New Approaches: Co-Management Agreements and Professional Services and Integration Agreements

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Speakers

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Everything we say today is opinion. We are not dispensing legal advice, and listening does not establish an attorney-client relationship. This discussion is off the record. Anything we say cannot be quoted without our prior express written permission.
Co-Management Agreements – Transaction Issues

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Overview

- Proposition and Goals of CSL Co-Management Arrangements
- Big Picture Background
- Possible Structural Options for CSL Management Arrangements
  - Structure
  - Management Services
  - Compensation
  - Diagram - Pros/Cons
- Questions
CSL Proposition and Goals

- Long-term relationship with physicians in various clinical specialties to:
  - Integrate Clinical and Administrative expertise in an economically aligned service management model
- Improve scope, quality and accessibility of health care to hospital patients
- Increase efficiency in the provision of services
- Enhance and expand programs in the region
- May cover inpatient, outpatient, ancillary and/or multi-site services
Big Picture Background
Traditional Service Line Issues

- No standardized procedures and oversight (supplies, labor, scheduling, equipment, etc.)
  - Increased community health care costs
- Varying/Misaligned interests
  - Sub-optimal efficiency and efficacy
- Limited channels for physician input
  - Physician insights not fully leveraged
Big Picture Background
Desired New State

- Standardized procedures and oversight (supplies, labor, scheduling, equipment, etc.)
  - Decreased community health care costs
- Aligned professional and economic interests
  - Optimal efficiency and efficacy
- Formal channels for physician input
  - Fully leverage physician’s clinical judgment and experience
Possible Options for Structuring CSL Management Arrangements

- **Option 1**
  - Specialty physician groups and Hospital form new entity to provide CSL Management Services to Hospital
  - Hospital enters into a CSL Management Agreement with new entity

- **Option 2**
  - Hospital enters into a CSL Management Agreement directly with specialty physician groups or individual physicians
Array of Co-Management Services

- Numerous areas of CSL where Clinical expertise is essential, including:
  - Development of clinical care protocols and pay for performance metrics
  - Budget process, including quality/price analysis on new equipment and technology
  - Strategic planning process for growth of CSL
  - Physician deployment, staffing and recruitment
  - Development of Quality and Efficiency metrics
Option 1 – Structure

- Hospital and physician groups create new entity ("Newco") to provide CVSL management services to Hospital
  - Newco typically formed as an LLC
    - May be special considerations for a CPOM State
  - Hospital and physicians or physician groups invest in Newco
  - Newco offers investment opportunity to other physician investors (either simultaneously with or shortly after initial formation)

- Newco’s Board of Managers ("Newco’s Board") created to oversee operation of Newco and provision of services to Hospital

- Newco enters into a Management Services Agreement with Hospital under which Newco provides comprehensive medical oversight and management of the CSL
  - Selected physicians provide services on behalf of Newco as independent contractors to Hospital
  - Hospital provides space, facilities and support services (e.g., IT, data analysis, marketing, human resources, clerical) as necessary for Newco to provide services
Option 1 – Structure Issues

- Model potentially allows for smaller hospital equity investment in Newco while preserving significant Newco Board representation. To illustrate, Newco could be setup as follows:
  - Equity interests split 25% - 75% among Hospital and physicians, respectively
  - Hospital appoints 1 of 4 Newco board members
  - Significant matters require a majority and the affirmative vote of the hospital member
  - FMV considerations influence equity split

- If Hospital lacks direct control of Newco Board, then other provisions become more critical, e.g., Hospital’s rights under Management Agreement, ability to terminate, etc.)
Option 1 – Management Services

- Newco typically appoints an Executive Medical Director ("EMD")
  - EMD is responsible for administration and operation of the CVSL, including supervision of each Clinical Medical Director (each a “CMD”) and the CSL Administrator, and reports regularly to Newco’s Board.*

- Newco typically has a CSL Administrator ("ADM")
  - ADM provides administrative oversight of the CVSL, including supervision of clinical department personnel, and reports regularly to the EMD and Newco’s Board.*

- CMDs are recommended by Newco’s Board for approval by Hospital
  - CMDs work in cooperation to provide clinical policymaking authority and influence in connection with the operations, strategic direction and program development of their respective units/departments
  - CMDs report regularly to the EMD.*

- Often, the Chair of Newco’s Board reports regularly to the CEO of the Hospital or a Board Designated Committee.

- EMD, CMDs and all physician Board Members must be members of Newco.

* All reporting relationships are tailorable, and typically include additional “dotted-line-reporting” to designated members of Hospital management.
Option 1 - Compensation

- Hospital typically pays Newco an annual management fee, consisting of:
  - a monthly fixed component (based on services provided); and
  - an annual variable (incentive bonus) component tied to accomplishment of annual performance objectives (e.g., quality, efficiency, patient satisfaction, product standardization, etc.), which would be established in advance each year
- Newco pays its medical directors per hour, with eligibility for contingent performance fees
- Newco apportions distributions of any profits based on proportionate ownership interests
Option 1 – Diagram

Hospital or Health System

- CSL
- Capital Contributions
- Management Infrastructure

$ Service Line Management Agreement

Newco

- Profit Distribution
- Profit Distribution

- Capital Contributions
- Management Infrastructure

P / PG

P / PG

P / PG

P / PG
Option 1 – Pros/Cons

♦ Pros

• Arrangement can include all interested groups
• Designed to align interests of all competing groups
• Arrangement would likely be longer-term (e.g., 3 or more years)
• Potentially a vehicle to share expertise gained (e.g., with Hospital’s consent, Newco could manage CSLs for additional hospitals)

♦ Cons

• Some physician groups may not want to invest capital into a management company such as Newco
Option 2 – Points of Comparison to Option 1

- Hospital enters into a CSL Management Agreement with one or more group(s)/physician(s)
- No new legal entity needed; group(s)/physician(s) simply sign a contractual agreement
- Hospital may directly terminate non-performing manager without terminating entire agreement
- Does not require significant up front investment by Hospital or group(s)/physician(s)
- Arrangement tend to be shorter term (e.g., 1 year)
Professional Services Agreements – Transaction Issues

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Overview and Summary of Relationship
Hospital – Advantages:

- Creates Potential Long-Term Relationship
- Avoids Acquisition Costs
- Mechanism For Restrictive Covenants
Physicians – Advantages:

- Provides Financial Guarantee
- Allows Physician Group Independence
- Often Better Managed Care Rates
- Mechanism For Physician Recruitment
Key Elements – Part I

- Creation of Hospital-Controlled Physician Organization
- Shared Governance -- Joint Operating Committee
- Control and Authority
- Responsibility for Practice Facilities
- Clinical Integration
Key Elements – Part II

- Full-Time Exclusive Practice
- Compensation For Services
- Billing and Collection/Reassignment
- Managed Care Contracting Authority
Compensation Options:

- Flat Fee
- WRVU – Based Fee
- Coverage Payment
- Medical Director Payment
- Incentive-Based Bonus
- Periodic Redetermination
- Outside 3rd Party FMV Opinion
Optional Elements:

- Acquisition of Group Assets
- Transition of Group Employees
- Name/Branding
- Hospital Option/ROFR
- Restrictive Covenants
- Unwind/Post-Termination
Legal Issues – Part I

- Compensation-Related
  - Stark/Anti-Kickback Issues
  - 501(c)(3) Issue
Legal Issues – Part II

• Managed Care Contract Related
  • Antitrust
Other Legal Issues

- Staff Leasing
- Governance – 501(c)(3) Issues
- Term/Termination – Bond Financed Property–Rev. Proc. 97-13
- Reimbursement
  - Medicare Provider Based Status
- Ancillary Services – Stark
- Restrictive Covenants – Enforceability
Stark and Anti-Kickback Issues

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Physician Integration Strategies: Key Health Regulatory Considerations

- **Stark Law**
  
  - Basics: Prohibits a physician from referring Medicare/Medicaid patients for designated health services when the physician has a financial arrangement (through ownership or compensation) with the entity and there is no exception for the arrangement.
  
  - Applicable Exceptions
    - Bona Fide Employment
    - Personal Service Arrangements
    - Fair Market Value
    - In-Office Ancillary Services/Group Practice Definition
    - Space and Equipment Lease
    - One-Time Transaction

  - Indirect compensation analysis: where there is an intervening entity between the DHS entity and the referring physician, payment to the physician cannot take into account volume or value of referrals to the DHS entity.

  - Incentive payment & shared savings programs *(Proposed)*
    - Published Nov. 19, 2008 (included in 2009 Medicare Physician Fee Schedule Update, 73 Fed. Reg. 69726)
    - Rule has not been finalized
    - Narrowly drafted; adopts many of the same criteria identified in OIG advisory opinions
Physician Integration Strategies: Key Health Regulatory Considerations

- Anti-Kickback Statute
  - Basics: Precludes payment or receipt of remuneration, directly or indirectly, intended to induce the provision of covered services to government program patient
  - OIG advisory opinions (AO) on gainsharing
    - Series of AOs starting in 2001 involving cardiologists, cardiovascular surgeons, orthopedic surgeons, neurosurgeons and anesthesiologists
    - OIG identified criteria that minimized risk of violating AKS
      - Participation limited to physicians on hospital’s medical staff
      - Potential savings capped based on prior year’s admissions
      - Only one-year program
      - Overall payment amount capped
      - Payments distributed to physicians per capita
      - Contracts set forth significant specificity as to how payments could be earned
  - Employment Exception
  - Personal Services and Management Contracts Safe Harbor
Physician Integration Strategies: Key Health Regulatory Considerations

- **Civil Monetary Penalty Statute**
  - Basics: Prohibits direct or indirect payments that are intended to induce a physician to reduce or limit services to Medicare or Medicaid Patients
  - OIG’s July 1999 Bulletin—Gainsharing Arrangements and CMPs for Hospital Payments to Physicians to Reduce or Limit Services to Beneficiaries

> “absent legislative relief, section 1128A(b)(1) of the Act prohibits any gainsharing arrangements that involve payments by or on behalf of a hospital to physicians with clinical care responsibilities, directly or indirectly, to induce a reduction or limitation of services to Medicare or Medicaid patients.”
Physician Integration Strategies: Key Health Regulatory Considerations

- Total compensation to physicians must not exceed fair market value
  - Independent valuation strongly advised

- Numerous wrinkles and caveats mean compliance issues will be present throughout design/implementation of arrangements
Antitrust Issues

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Legal Issues:
Key Antitrust Considerations

- Combinations among competitors raise Sherman Act questions (e.g., price fixing; market allocation):
  - Is there sufficient financial and/or clinical integration in the arrangement to permit going to market as a single entity?
  - Is joint contracting reasonably necessary to achieve goals of integration?
  - If the same group manages competing entities, are there sufficient safeguards to prevent illegal information sharing or other improper coordination?
Legal Issues:

Key Antitrust Considerations (con’t)

- The size of the combination may raise market power/monopolization questions:
  - Combining large hospital with large group of physicians can create leverage/foreclosure issues.
  - Must evaluate on specialty-by-specialty basis.
  - Joint Statement on ACOs provides some guidance on comfort levels.

- Procompetitive goals of arrangement (efficiencies, quality enhancement, etc.) are key.
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