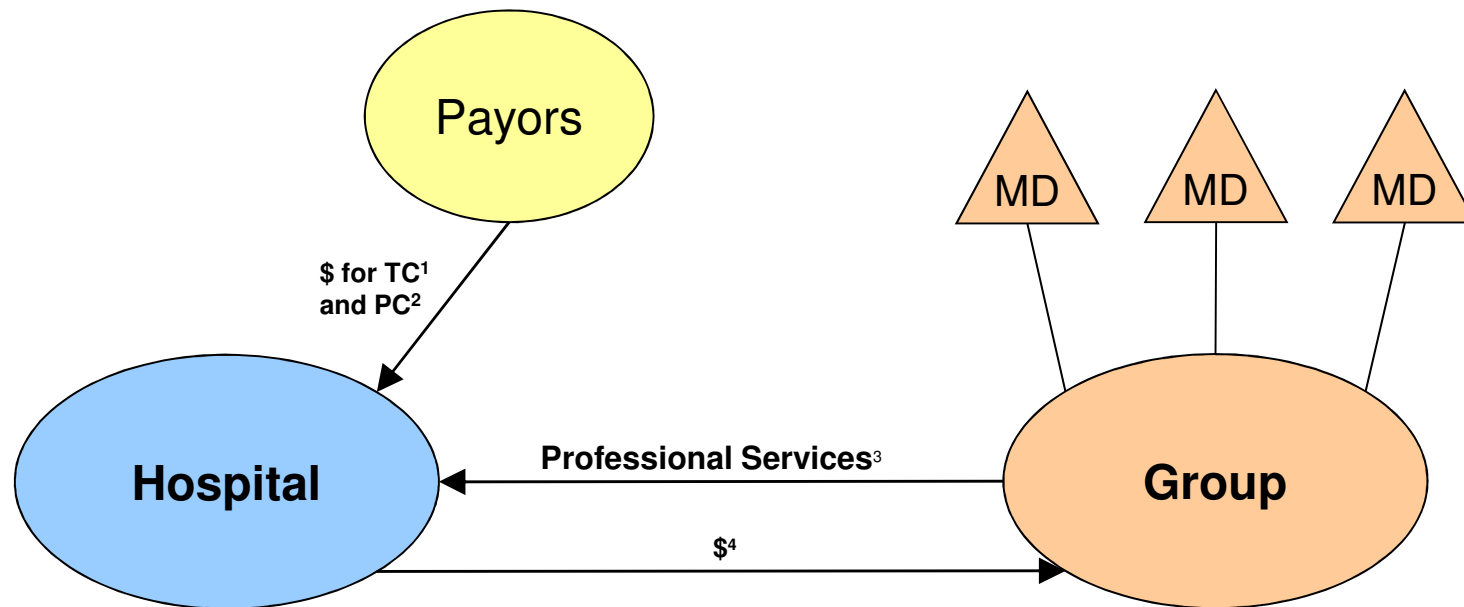
Management Services Arrangement Model

- Structure:
 - Very similar to a more traditional under arrangements model except that Group cannot perform the complete service (i.e., cannot provide turn-key cath lab services and sell to Hospital).
 - Group may provide management services, space, supplies, and either the equipment OR the technical staff (but not both).
- Agreements:
 - Various leases (space, equipment, staff)
 - Management service agreement

Management Services Arrangement Model

- Advantages:
 - Can restructure existing “under arrangements” deals without completely unwinding them.
 - Continues to allow for integration with physicians.
- Disadvantages:
 - Level of payments to Group through leases and management agreement is not likely going to be at the same level as what was paid for the entire service in a traditional under arrangements deal.
 - Complex structure to implement and manage.

PSA Model



1. Hospital bills for the non-professional services (facility or technical charge)
2. Group/MDs reassign right to bill for the professional services to Hospital
3. Group provides professional services to Hospital
4. Hospital pays Group an FMV fee for professional services

PSA Model

- Structure:
 - No new structure required
 - Group / MDs reassign PC to Hospital
- Agreements:
 - PSA for services (compensation must be structured to meet exceptions/safe harbors & be FMV)
- Advantages:
 - Simple to implement because no new legal structure
- Disadvantages:
 - Does not necessarily provide level of integration opportunities hospital or physicians desire
 - Usually fairly short duration before needing to renegotiate

Regulatory Background

Stark Law

Stark law prohibits:

- physicians from referring Medicare patients
- for certain designated health services (DHS)
- to an entity
- with which the physician or a member of the physician's immediate family has a financial relationship
- unless an exception applies

Stark Law

Sanctions include:

- denial of payment
- refund of amounts improperly billed
- CMPs - \$15K per item plus 2x amount claimed - \$100K for "circumvention schemes"
- exclusion
- FCA liability

Anti-kickback Statute

Anti-kickback statute prohibits:

- the knowing and willful
- 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

Anti-kickback Statute

- Pre-PPACA “intent” has differing meanings
 - specific intent to violate AKS
 - intent to commit “illegal act”
 - intent to commit act, knowing that it’s unjustifiable and wrongful
- PPACA “intent”
 - a person need not have actual knowledge of AKS or specific intent to commit an AKS violation

Anti-kickback Statute

- Penalties
 - Criminal fines and/or prison
 - CMPs - \$50K plus up to 3x illegal remuneration
 - Exclusion
- PPACA
 - AKS now specifically actionable under False Claims Act ("FCA")

FCA Primer

FCA primarily covers:

- “presenting” a claim with “knowledge” that it was false or fraudulent
- false claims submitted with the “intent” to induce payment by the government

Statute of limitations

- generally 6 years (or 3 years after material facts known or should have been known by government), but in no case more than 10 years

Liability:

- Penalties - up to \$11,000 per false claim
- Damages – 3 times the payment amount
 - Timeframe for potential damage reduction – 30 days after discovery

Recent Changes to FCA

May 20, 2009 - Fraud Enforcement and Recovery Act (FERA) expanded scope of FCA

Most significant change – FCA exposure for the knowing retention of overpayments even where no false statement or false claim made

- Presentment of a false claim with knowledge or bad intent no longer required
- Claims submitted without knowledge of their falsity that result in an overpayment can become a “false claim” if discovered and not repaid

Recent Changes to FCA

Appears to apply to the submission of claims to private entities administering government funds (i.e., Medicare and Medicaid managed care programs)

Expands statute of limitations:

- Filing of a *qui tam* complaint effectively “tolls” the statute of limitations
- Government can “relate back” to the original *qui tam* action

Tax-Exempt Issues

- Tax-exempt entities may not use proceeds to benefit private individuals
- Rev. Proc. 97-13 safe harbors for tax-exempt bonds
- Compensation must be “reasonable” and vetted in an appropriate fashion (i.e., rebuttable presumption by Board approval of compensation arrangements with disqualified persons to avoid Intermediate Sanctions)
- New Form 990 disclosures

Employment Model Regulatory Issues

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 (see Tuomey later on)

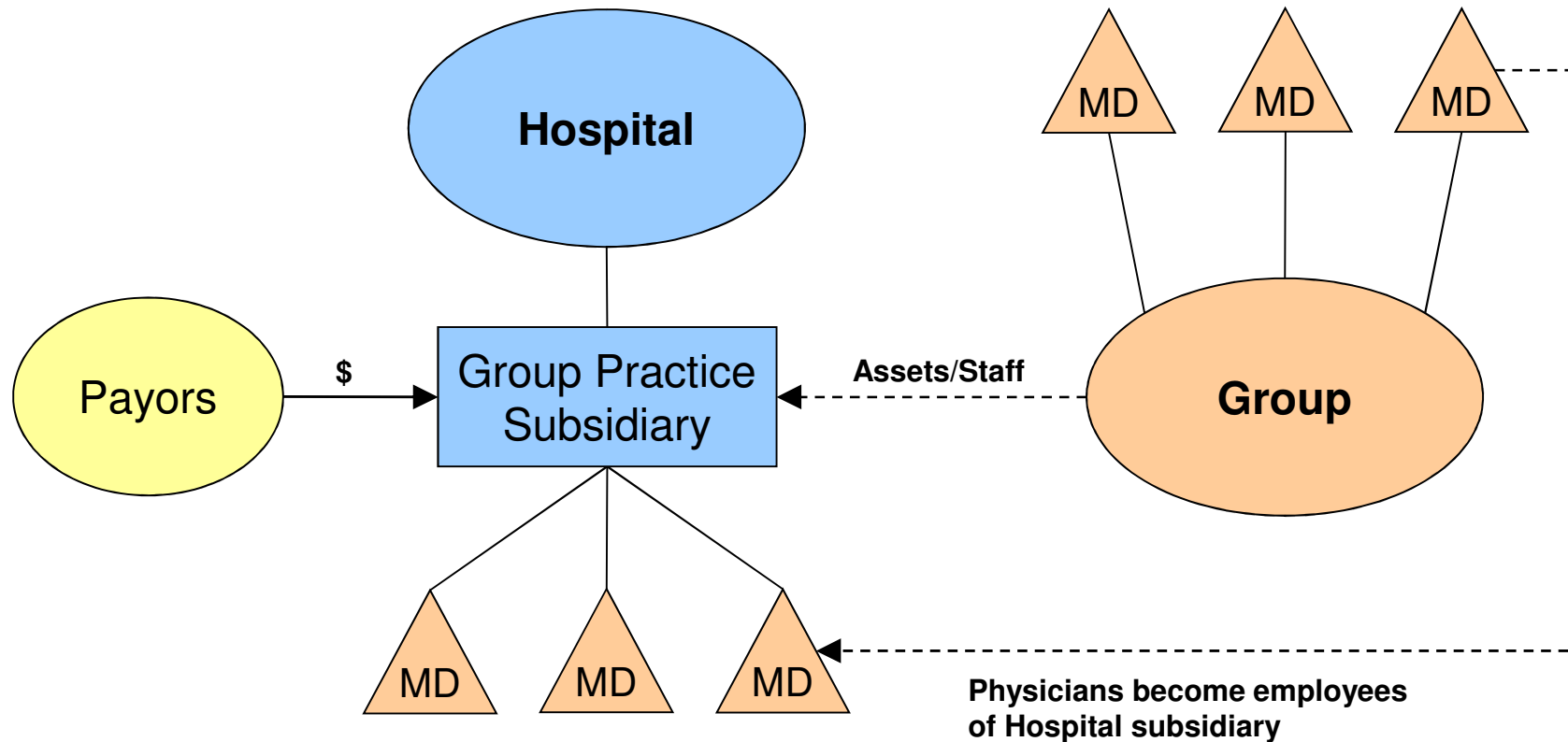
Productivity bonuses are permitted, but ONLY for personally-performed services (no "incident-to" or ancillary services)

Employment Model Regulatory Issues

Anti-kickback 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.

Group Practice Subsidiary Model



Group Practice Subsidiary Model Regulatory Issues

Stark In-Office Ancillary Services Exception:

- Protects arrangements where ancillary revenue is distributed 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
- NOTE: Must satisfy the Stark definition of a “Group Practice”

Group Practice Subsidiary Model Regulatory Issues

Highlights of the “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; not just a rubber stamp
 - Governing body representative of the group practice
 - Effective control of group’s assets, liabilities, budgets, compensation and salaries
 - CMS has not prescribed the process
- Unified business having consolidated billing, accounting, & financial reporting

Group Practice Subsidiary Model Regulatory Issues

- 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

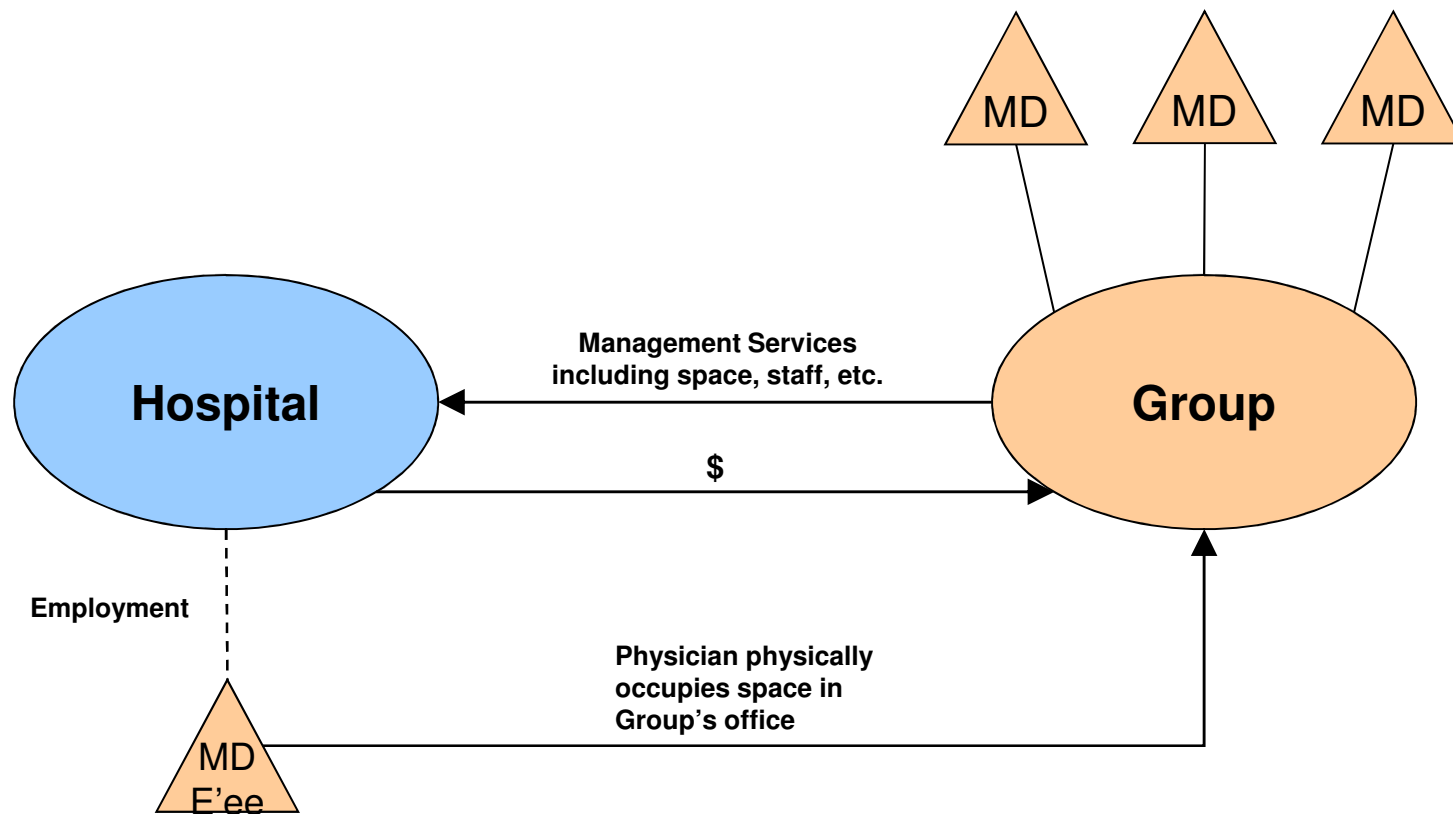
Group Practice Subsidiary Model Regulatory Issues

- 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

Group Practice Subsidiary Model Questions/Considerations

1. Organizational and governance documents will be needed for Group Practice
2. New employment agreements will be needed (between physicians and Group Practice)
3. Will hospital purchase services from Group Practice?
4. Will Group Practice purchase management services from hospital?
5. Will Group Practice lease space or equipment from hospital?
6. If the Group Practice model is adopted, will it be able to sustain itself? (Reminder: hospital cannot subsidize Group Practice)
7. Will there be a desire for more than one Group Practice?
8. Will the physicians want the level of control and participation needed for a Group Practice?

Recruitment ("Seating") Model - Alternative to Traditional Recruitment

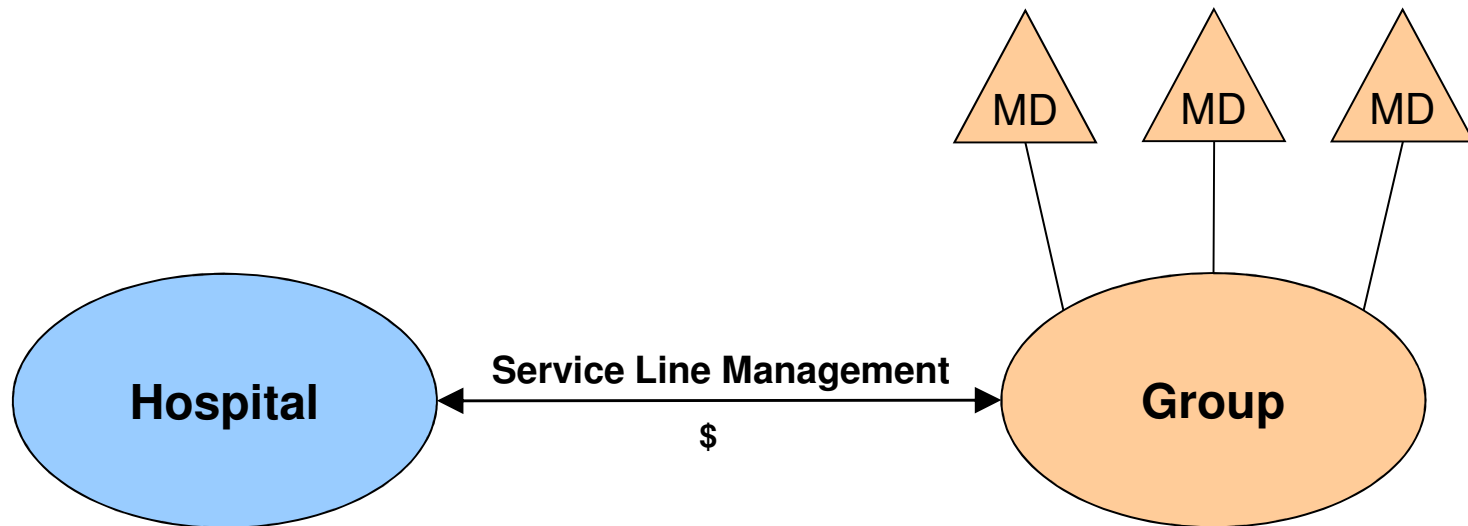


Recruitment (“Seating”) Model – Regulatory Issues

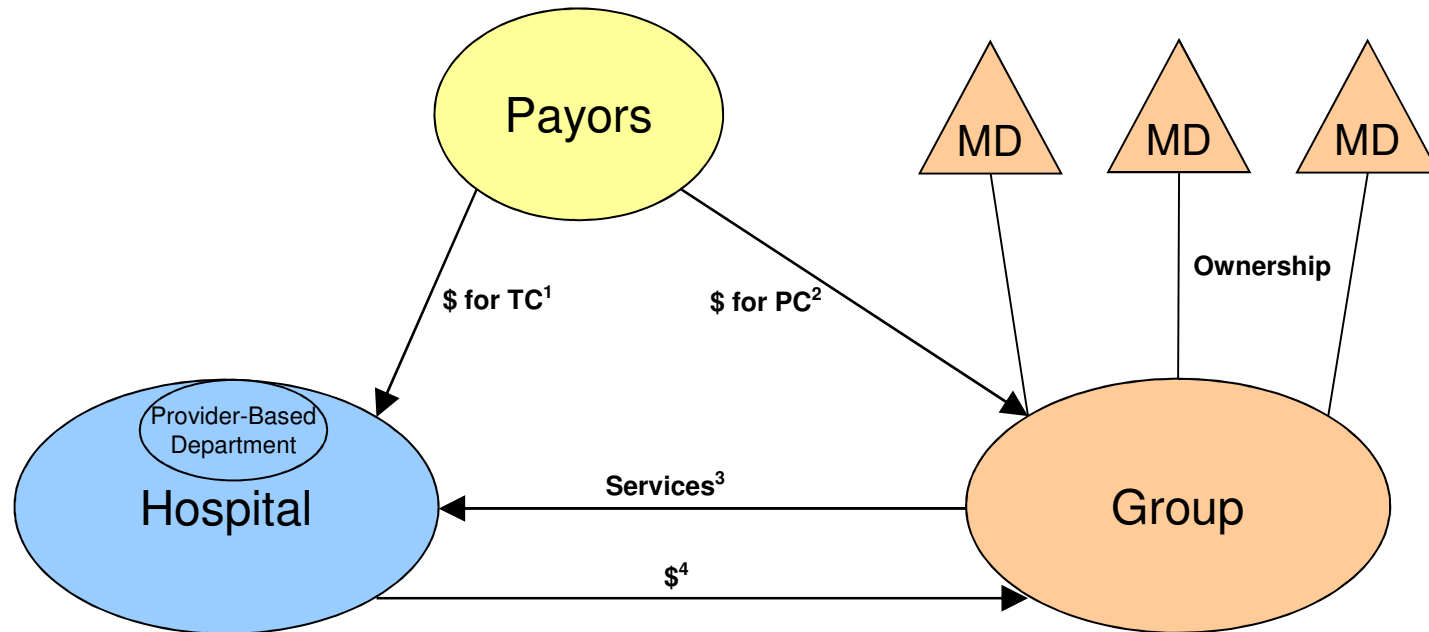
Recent changes and clarifications to the Stark laws make seating arrangements more difficult to achieve

- Each component of the arrangement must meet its own Stark exception
- Equipment and space leases and “exclusive” requirement

Clinical Co-Management Model

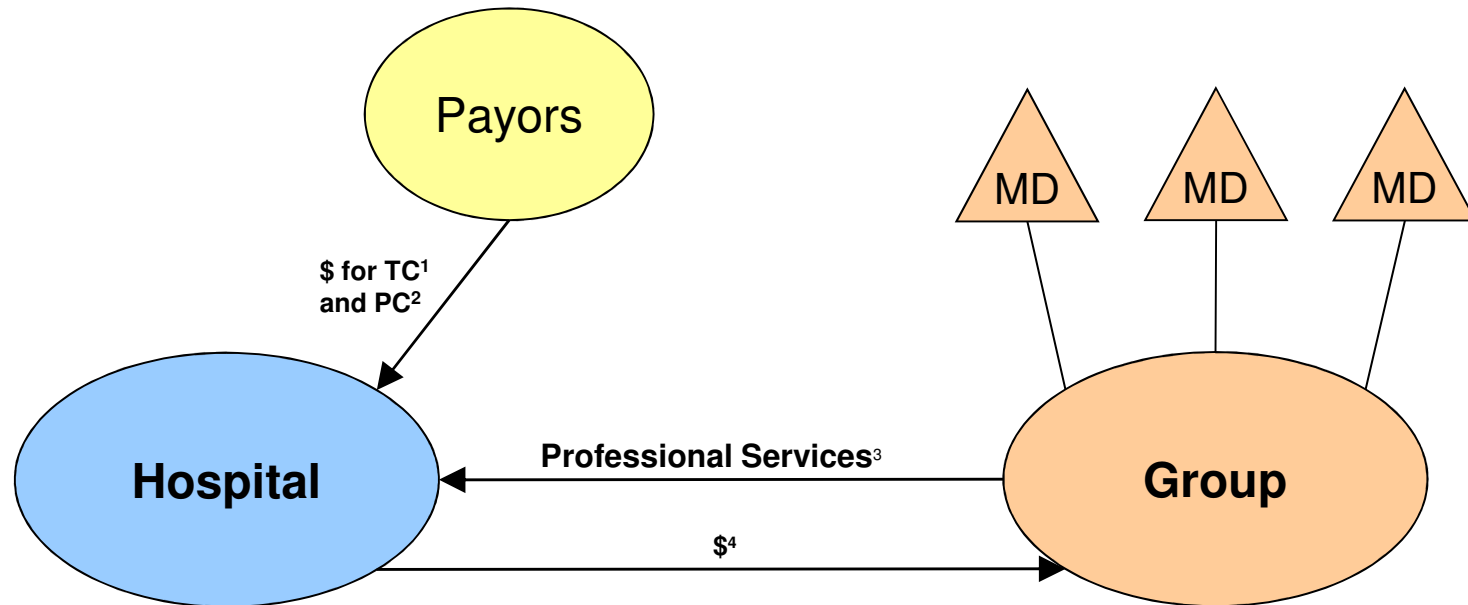


Management Services Agreements - The "New" Under Arrangements



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Personal Service Arrangements Exception Requirements

- 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

Personal Service Arrangements Exception Requirements

- 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

Common Issues Related to Personal Services Exception

- In Writing
 - What?
 - When?
- Fair Market Value
 - Most critical element of exception
 - How determined?
 - Must reflect needed services
 - Do not back into the \$\$
 - Review annually to determine if services still needed and still FMV

Common Issues Related to Personal Services Exception

- Term
 - Must be for at least 1 year
 - Should not be longer than 2-3 years to meet FMV requirements without valuation opinion
- Set in Advance
 - What does this mean?
 - Amendments?

Commercial Reasonableness

- “An arrangement is a sensible, prudent business arrangement from the perspective of the parties involved, even in the absence of potential referrals.”
- “Commercially reasonable in the absence of referrals if the arrangement would make commercial sense if entered into by reasonable parties even if there were no potential DHS referrals.”

Commercial Reasonableness

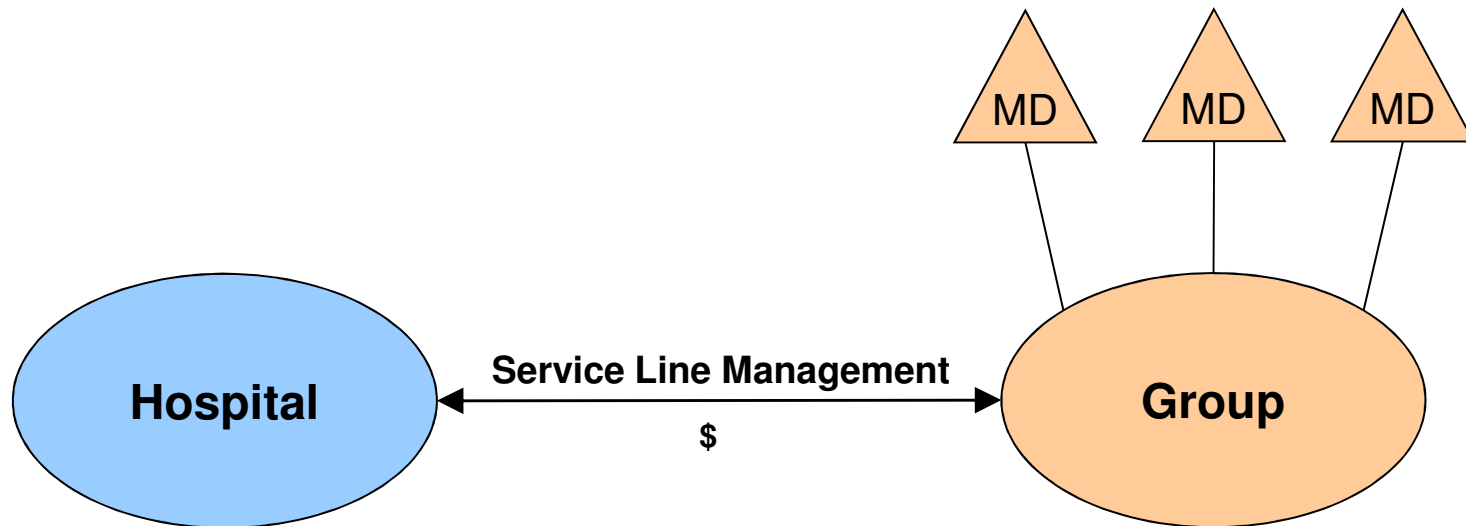
- Tuomey case sheds new light on importance of commercial reasonableness.

“No reasonable hospital would enter into agreements like these if it were not confident that the revenue stream it secured through the physicians’ committed referrals of valuable outpatient procedures would more than cover these losses.”

Percentage-Based Compensation and Per-Click Arrangements

- CMS has historically flipped its position on percentage-based compensation and per-click arrangements.
- Effective October 1, 2009, percentage-based compensation and per-click arrangements in space and equipment leases are prohibited.
 - Applies to arrangements using the space rental, equipment rental, fair market value or indirect compensation exceptions
 - May still use %-based compensation and per-click arrangements for personally performed physician services, management services and billing services
 - Watch out for office-sharing arrangements

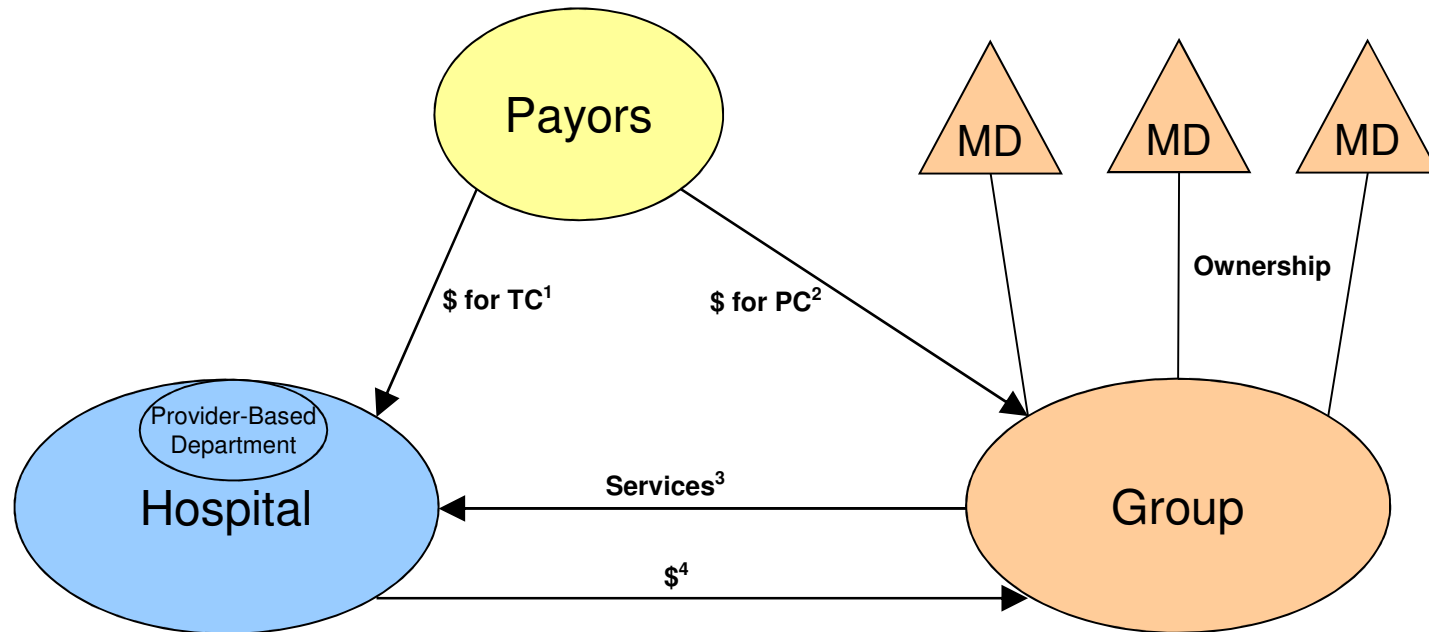
Clinical Co-Management Model



Clinical Co-Management Regulatory Issues

- What can physicians provide that hospital doesn't have to lease to them to provide back to hospital?
- Contractual joint venture issues can arise if a new service is involved.
- Tax-exempt bond rules can bite you if the physicians are using bond-financed space to provide services.

Management Services Agreements - The "New" Under Arrangements

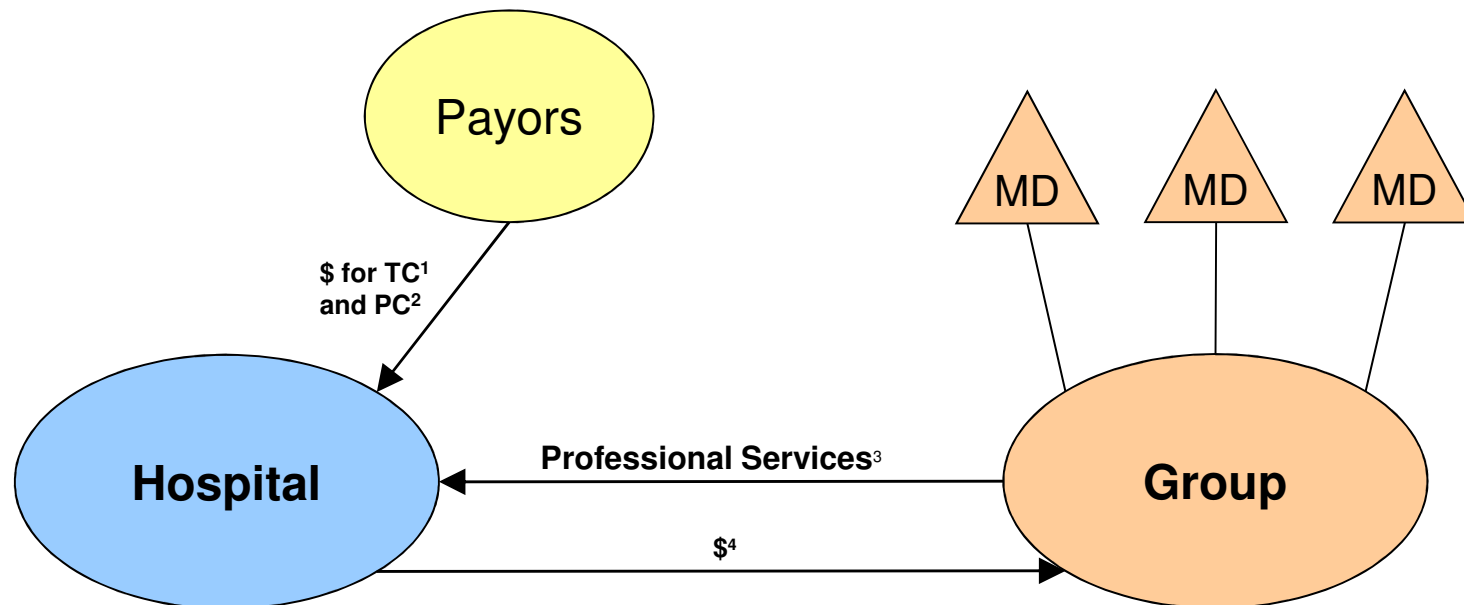


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MSA Regulatory Issues

- Economics tough to work out if hospital unit isn't provider-based.
- What can physicians provide that hospital doesn't have to lease to them to provide back to hospital?
- Contractual joint venture issues can arise if a new service is involved.
- Tax-exempt bond rules can bite you if the physicians are using bond-financed space to provide services.

PSA Model



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PSA Regulatory Issues

- Increasingly used for specialists with declining reimbursements, declining procedures, or both, but hospital still needs the services.
- Be careful of Tuomey and “or other business generated.
- FMV re-determination in future years is crucial.
- Can be pre-cursor to employment down the road – be careful parties don’t resort to subsequent employment to achieve what can’t be done in a PSA.
- Issues when physician complement in group change.

Post-PPACA Considerations

- Stakes raised considerably for holding overpayments
- Whistleblower plaintiffs' bar influence enhanced in governmental enforcement
- CMS Stark self-disclosure protocol released on Sept. 23, 2010 – offers little, exposes lots

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