



Health Care Reform, Stark and Physician/Hospital Alignment Strategies

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Today's Agenda



- Understanding effects of PPCA on hospitals and physicians
- More reimbursement and legal constraints on physician's ancillary activities.
- Physician/hospital alignment after PPACA
- These constraints can create opportunities for hospitals.

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The Regulatory Burden

- Healthcare is the most regulated industry
 - Nuclear energy is second
 - Federal, state, and local impact on every aspect of the healthcare industry
- Stark Law
 - Prohibits physicians from referring to an entity with whom he/she or a family member has a financial relationship, unless the relationship meets an exception
- Anti-kickback Statute
 - Prohibits payment in any nature in exchange for referrals of health care services that are paid by the government



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Recap of 2010 Health Reform

- Patient Protection and Affordable Care Act (March 23, 2010)
- Themes: Cost, Quality and Accountability
- Predicted Impact: Provide coverage for 32 million uninsured (92% of all Americans)



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Current State of PPCA

- ????
- Numerous Constitutional Challenges
- Uncertainty: U.S. Supreme Court will decide in 2012



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What is Out

- In - Office Ancillaries
- Physician Owned Hospitals
- Duties to Disclose
- Holdover Requirments



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In-Office Ancillary Billing and Building Requirements



Figure 7-15 Whole body bone scan

- Building
 - “centralized building”
 - “same building” in which certain other services are provided (based upon various hourly requirements)
- Services must be billed by the physician performing or supervising the services, by a group practice of which the physician is a member, or by an entity that is wholly owned by such physician or group practice.
- In-office scans generally protected by the in-office ancillary exception.

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More on In-Office Ancillaries...



- Patient PPCA amended to include In-Office Ancillary Services Exception (section 6003)
 - Referring physician must inform patient **in writing** that the patient may obtain the service from a person other than the referring physician or the physician's group practice.
 - Referring physician must provide list of **suppliers** who furnish such services in the area **where the patient resides**.
 - Applies to: MRI, CT, PET and any other DHS the Secretary determines appropriate.

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Physician Ownership of Hospitals



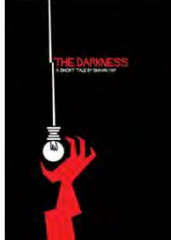
- PPCA amended the Rural Provider and Whole-Hospital Ownership Exceptions for Physician-Owned Hospitals (section 6001)
 - A physician-owned hospital must have physician ownership or investment **and** effective Medicare provider agreement as of December 31, 2010.
 - Very limited exception process, hospitals cannot expand the number of operating rooms, procedure rooms, or licensed beds in place as of date of enactment.
 - The aggregate percentage of the total value of ownership in the hospital, or an entity whose assets include the hospital, held by physician owners and investors cannot increase post-enactment (3/23/2010).
 - Hospitals must meet other specified requirements regarding conflicts of interest, bona fide investments and patient safety issues.

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More on Physician Ownership of Hospitals...

■ The “under development” rule:

- Expansion will only be permitted if Medicare certification obtained by 12/31/2010
- Projects subject to the vagaries of the certification process.
- Alternatives if deadline not met.
 - ASC?
 - Other STARK Exceptions
 - Later



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Duty to Disclose

- False Claims Act – Changes to the FCA language made as part of Fraud Enforcement and Recovery Act of 2009 (FERA)
- It is now illegal to “knowingly conceal...or knowingly and improperly avoid...or decrease...an obligation to pay or transmit money or property to the Government...” See 31 U.S.C 3729(a)(1)(G).
- Eliminated the old statutory language’s need for a “false statement or record” – mere knowledge is apparently enough.



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More on Duty to Disclose..

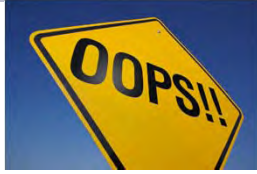
- Section 6402 of the PPCA:
 - Requires reporting of overpayments within 60 days of identification (or due date of next cost report, if applicable)
 - Reports to be made to:
 - Secretary (OIG, CMS),
 - State, or
 - Carrier, intermediary or contractor
 - Violations actionable under the FCA



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Holdover Requirements

- Lease and Personal Services exceptions permit 6-month holdover terms
- For amendments to compensation, CMS recommends (requires?) terminating existing agreement and entering into new agreement
- Temporary non-compliance rule, in compliance for 180 days preceding non-compliance, fell out for reasons beyond control of entity and promptly corrected upon discovery, or within 90 days of non-compliance
- Missing signature rule
 - Only for failure of "signature" requirement
 - 30 days for "non-inadvertent"; 90 days for inadvertent



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What is In

- Employment
- Direct Payments
- Personal Service
- Fair Value
- Co-Management
- Joint Ventures
- ACO's
- And Beyond



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Employment

- Stark Exception: Payments to employees for identifiable services permitted, provided total compensation is at fair market value and bonus not based on volume or value of referrals



Thousands of
Medical Jobs
Hospital Jobs
Healthcare Jobs



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Creative Compensation Example



Aggressive Memorial Hospital opens a new ASC and looks for ways to make it attractive to local surgeons. It begins a program in which it makes surgeons part-time employees of the Hospital.

Under the arrangement, the physicians have employed status with respect to the surgeries they perform at the ASC. The physician assigns his/her right to bill the professional fee for the surgery to the Hospital and is paid a "salary" equal to 120% of the professional fee. The physician receives a W-2.

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Analysis of Creative Compensation



- *U.S. ex rel. Drakeford v. Tuomey (D. S.C. 2010)*
 - Qui tam suit under the FCA where physician alleged Hospital entered into part-time employment arrangements with local physicians to perform outpatient procedures at Hospital ASC that violated Stark
 - Alleged payments were not FMV and took into account the value or volume of referrals.
 - Hospital said employment exception to Stark met because bona fide employees and the compensation was FMV and did not vary or take into account referrals
 - Jury verdict:
 - \$41 million on Stark overpayment liability.
 - Defense verdict on FCA.

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Correct Analysis of Compensation...



- Stark exception
 - Payments to employees
 - Identifiable services
 - Total compensation is at fair market value
 - Not based on volume or value of referrals
 - Commercially reasonable
 - Note: CMS will look beyond W-2 to underlying bona fides
 - 72 Fed. Reg. 51,014 (Sept. 5, 2007)

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Direct Payments



- Potential Stark Exceptions
 - Personal services
 - Fair market value
 - Proposed incentive payment/shared savings exception

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Personal Service Exception



- Arrangement is in writing, signed by the parties, specifies the services covered
- Arrangement covers all services to be provided by physician to entity
- Aggregate services contracted for may not exceed those reasonable and necessary for the legitimate business purposes
- Term must be at least one year (if terminated, may not enter into the same arrangement during the first year of the original term)
- Compensation must be set in advance and except for physician incentive plans, does not take into account the volume or value of referrals or other business generated between the parties
- Services may not involve the counseling of an unlawful business arrangement

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Fair Market Value Exception



- Arrangement is in writing, signed by the parties, specifies the services covered
- Set timeframe of one year
- Arrangement covers all services to be provided by physician to entity

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More on Fair Market Value Exception...



- Compensation must be set in advance and not take into account the volume or value of referrals or other business generated between the parties
- Arrangement must be commercially reasonable
- Cannot violate other laws
- Services may not involve the counseling of an unlawful business arrangement

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When there is Chaos



There is opportunity

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Strategies to Increase Revenue in Competitive Environment

- Hospital Outpatient Department ("HOPD")
- Split-Billing
- Gainsharing
- Overhead reduction strategies (MSOs, IPAs, and GPOs)
- Preparing for health reform (ACOs, medical homes, HR issues, impact on stakeholders)
- Management and co-management arrangements, PSAs



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Hospital Outpatient Department (“HOPD”)



- Hospital providers receive significantly higher reimbursement than free-standing or physician-owned providers
- HOPD status provides higher reimbursement for ancillaries, diagnostics, and other services outside of the hospital
- Provides increased reimbursement and operational flexibility under management agreement
- Realization of increased reimbursement and retention of efficiency and convenience for patients

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IDTF v. HOPD

Procedure Code	Reimbursement Rate as IDTF							Total
	Medicare 15.6%	MMO 19.5%	Aetna 8.4%	Anthem 13.7%	W/C 8.9%	Other 33.7%	100.0%	
70651	5.5%	\$ 397.67	\$ 362.02	\$ 402.58	\$ 344.68	\$ 962.55	\$ 425.00	\$ 447.20
70653	5.0%	\$ 628.37	\$ 656.99	\$ 626.37	\$ 419.65	\$ 1,184.84	\$ 650.00	\$ 862.56
72141.B	39.0%	\$ 401.16	\$ 385.02	\$ 406.00	\$ 349.26	\$ 707.70	\$ 425.00	\$ 426.63
73221.721	44.6%	\$ 391.70	\$ 373.88	\$ 393.66	\$ 312.90	\$ 709.83	\$ 425.00	\$ 412.12
Average	94%	\$ 395.22	\$ 371.62	\$ 388.22	\$ 316.33	\$ 706.19	\$ 412.03	\$ 437.21

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70651	5.5%	\$ 397.67	\$ 1,102.20	\$ 1,102.20	\$ 1,102.20	\$ 962.55	\$ 1,102.20	\$ 978.46
70653	5.0%	\$ 628.37	\$ 1,202.00	\$ 1,202.00	\$ 1,202.00	\$ 1,184.84	\$ 1,202.00	\$ 1,109.84
72141.B	39.0%	\$ 401.16	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 707.70	\$ 1,000.00	\$ 879.37
73221.721	44.6%	\$ 391.70	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 702.83	\$ 1,000.00	\$ 878.06
Average	94%	\$ 385.22	\$ 958.72	\$ 958.72	\$ 958.72	\$ 706.19	\$ 958.72	\$ 899.61

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Split-Billing



- HOPD bills technical and professional components separately as opposed to using one global rate
- Sum of facility fee (billed by hospital) and professional fee (billed by physician) larger than global rate billed by physician office

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Split-Billing Results

Provider Based Billing/MGMA Analysis - Medicare Rates							
Procedure Code	In-Office Global Fee	In-Facility Pro Fee	Medicare In-Facility Technical Fee	Total by Site of Service	Increase in Total	% Increase of Facility over Office	
99213	In Office	\$59.59			\$59.59		
	In Facility		\$44.21	\$68.96	\$113.17	\$53.58	89.90%

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Gainsharing



- Sharing of cost savings attributable to physician efforts in controlling the costs of providing patient care. Typically, the share given to physicians is expressed as a percentage of cost savings.
- Provides hospitals and physicians with valid cost-reduction measures by aligning incentives
- Successful if focus is on accountability and quality, while protecting against illegal compensation for referrals
- Leads to a more efficient healthcare system by reducing overuse of resources and improving or maintaining patient quality of care

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MSOs, IPAs, and GPOs



- Strategies to reduce overhead and preserve independent physician practices
- Area physicians band together and use their leverage to achieve operating efficiencies (i.e. decreased malpractice insurance premiums, consolidated back office activities, discounted office and medical supplies, etc.)

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Accountable Care Organizations

- Typical ACO would include a hospital, primary care physicians, specialists and other medical professionals
- Services are still billed under fee-for-service, but the organization's members would coordinate care for their shared Medicare patients with the goal of meeting and improving on quality benchmarks
- Because ACO members are held jointly accountable for this care, they would share in any cost savings that stem from the quality gains
- But, are they viable???



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Management and Co-Management Arrangements

- Alternative to physician employment arrangements
- Reward participating groups or physicians for their efforts in developing, managing, and improving quality and efficiency of a particular hospital service line
- Attractive option in light of decreasing reimbursement rates



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