ALIGNMENT OF PHYSICIAN-HOSPITAL INCENTIVES IN THE POST-HEALTH CARE REFORM WORLD

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OVERVIEW OF PRESENTATION

- Forces Driving Integration
- Integration Models
- Stark/Anti-Kickback
- Medical Malpractice Liability
- IRS Issues with Incentive Compensation
- Credentialing and Peer Review of Affiliated /Employed Physicians
- Antitrust

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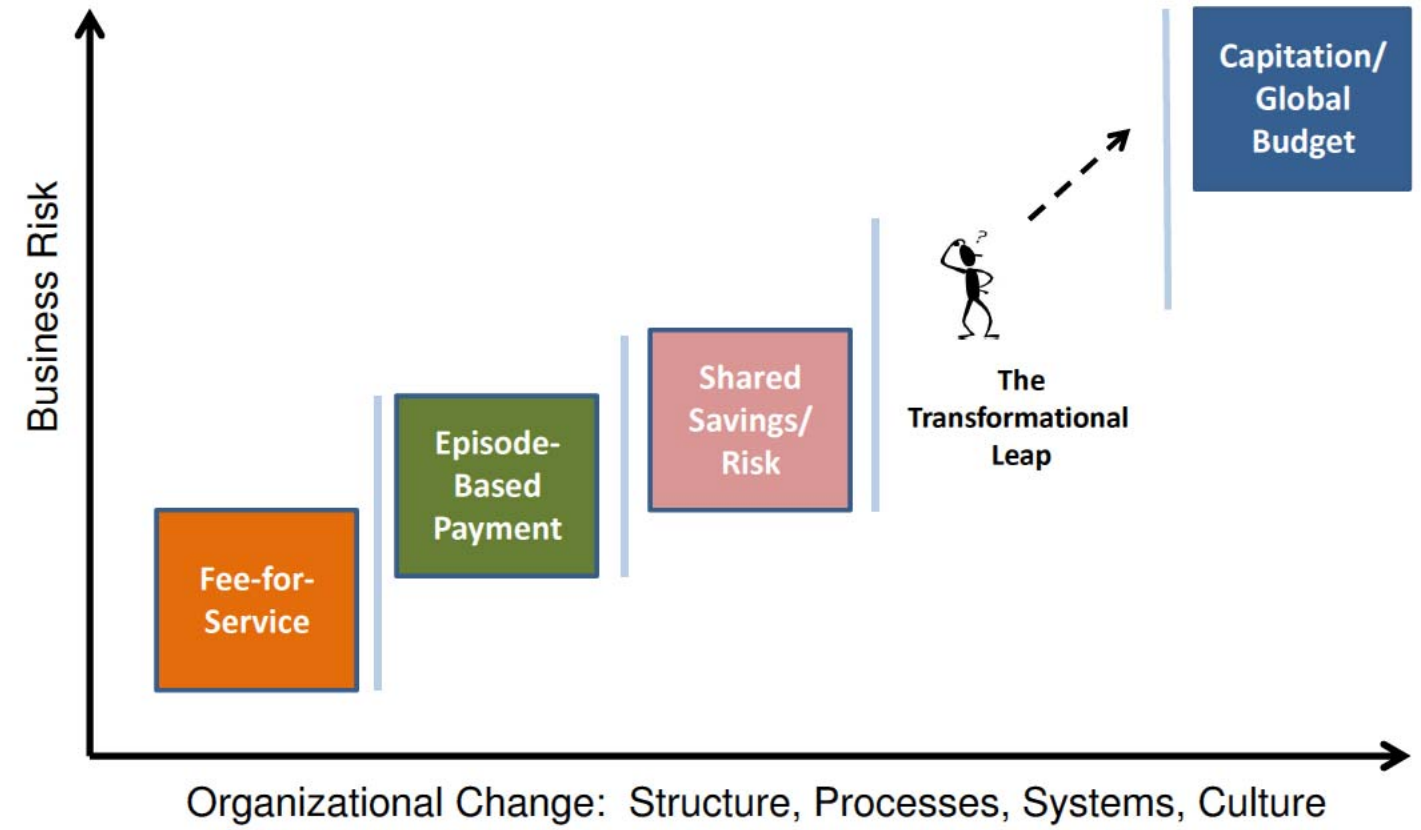
Industry Perspectives

- Health care systems need to evolve from a fee-for-service, asset-based business model to a risk management, value-based model.
- The transformation will have an impact on how clinical services are targeted, developed, and managed: "the just-right services, with resources managed to produce maximum value."
- The shift from fee-for-service to shared risk and full-risk contracting will be a transformational leap for most organizations.

From Fee-for-Service to Risk and Value: A Transformational Leap



Source: Integrated Clinical Systems, INC.

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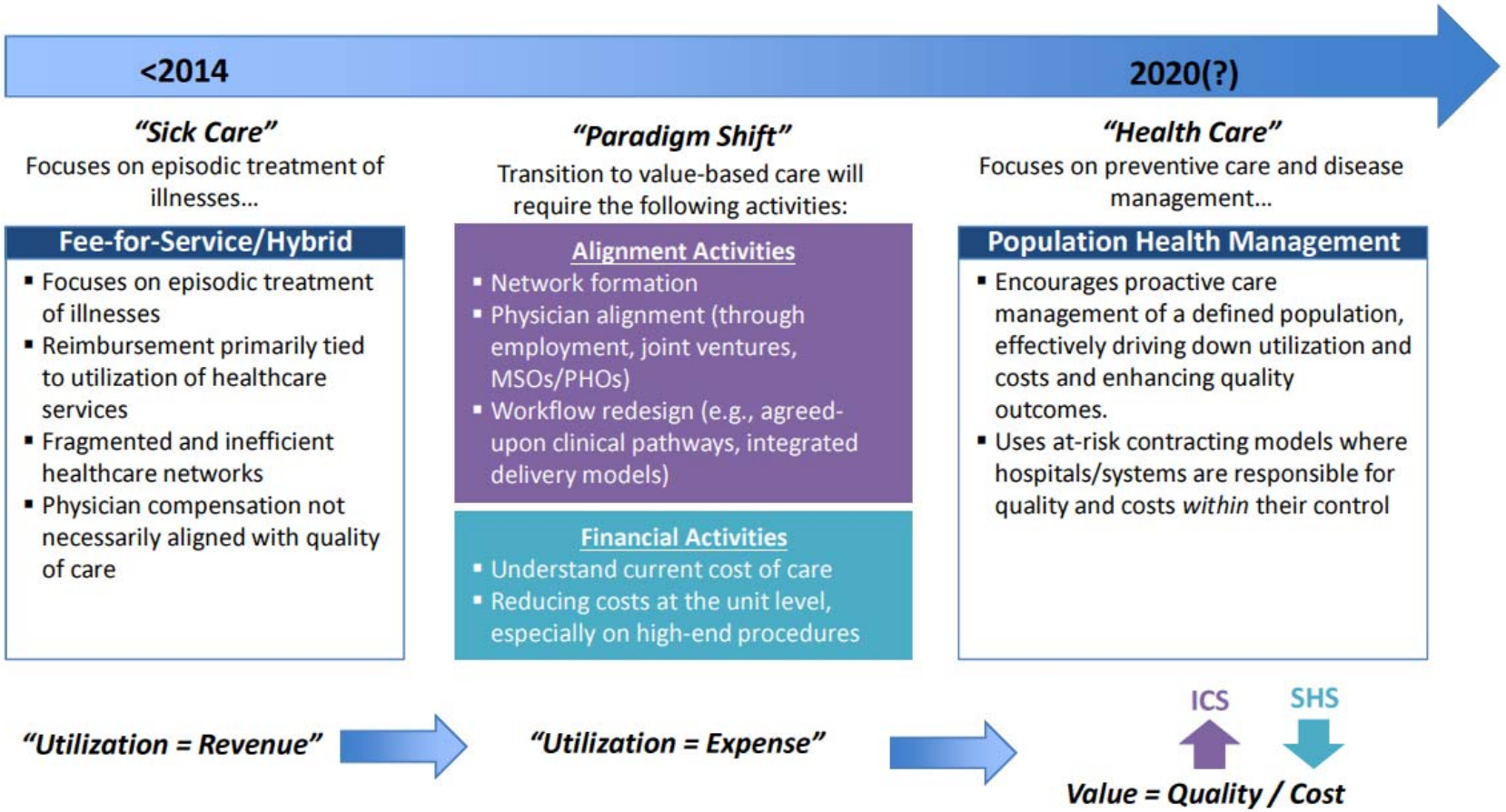
Shifting the Focus: From Sick Care to Health Care



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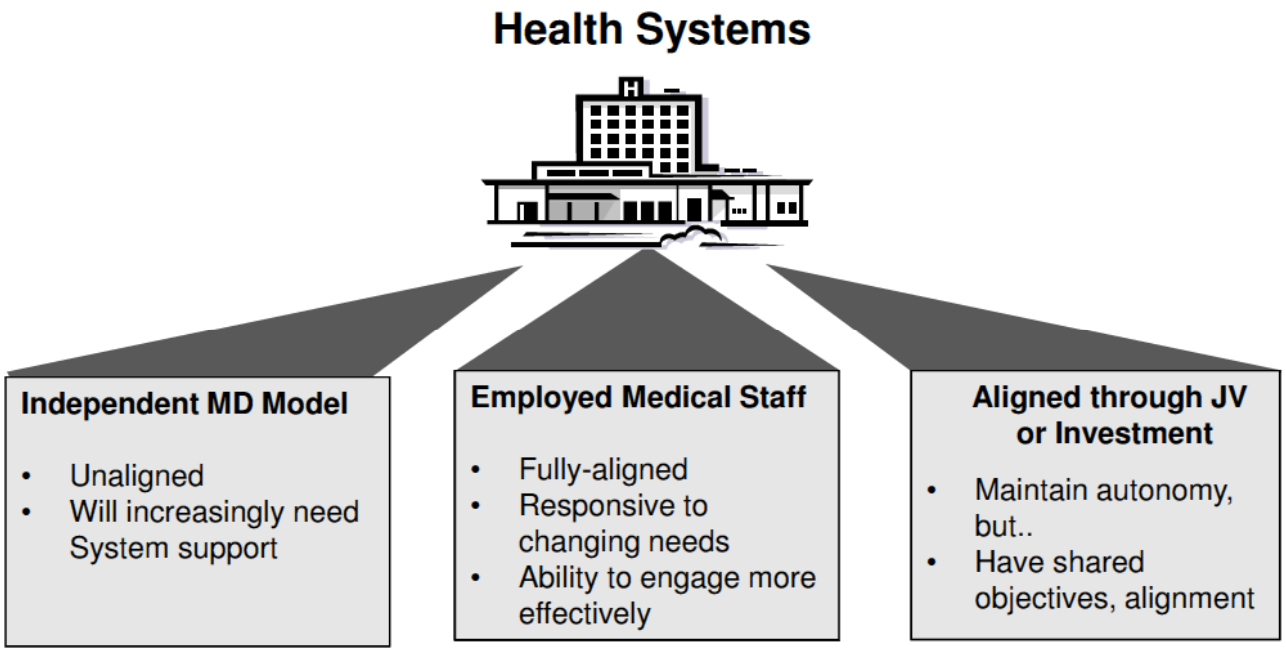
Different Forms of Physician Alignment Models are Emerging—



Source: Integrated Clinical Systems, INC.

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Desired Attributes of a Compensation Model

✓**Reasonably values and compensates** all aspects of physician clinical responsibilities, consistent with national/regional benchmarks.

✓Enables the Hospital to manage and **deploy assets** as needed by the network.

✓Provides physicians with **incentives to support network priorities** (e.g., quality, efficiency, patient-centered care).

✓Encourages and **supports service line development** and growth.

✓**Supports various payer models**, including fee-for-service, value-based payment, shared savings, capitation, and population health management.

✓Ensures that the **risks and rewards of Hospital decisions are shared** by the overall network.

✓Encourages **innovation**.

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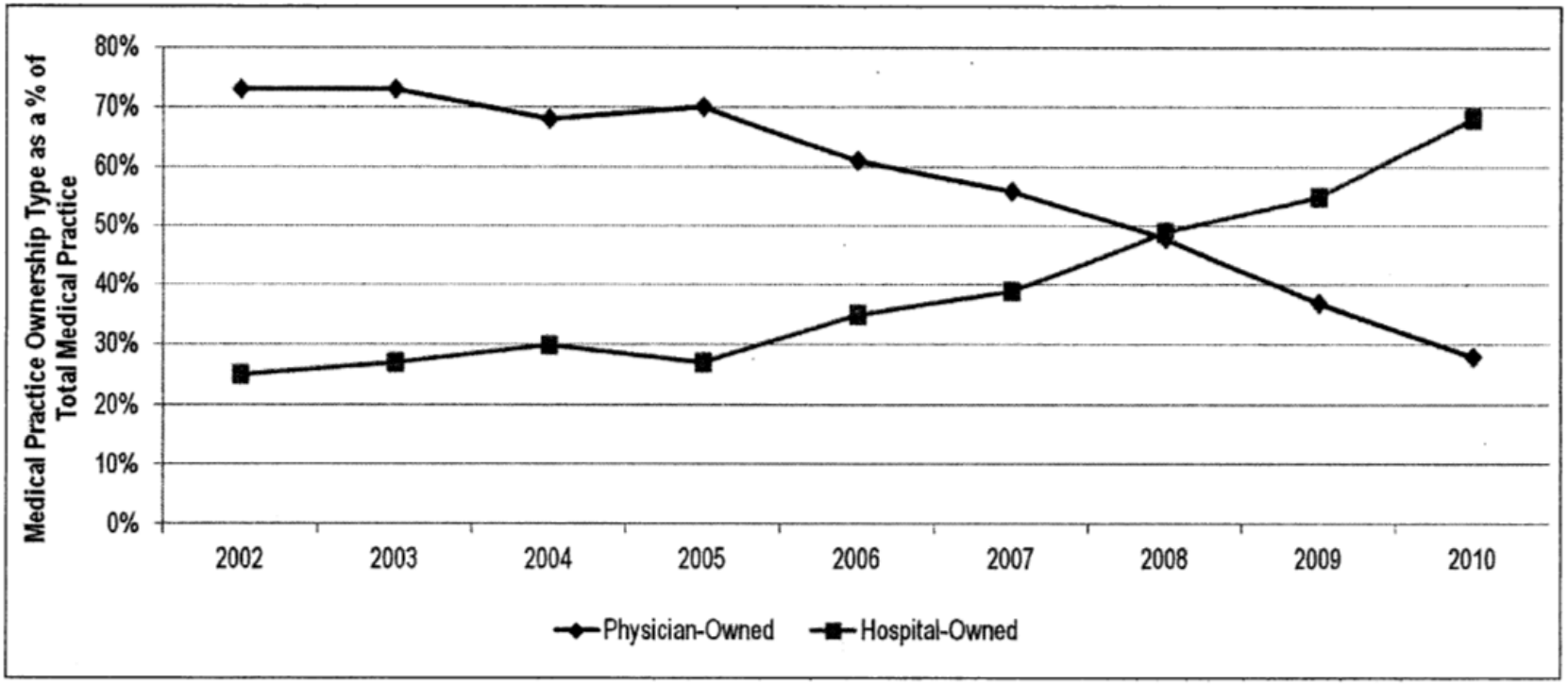
Hospital Ownership of Physician Practices Has Overtaken Physician Ownership



Source: MGMA Physician Compensation and Production Survey Report ; Organization Ownership 2011 based on 2010 data; Wall Street Journal, "Shingle Fades as More Doctors Go To Work for Hospitals," November 8, 2010

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PLUS Medical PL Symposium

Physician Integration: Key Considerations

- Not all physician integration will lead to employment
- "Alignment" of Hospitals and physicians takes many forms
  - Networks
  - Joint Ventures
  - Contractual Partnering
  - IPAs, PHOs, etc.
- Physicians and Hospitals will need to more closely collaborate than ever before to improve outcomes, reduce costs, maximize reimbursement

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PLUS Medical PL Symposium

"IT'S DÉJÀ VU ALL OVER AGAIN" (Yogi Berra)

1982: Medicare shifts from cost-based to DRG reimbursement for inpatient hospital services

1984: Ohio's Blue Cross statute amended to permit shift from cost-based to prospective reimbursement / BCBSO institutes competitive bidding

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"IT'S DÉJÀ VU ALL OVER AGAIN" (Yogi Berra) (cont'd)

1986: Greber case adopts "one purpose" test for Anti-Kickback Statute

1989: Stark Law enacted

1994: BCBSO acquires controlling interest in St. Luke's Medical Center in Cleveland

2014: Key provisions of PPACA become effective/shift to "value-based" reimbursement

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STARK / ANTI-KICKBACK ISSUES

Stark Law Prohibition

1. Entity cannot bill a federal program
2. For a "designated health service"
3. Provided to a patient referred by the physician to the entity
4. If the physician has "Financial Relationship" (compensation or ownership)
5. With the billing entity

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STARK / ANTI-KICKBACK ISSUES
(CONT'D)

Anti-Kickback Statute Prohibition

- Payment or receipt
- Of any form of remuneration
- In return for
- Referral / arranging referral
- Of item / service to be reimbursed by a federal health program

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STARK / ANTI-KICKBACK ISSUES
(CONT'D)

Penalties for Violation:

- Denial of reimbursement
- Civil monetary penalties of $25,000 per violation plus 3X amount billed
- Jail terms up to 5 years
- Exclusion from Medicare/Medicaid

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STARK / ANTI-KICKBACK ISSUES
(CONT'D)

Stark Exceptions / AKS Safe Harbors:

- Employment
- Personal service contracts
- Leases
- Fair Market Value transactions
- Practice acquisitions

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STARK / ANTI-KICKBACK ISSUES
(CONT'D)

- Shift in physician compensation from productivity model (*e.g.*, RVUs) to pay-for-performance model (*e.g.*, incentive payments for meeting quality, cost, and/or wellness matrix) presents new fraud and abuse issues relative to calculating fair market value

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STARK / ANTI-KICKBACK ISSUES
(CONT'D)

Tuomey Case:

- $277M awarded against Hospital due to excessive compensation paid to part-time employee physicians (on appeal)
- Payment for non-compete clause constituted illegal remuneration for anticipated referrals

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STARK / ANTI-KICKBACK ISSUES
(CONT'D)

Tuomey Case (cont'd):

- Full-time compensation/benefits paid to part-time physician employees (base salary plus productivity/quality incentives)
- Hospital went "attorney shopping" until it obtained favorable opinion

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STARK / ANTI-KICKBACK ISSUES
(CONT'D)

Halifax Case:

- Qui tam case brought by director of physician services whose concerns were ignored
- Hospital's tracking of referrals by employee-physicians is indicator of value-based compensation
- Total compensation (salary & bonus) exceeded FMV

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STARK / ANTI-KICKBACK ISSUES
(CONT'D)

Halifax Case (cont'd):

- Bonuses paid to oncologists were based on percentage of revenues from hospital's oncology program to which oncologists referred
- Government demanded $500M / hospital settled for $85M

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Medical Malpractice Issues

- Increased liability risk in “value based” payment system/clinical pathways that incentivize elimination of “unnecessary” tests and procedures
- Will quality targets for incentive payments create higher standard of care

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Medical Malpractice Issues (CONT'D)

- Will plaintiff's attorneys argue that cost saving payment incentives compromise physician's duty of care to patients
- Need joint defense/insurance arrangements to align incentives and minimize risks

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IRS ISSUES WITH INCENTIVE COMPENSATION

Private Activity Bonds:

•Interest on tax exempt hospital revenue bonds may become taxable if they constitute "private activity bonds," *i.e.*, more than 5% of the proceeds of which finance Hospital facilities that are used in the trade or business of a non-exempt person or entity

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IRS ISSUES WITH INCENTIVE COMPENSATION (cont'd)

Examples of possible private business use:

- Lease to a for-profit SNF, LTAC provider, gift shop operator, etc.
- Service contract with hospital-based physician group, food service provider, etc.
- Management contract with for-profit management company

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IRS ISSUES WITH INCENTIVE COMPENSATION (cont'd)

IRS Revenue Procedure 97-13:

- Provides safe harbors for certain types of service/management contracts (not leases)
- Cannot be based on net profits (gross revenue OK)
- Limits:
  - Percentage of fixed vs. per-unit compensation
  - Term of contract/termination rights

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IRS ISSUES WITH INCENTIVE COMPENSATION (cont'd)

Hospitals should audit existing contracts:

- Determine if any fall outside 97-13 (bond counsel review)
- Incentive payments for achieving quality/cost reduction goals not contemplated by 97-13
- Calculate whether private use contracts involve bond-financed facilities and exceed 5% limit

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IRS ISSUES WITH INCENTIVE COMPENSATION (cont'd)

Possible corrective actions:

- Amend non-compliant contracts, if possible
- Substitute facilities included in definition of bond-financed
- Redeem portion of bonds attributable to private activity

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CREDENTIALING/PEER REVIEW ISSUES

The world we used to live in:

- Physicians are independent from the Hospital
- Relationship is defined solely by the Medical Staff Governing Documents
- Hospital liability is limited to negligent credentialing claims
- Medical Staff process is managed by the Medical Staff

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CREDENTIALING/PEER REVIEW ISSUES (cont'd)

The world we used to live in: (cont'd)

- Medical Staff peer review information is not provided to any other internal department or external entity
- Medical Staff process comes with attendant procedural due process rights and potential HCQIA reportability issues

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CREDENTIALING/PEER REVIEW ISSUES (cont'd)

<u>The world we are moving into</u>:

- Physician is employed by the Hospital
- Relationship between the physician and the Hospital is defined by employment law
- Hospital liability includes both vicarious liability and negligent credentialing

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CREDENTIALING/PEER REVIEW ISSUES (cont'd)

The world we are moving into: (cont'd)

- Even if physician is not employed by Hospital, relationship may be governed by contract
- Information may need to be provided to other internal departments or external entities (*e.g.*, ACO)
- Ability to practice may, at times, be limited without resort to Medical Staff procedural due process rights and may or may not create reportability issues

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CREDENTIALING/PEER REVIEW ISSUES (cont'd)

Issues:

- Is this a medical staff matter?
- Is this a compliance issue?
- Is this an employee/Human Resources matter?
- Is this a contract issue – can you just terminate?
- Regardless, how do you first capture the matter in order to make an intelligent decision on how the issues should be triaged?

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CREDENTIALING/PEER REVIEW ISSUES (cont'd)

Ohio's peer review privilege extends protection to both providers and the entities themselves provided that the entity:

- Conducts as part of its regular business activities professional credentialing or quality review activities
- The information is developed or used by or on behalf of a peer review committee

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CREDENTIALING/PEER REVIEW ISSUES (cont'd)

Potential advantages to Medical Staff resolution:

- Peer review protection
- HCQIA immunity
- Quality issues being decided by the Medical Staff
- Rights of practitioners protected by procedural due process rights

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CREDENTIALING/PEER REVIEW ISSUES (cont'd)

Potential advantages to Human Resources resolution:

- Potentially quicker resolution
- No hearing rights attached
- Potentially no reporting obligations

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CREDENTIALING/PEER REVIEW ISSUES (cont'd)

Employment challenges:

- What is the impact of a limitation on clinical privileges? Paid leave? Unpaid leave?
- Will the Hospital alienate the medical staff if the Hospital terminates employment in situations where the Medical Staff believes corrective action would be more appropriate?

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CREDENTIALING/PEER REVIEW ISSUES (cont'd)

Non-Employment contract challenges:

•If the intent of the contract is clinical integration, you need to:

1. Be able to share protected peer review information
2. Decide what information can be made public and what information needs to stay protected
3. Develop a written process that explains how the protected process works, what information is being shared, and how this process fits within each state's protected peer review process

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CREDENTIALING/PEER REVIEW ISSUES (cont'd)

Determining the best route (HR v. Medical Staff):

- Make decision as quickly as possible
- Consideration of whether peer review protection is necessary
  - If you decide too late that peer review protection is necessary, much of the otherwise protected information will be subject to discovery
- Does the concern raise "quality" issues
- Could vary issue-to-issue

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CREDENTIALING/PEER REVIEW ISSUES (cont'd)

- House Bill 123, effective May 20, 2014, makes clear that Ohio's peer review privilege applicable to "health care entities" includes accountable care organizations; hospital groups owned, sponsored or managed by single entities; and combinations of health care entities

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CREDENTIALING/PEER REVIEW ISSUES (cont'd)

- Ohio's peer review privilege provides that a peer review committee's proceedings and records are to be held in confidence and are not subject to discovery, nor are they to be introduced into evidence in any civil action against a health care entity or provider.
- The new law clearly states that, in the event of the disclosure any such peer review information, the loss of privilege would only apply to the information that was actually disclosed; it would not result in a loss of privilege to the information that was not disclosed.

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CREDENTIALING/PEER REVIEW ISSUES (cont'd)

- House Bill 123 also makes explicit that health care entities may share protected peer review information and the privilege will continue to apply so long as the shared information is only used for peer review purposes.

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ANTITRUST ISSUES

- Antitrust issues arise when the acquisition (employment) of physicians leads to a dominant market position for the Hospital and/or physicians in any health care service line(s).

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ANTITRUST ISSUES (cont'd)

- Any market share of more than 30 percent will invite a closer initial antitrust review to determine any possible anticompetitive impact. Obviously, the higher the market share the greater the need for antitrust guidance.
- The higher the degree of clinical and financial integration in the network, the less risk of being viewed as an illegal combination of competing providers.

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ANTITRUST ISSUES (cont'd)

- The antitrust analysis becomes a balance of the pro-competitive benefits versus the anticompetitive effects of such collaboration (the "rule of reason" test), *i.e*., whether the anticipated joint price negotiations and any competitive restrictions within the network are "ancillary" to and "reasonably necessary" to further the legitimate purpose the network, *i.e.*, to achieve cost efficiencies and increased quality of care that benefits patients and payers.

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