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Co-Management Re-emerges as a Hospital-Physician Integration Option

By Michael A. Dowell, Esq., guest author

Health care reform promotes performance-based pricing, value-based bundled payments, shared savings, and other payment models that are designed to focus on improving the value of care by improving quality and reducing costs. Clinical integration is a way for hospitals and physicians to bridge the gap between fee-for-service reimbursement and new value-based payment methodologies. The core feature of successful clinical integration requires the strategic alignment, collaboration and integration of hospital and physician goals. In order to recruit and retain physicians whose interest and efforts support service line growth, the hospital's goals for the service line must be aligned with those of the physicians. Engaging physicians in hospital service lines is critical to success, as physicians are the main driver of hospital volumes, profitability, quality and patient satisfaction. Hospitals that fail to achieve clinical integration with their medical staffs will be unable to effectively compete in a "value" driven health care economy.

One way physicians and hospitals are trying to achieve the goal of clinical integration is through co-management arrangements, which have re-emerged in recent years as a hospital-physician integration alternative to joint ventures or exclusive contract arrangements between hospitals and physicians who share mutual interests to lower costs, increase efficiency and improve quality through evidence-based medicine, coordination of care, and outcomes measurement and reporting.

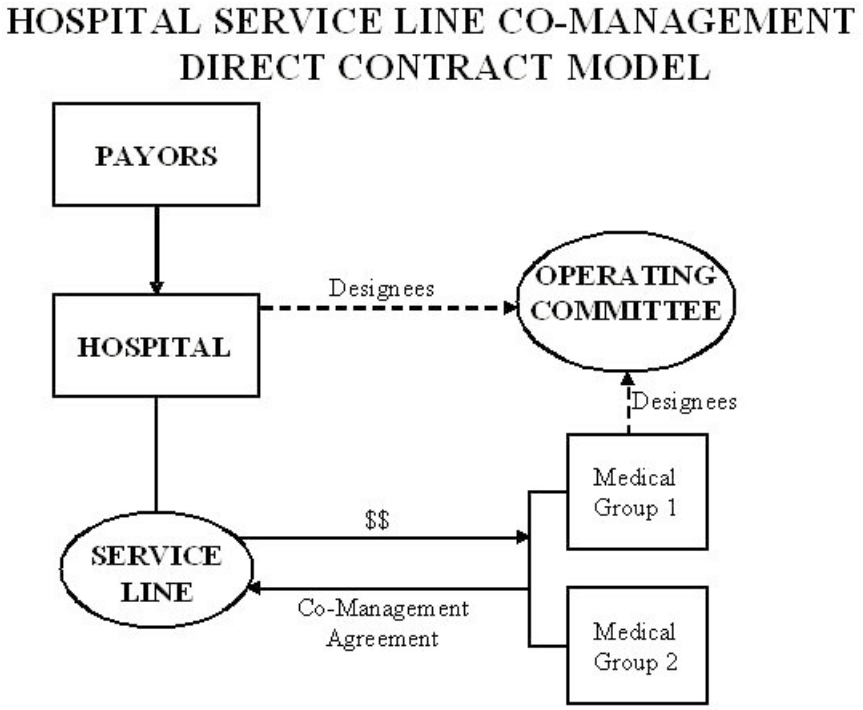
Defining Co-Management

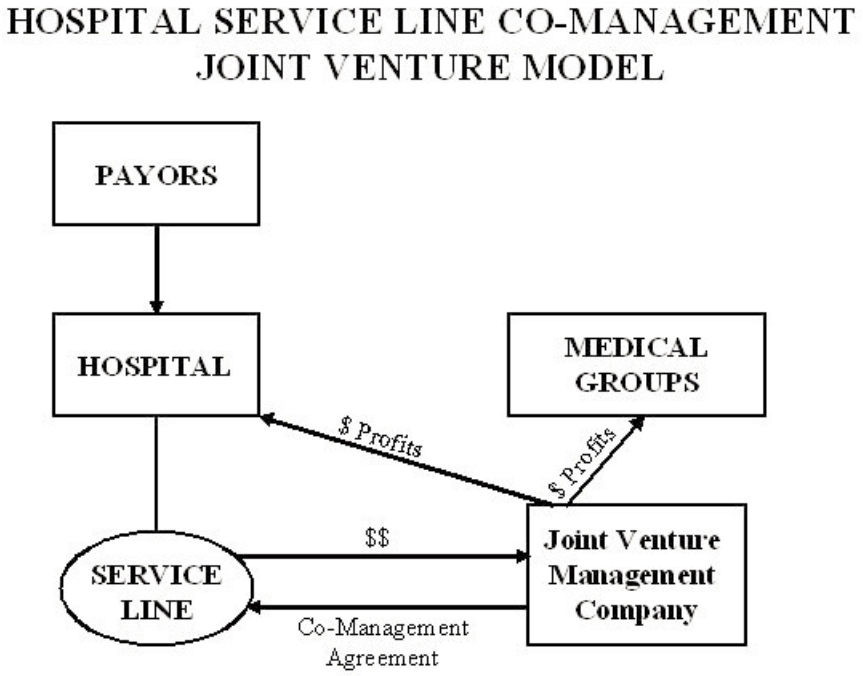
Co-management is a hospital/physician alignment strategy to elevate hospital service line performance. A co-management arrangement is an organized and formal mechanism to actively engage a group of physicians (may include one or more physicians, medical groups or faculty practice plans, or a joint venture entity owned in part or entirely by participating physicians and medical groups) to achieve greater operational efficiencies and improved patient care outcomes. The goal and objective of the co-management arrangement is to recognize and appropriately reward participating medical groups for their efforts in developing, managing and improving quality and efficiency of a hospital service line. Co-management arrangements are typically focused on one clinical service line, such as cardiology, general surgery, orthopaedic surgery, oncology or spine surgery service lines. The co-management model may also be used with ambulatory surgery centers, outpatient imaging centers, emergency departments, radiation therapy, infusion centers, dialysis units, laboratories and mental health units. Cardiology is the most popular service line for clinical co-management; approximately 33% of large hospitals have introduced some form of cardiac clinical co-management arrangements.

The Co-Management Model

Under the co-management model, a hospital will enter into a management agreement with an organization that is either jointly owned or wholly owned by a medical group to provide the daily management services for the inpatient and/or outpatient components of a hospital service line. Often, the hospital and the medical group develop an agreement between the health entity and a management company formed for the purpose of providing the service line management services. The management company is usually organized as a limited liability company (LLC), and the term of the co-management agreement is typically three to five years, renewable by mutual consent, with compensation adjusted annually. Ownership can be by

individual physicians or by entities owned by individual physicians meeting investment criteria. Physician ownership is typically limited to physicians in a position to help the management company perform its services (e.g. practice in a relevant specialty). Hospitals or other health care organizations may also be an owner of the management company. Governance is generally delegated to a management board structured to provide representation of the participating specialties. Board subcommittees may be used to facilitate performance under the management agreement (e.g., finance committee, quality committee and operations committee).





How to Get Started

There are many issues associated with the strategic planning process to establish a co-management arrangement, including identifying duties and responsibilities for governance, management, and decision making, as well as establishing performance standards and reasonable compensation for services. The co-management model strategic planning process generally involves resolution of the following issues:

1. **Governance and Organizational Structure**. Form a steering committee that clarifies and reaches agreement on objectives, guiding principles, governance and organizational structure.
2. **Co-Management Services and Responsibilities**. Determine the scope of co-management services and responsibilities to identify the services that are included in the co-management arrangement, and to establish the responsibilities, duties, and authority of the co-managers.
3. **Physician Participation Criteria**. Develop a set of guidelines for initial and ongoing physician and medical group participation, including adherence to quality standards, confidentiality and conflict of interest rules.
4. **Performance Standards**. Develop and implement key metrics on clinical, operational, quality, utilization management, patient satisfaction and physician performance. Set benchmarks and timeframes that serve to provide measurability and objectivity.

5. **Co-Manager Compensation**. Determine the methodology and quantity of compensation to be paid to co-managers, and ensure that such complies with legal and regulatory requirements.

To effectively coordinate the tasks inherent in the strategic planning process, an integrated work plan should be prepared. The strategic planning process should be the product of meaningful input from the hospital and physicians. There should be effective information systems in place to provide clinical data to the hospital and physicians in a useful format, to measure success in the pursuit of clinical guidelines and quality initiatives. Organizational budgeting processes should be utilized to promote the efficient and effective coordination of care across hospital service lines.

The Co-Management Agreement

A written contract between the hospital and physician group(s) is necessary to detail the scope and nature of the clinical co-management arrangement and to help demonstrate compliance with federal and state health care regulatory and fraud and abuse laws. The management services agreement development process will incorporate the governance and organizational structure, co-management services, roles, responsibilities and expectations of the parties; physician participation criteria; benchmarks, timeframes and performance measures; and co-manager compensation terms developed during the strategic planning process. Primary issues of negotiation are likely to include: the physicians' compensation methodology; scope of services; quality improvement initiatives; use of research grant funds; medical office space for physicians; hiring and firing of non-physician clinical staff; billing and collections responsibility; termination; and restrictive covenants.

The co-management agreement typically requires the medical group to enhance the service line, create new service line opportunities, improve operations, integrate the physician members, and most importantly, align the goals of the physicians and the hospital around delivering high quality, efficient and effective health care. The co-management agreement also generally requires direct physician participation in the design and oversight of annual clinical capital and operating budgets, the development and implementation of clinical protocols, performance standards and business plans, medical director services, patient case management services, materials management, physician and patient scheduling, nurse and non-physician clinical oversight, the periodic assessment of the quality of patient care delivered, the measurement of patient, physician and staff satisfaction, and the development of community relations and educational outreach programs.

Compensation Methodology

Co-management models provide fixed compensation as well as performance-based compensation. The fixed compensation is an annual fee (generally payable on a monthly basis) that is consistent with the fair market value of the time and efforts of the participating physicians in the service line development, management and oversight process.

The incentive compensation, or bonus fee, is a series of pre-determined payment amounts (which must also be at fair market value and are generally payable quarterly or annually) which are contingent upon the attainment of specified, mutually agreed upon, objectively measured targets. Potential incentive compensation measures include program development, clinical quality and outcomes, patient, physician satisfaction measures, and operational process improvements. Operational, quality and satisfaction-based performance measures are typically based on baseline levels determined using the facility's historical and clinical data and/or comparable national or regional data, with incentives paid to reflect incremental improvement. Performance measures should use an objective methodology, be verifiable, be supported by credible medical evidence, and be individually tracked.

Co-Management Program Legal Compliance Issues

Hospital-physician integration cannot be achieved without legal risk. Contractual integration, such as co-management arrangements, generates numerous legal issues and must be structured in a manner to comply with applicable antitrust, anti-kickback laws, physician self-referral prohibitions, and tax-exempt organization law.

Antitrust Laws. A Federal Trade Commission qualified clinically integrated arrangement is an arrangement to provide physician services in which (1) all physicians who participate in the arrangement participate in active and ongoing programs of the arrangement to evaluate and modify the practice patterns of physicians and create a high degree of interdependence and cooperation among the physicians, in order to control costs and ensure the quality of services provided through the arrangement; and (2) any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement.

Anti-Kickback Laws. The federal anti-kickback statute is a criminal statue that generally prohibits the offering, payment, solicitation or receipt of any remuneration in order to induce referrals to another person or entity for the furnishing, or arranging for the furnishing, of any item or service that may be paid for in whole or in part by Medicare, Medicaid or any other federally funded health care program. An improperly structured co-management arrangement could be interpreted as an agreement to provider remuneration to physicians in exchange for referrals. Co-management compensation structures must be both at fair market value and commercially reasonable, and must not be structured to reward physicians for increased volumes or for reducing care for Medicare and Medicaid patients, pursuant to Stark and anti-kickback regulations. Management fees paid to the co-management organization could be interpreted as remuneration intended to induce referrals to the hospital. To avoid anti-kickback law risk, the co-management arrangement must be structured in a way to comply with the personal services safe harbor/exception or other applicable safe harbor/exception for anti-kickback laws; economic terms must be consistent with fair market value; and the arrangement should include protections to prevent physicians from selecting patients based on desirable acuities.

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Civil Monetary Penalty Statute. The civil monetary penalty statute prohibits a hospital from knowingly making a payment, directly or indirectly, to a physician as an inducement to reduce or limit services to a Medicare beneficiary. A co-management arrangement that incentivizes behavior to reduce costs or otherwise change physician behavior could violate the civil monetary penalty statute. Co-management incentive payments should be structured to avoid civil money penalties for payments to physicians to reduce care. Length of stay and expense budget-based incentives may raise civil monetary penalty issues; however, incentives can reward clinical improvement that correlates with reducing cost and reward cost-saving measures that do not adversely affect patient care. In *Office of the Inspector General Advisory Opinion 08-16,* the federal government approved a payment for performance arrangement between a hospital and physicians on the hospital's medical staff. Under the payment for performance program, a commercial insurer paid the hospital bonus compensation calculated as a percentage of the annual base compensation it otherwise paid to the hospital if the hospital met specified quality and efficiency standards. The insurer would pay the hospital a maximum amount of bonus compensation of 4% of the annual base compensation. To receive bonus compensation, the hospital was required to meet quality standards for all hospital patients (including Medicare, Medicaid and privately insured patients). The hospital entered into a quality enhancement professional services agreement with a physician entity for an initial term of three years, subject to automatic renewal for additional terms. Under the quality enhancement agreement, the hospital agreed to pay the physician entity a portion not to exceed 50% of the bonus compensation the hospital received from the commercial insurer for meeting the quality targets. Upon receipt of its payment, the physician entity will distribute the hospital payment to its physician

members on a per capita basis. The program also includes a cap on payments to the physician entity, which is tied to the base compensation paid by the commercial insurer to the hospital. Any increase in patient referrals to the hospital due to an increase in annual base compensation received by the hospital from the commercial insurer would not increase the annual payment to the physician entity. In addition, the hospital was required to monitor the implementation of quality targets throughout the program to ensure that they do not result in inappropriate reductions or limitations on patient care—and the hospital agreed to terminate application of any quality target determined to have an adverse effect on patient care. Likewise, the hospital agreed to terminate physicians with significant referral increases to the hospital from participation in the program. The hospital will also inform all patients about the program in writing.

In its analysis of the hospital payments to the physician entity under the civil monetary penalty law, the OIG declined to impose penalties due to the presence of the following program safeguards designed to reduce the risk of fraud and abuse:

• The quality targets are based on credible medical evidence indicating that they improve patient care;
• If a quality standard is contraindicated for a particular patient, the hospital payment to the physician will not be reduced;
• The quality targets are reasonably related to the practices and patient population of the hospital; and
• The hospital will monitor the quality targets and their implementation throughout the program to avoid inappropriate limits on patient care or services.

The OIG also noted that the base compensation and bonus compensation paid by the commercial insurer to the hospital, as well as the physicians' quality efforts, involved all hospital patients admitted with the specified conditions—not just those patients insured by the commercial insurer.

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Similarly, the OIG declined to impose administrative sanctions under the anti-kickback statute based on the presence of the following program safeguards:

• The membership of the physician entity will be limited to physicians who have been on the active medical staff for at least one year, thereby minimizing the likelihood that the arrangement will attract referring physicians or increase referrals from existing physicians;
• Compensation paid to the physician entity will be subject to a cap tied to the base compensation paid by the private insurer to the hospital in the base year so that increases in patient referrals to the hospital will not increase hospital payments to the physician entity;
• The physician entity's distribution of hospital payments to its physician members will be on a per capita basis—and participation in the program will be offered to all physicians, not just high-referring physicians (these factors will serve to reduce the risk of rewarding individual physicians for referrals to the hospital);
• The commercial insurer will oversee the arrangement to ensure that hospital payments to physicians are based on meeting the quality standards based on the Quality Measures Manual published by The Joint Commission with input from CMS; and
• The program will be limited to a three-year term (the OIG expressed no opinion on the potential future renewal terms of the program but nevertheless suggested that payments in subsequent terms should not be based on improvements achieved in prior years such that incentives for achievement of new improvements should be included in future terms).

Stark Law Self-Referral Prohibition. The Stark law generally prohibits a physician from making referrals for certain designated health services to entities with which he or she has a financial relationship, unless an exception applies. Payments to physicians under a co-management agreement constitute a financial relationship. Designated health services include inpatient and outpatient hospitals services; thus an exception to the Stark Law

must be satisfied. The new Stark regulations eliminated hospital-physician "under arrangement" transactions and proposed a new exception for certain "incentive payment and shared savings programs," such as co-management and gain-sharing arrangements. The proposed exception closely resembles the model of gainsharing programs approved by the OIG in a series of advisory opinions addressing civil monetary penalty and anti-kickback concerns. The primary difference between the proposed rule and the OIG-approved programs is that the proposed rule covers both pay for performance (as "incentive payment programs") and gainsharing arrangements (as "shared savings programs").

The proposed "Incentive Payment and Shared Savings Programs" exception ("Shared Savings Exception") provides that "[r]emuneration in the form of cash or cash equivalent payments, but not including non-monetary remuneration, provided by a hospital to a physician on the hospital's medical staff or to a qualified physician organization" will not create a "financial relationship" for Stark Law purposes, provided that certain conditions are met. The CMS proposal to exclude such financial relationships from the operation of the Stark Law is relatively narrow, and CMS acknowledges that it is unlikely to cover many arrangements. Significantly, the proposed exception would protect only incentive payments and shared savings programs offered by hospitals. Further, CMS is proposing to protect remuneration only in the form of cash (or cash equivalent) payments made by a hospital, and the exception would be limited to payments to physicians who actually participate in the achievement of the patient care quality measures or cost saving measures. Under the proposed exception, the hospital may not determine eligibility for physician participation in a program based on the volume or value of referrals or other business generated between the parties. The proposed rule would also require written disclosure to patients whose patient care at the hospital relates to any of the measures that are part of the incentive or shared savings program.

Tax-Exempt Organization Requirements. Co-management arrangements raise two primary tax exemption questions. First, if a new "umbrella" entity is formed (as opposed to using a series of agreements among existing entities), whether the entity can qualify for tax-exempt status; and second, whether any shared savings or other payments between or among the hospital and physicians will be consistent with the tax-exempt status of the hospital. Tax-exemption rules require reasonable compensation; prohibit private inurement, private benefit or excess benefits; and prohibit co-management compensation from being based on "net earnings" of a hospital or service line. Co-management arrangements should obtain comparability data, independent approvals and documentation to establish rebuttable presumption of reasonable compensation under intermediate sanction regulations.

Conclusion

Integrated hospital-physician arrangements, which align clinical and financial interests, will be critical to the success of hospitals and health systems in the future value-driven healthcare delivery and payment system. Co-management agreements are a good option for hospitals and medical groups that desire to align physician incentives related to utilization, cost, service and quality objectives, but do not want to move to a more integrated model such as a medical foundation or employment model. Co-management agreements can enhance physician satisfaction by allowing them to participate in the operational and strategic efforts of the hospital. At the same time, the hospital can gain from possible cost reductions and secure key physician groups in one of the most important service lines of the hospital.

In order to avoid regulatory or compliance complications, an independent valuation consultant should be engaged to provide a certified opinion that the co-management arrangement is both a fair market value and commercially reasonable, as well as to assist the health care enterprises involved in defining the scope of the activities performed by the co-management company and extensively review the appropriateness of the metrics that determine reimbursement. Experienced health care law counsel should be retained to structure the arrangement in a manner that complies with antitrust

laws, the civil monetary penalty statute, anti-kickback statute, physician self-referral statute, false claims act, tax-exemption intermediate sanctions, and provider-based status rules.

Hospital boards of directors and executives should be taking steps to align their organizations with physicians as needed to sustain the level of physician integration required to achieve the goals and objectives of a value-driven health care delivery system. Clinical integration can address the challenges of health care reform, as long as hospitals develop the governance structure, physician incentives, quality and value metrics, and infrastructure to support a clinical integration program. Hospitals and health systems that develop successful hospital-physician alignment strategies will be able to sustain a competitive advantage by maintaining and enhancing revenue, utilization and market share in both inpatient and outpatient care areas.

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