Clinical Co-management Summary

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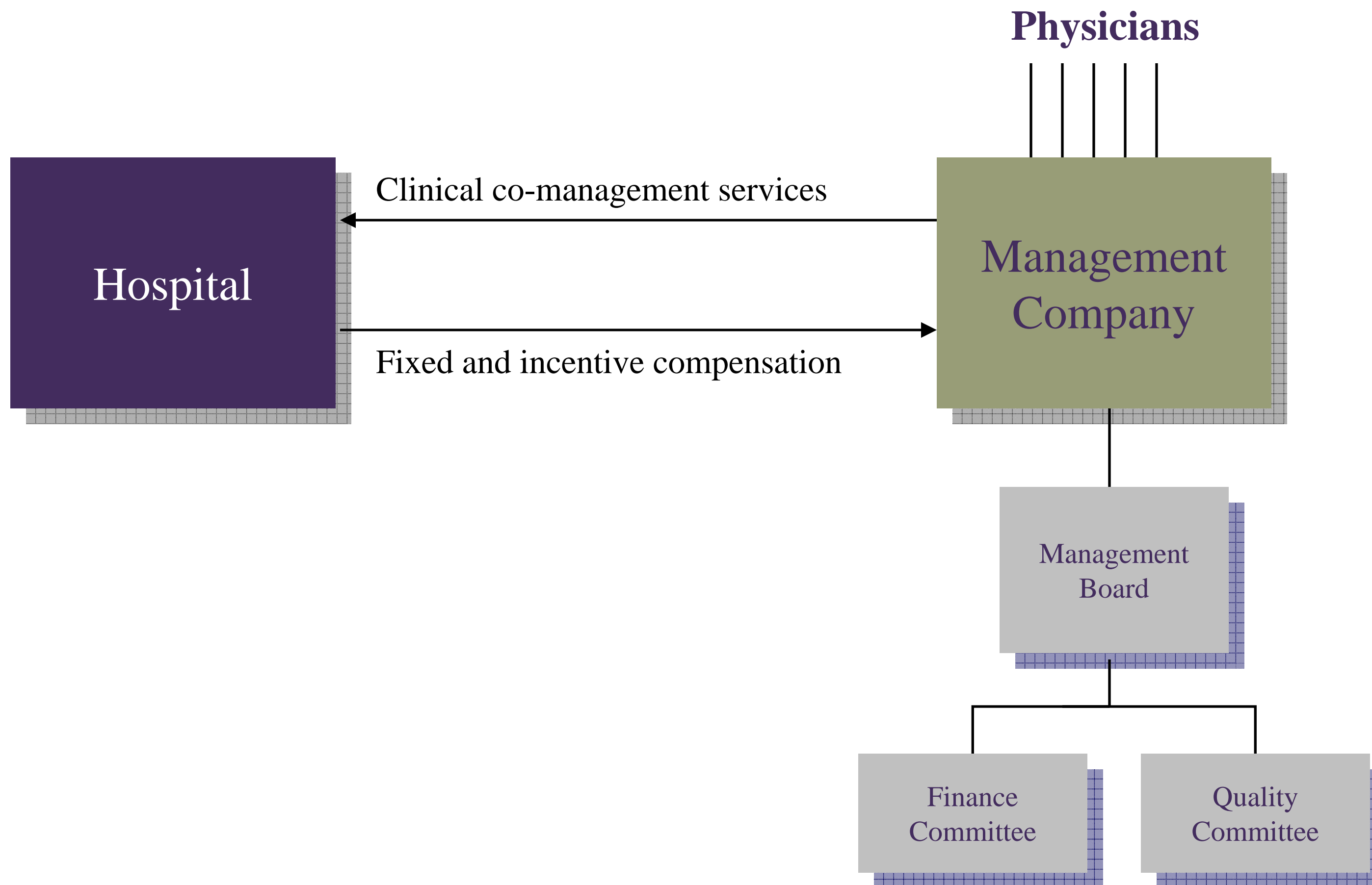
Overview of Clinical Co-Management Model

- Clinical Co-Management Agreement compensates physicians for the management of a hospital department or service line
- Contract is between the hospital and a management company formed for the purpose of providing the clinical co-management services
- Contract typically provides for fixed and incentive compensation
- Contract term is typically one to three years, renewable by mutual consent, with compensation adjusted annually
  - Longer term possible if no bond-financed facilities involved, but compensation should be reevaluated annually and current guidance indicates that incentives metrics should be renormed

Legal Structure of Transaction



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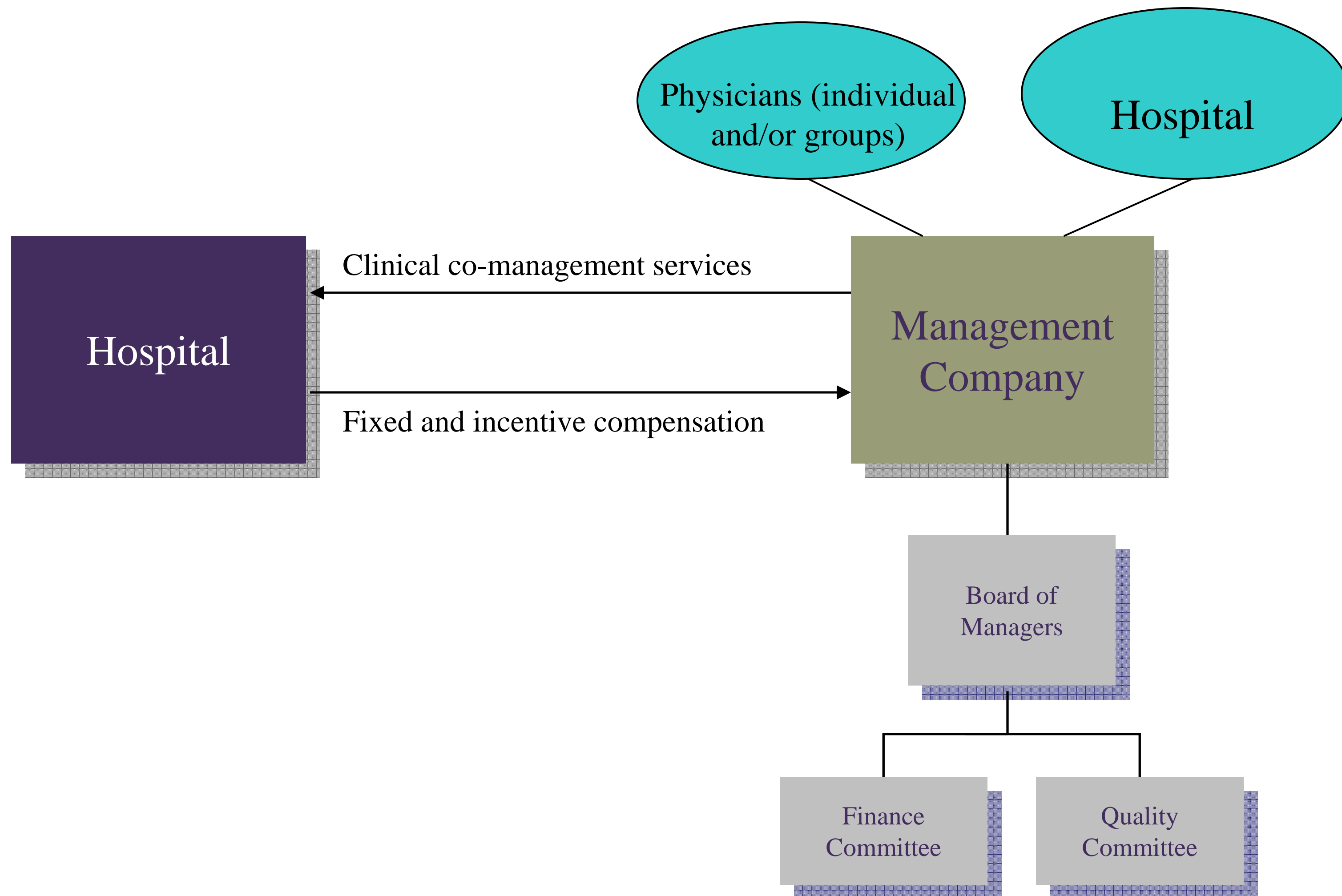


Structure of Management Company

- Typically a limited liability company
- Ownership can be by individual physicians or by entities owned by individual physicians meeting investment criteria
- Hospital may also be an owner
- Governance generally delegated to a Management Board structured to provide representation of the participating specialties
- Board subcommittees may be used to facilitate performance under Management Contract (e.g., Finance Committee, Quality Committee)

Physician Participation

- Typically limited to physicians in a position to help Management Company perform its services
  - Hospital active/provisional medical staff membership in good standing
  - Practice in a relevant specialty
  - Quality standards (e.g., no adverse professional review actions within five years)

- Physicians provide initial capitalization of Management Company (or physicians and hospital if management company is to be jointly owned)
  - Typically used to pay Management Company's share of start-up expenses (legal, consulting fees etc) and for working capital, insurance, furniture, equipment, if any
- Hospital pays fixed compensation in monthly installments to management company
  - Used primarily to pay operating expenses (e.g., staff, if any) and to pay physicians compensated on an hourly basis (committee members, medical directors)
- Hospital pays incentive compensation quarterly or annually
  - Funds equity returns to owners

Potential Incentive Compensation Measures

- Potential measures include:
  - Operational process improvements
  - Quality indicators
  - Satisfaction measures
  - Program development
- Targeted toward areas where potential for improvement has been identified
- Provide for partial payment for attainment of incremental goals

Potential Incentive Compensation Measures

- 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

Potential Incentive Compensation Measures

- Operational process improvements
  - Incentives for efficient behavior that does not result in reductions of care
    - Example: Interval from admission to surgery
    - Example: OR turnaround
    - Example: OR first case on-time start rate
    - Example: Wait time (procedure room staff waiting for physician after patient ready)
  - Incentives for behavior that improves quality of care
    - Should be targeted at specific areas where clinical improvement is possible

Potential Incentive Compensation Measures

- Quality measures
  - Example—reductions in defined specified complication rates
  - Example—achievement of defined external measures of excellence in care

Potential Incentive Compensation Measures

- Satisfaction measures
  - Example—patient satisfaction survey results (e.g., likelihood of recommending facility.)
  - Example—staff satisfaction survey results
- Program development
  - Achievement of identified milestones (not measured by volumes) in developing the hospital’s service line

Examples of Duties Under Management Agreement

- Participation in committee meetings with hospital representatives (agreements will provide for a joint operating committee with principal oversight of the service line)
- Providing Medical Director services
  - Medical directors jointly agreed upon by Management Company and hospital (existing contracts rolled into the new model)
- Providing operational and financial oversight
- Participating in development of plans and budgets
- Evaluating and making recommendations regarding staffing and utilization of supplies
- Developing and implementing processes of standardization

- Solving quality and performance problems/leading quality review and improvement activities
- Developing policies, procedures and pathways
- Supervision of administrator/executive director of program
  - In some models, non-physician administrator is employed by management company
- Providing program development services

Process to Structure the Arrangement

- Task force of interested physicians and hospital representatives formed to structure transaction with assistance of counsel
- Outside consultant typically retained to provide baseline assessment of hospital operations, advise on areas for improvement and potential metrics for incentive compensation
- Task force agrees on areas to be managed and where improvements are possible
- Task Force agrees on duties under the management agreement and incentive metrics
- Valuation company retained to value services under the management contract
- Management company formed
- Equity interests offered to prospective physician investors through private placement offering (if necessary)
- At close of offering, Company enters into management contract

Valuation Methodology

- Methodology typically takes into account physician time requirements (based on comparable hourly rates for specialty performing administrative duties) and comparables from health care management companies (adjusted to reflect more limited duties) or other comparables for providing quality improvements
- Comparables typically are based on percentage of revenues
  - If so, revenue figures prior to clinical co-management discussions should be used
  - Valuation in 3-4% of net revenues range would not be atypical, but actual figure will be determined by valuator based on all relevant facts and circumstances
- Management company comparables are usually most relevant for purposes of setting maximum compensation under the agreement assuming all incentive measures are met, while hourly rate number is most relevant to setting minimum compensation and setting rates to be paid to board and committee members

Legal Requirements

- To avoid Anti-kickback Statute risk:
  - Economic terms must be consistent with fair market value
    - Management Company equity returns must be proportionate to ownership
    - Payments under Management Agreement and by Management Company to physicians for services must be consistent with fair market value
    - Incentives cannot be structured in a way that rewards physicians for increased volumes
  - Protections to avoid “cherry-picking” of patients based on acuity desirable (e.g., hospital monitors acuity levels and has ability to terminate the Management Agreement if there is a material change in acuity)

Legal Requirements

- Incentives must be structured to avoid civil money penalties for payments to physicians to reduce care to Medicare/Medicaid patients under their direct care (the “CMP Statute”)
  - Penalties of $2,000 per patient imposed on both hospital paying incentives and physicians receiving incentives
  - Incentives can reward clinical improvement that correlates with reducing cost and can reward cost-saving measures that do not adversely affect patient care
  - Expense budget-based incentives may raise CMP Statute concerns, particularly in smaller program or if not based on entire program budget
  - Length-of-stay incentives may raise CMP Statute concerns

Advisory Opinion 08-16

- HHS Office of Inspector General approved an arrangement for a hospital to share with physicians a portion of quality-based incentive payments received by the hospital from a commercial insurer

Advisory Opinion 08-16

- Favorable factors with respect to CMP Statute:
  - Credible medical support that arrangement could improve patient care and was unlikely to have adverse effects
  - Bonus compensation not reduced where standard contraindicated for a patient
  - Quality targets reasonably related to patient population
  - Performance measures clearly and separately identified
  - Patients admitted to the Hospital with one of the conditions subject to the quality targets will be informed of the program in writing, and prior to admission where feasible
  - Protections against inappropriate reductions or limitations in patient care or services

Advisory Opinion 08-16

- Favorable factors with respect to Anti-kickback Statute analysis:
  - Physicians must have been on the active medical staff for at least a year
  - Increase in patient referrals would not result in an increase in compensation
  - Physicians whose referral patterns significantly change in a manner beneficial to the Hospital will be terminated from the program
  - *Per capita* distribution of compensation to physicians
  - Transparent arrangement with specific quality targets from CMS Quality Measures Manual
  - Arrangement limited in time (three-year contract)

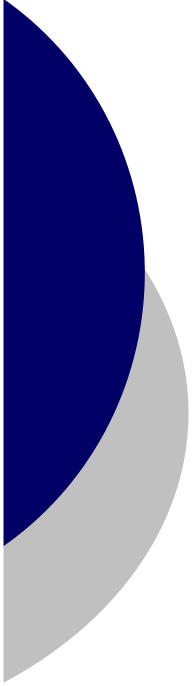
- Financial arrangements between hospitals and referring physicians must fall under a Stark Law exception
- Agreements with entities that are not themselves physician practices, such as the LLC, are analyzed as indirect compensation arrangements and generally will be permissible under Stark as long as compensation does not vary with or take into account referrals or other business
- CMS has proposed, but has not finalized, a Stark Law exception for incentive arrangements
- Areas of concern include:
  - “stinting” (limiting the use of quality-improving but more costly devices, tests or treatments)
  - “cherry-picking” (treating only healthier patients at the hospital)
  - “steering” (avoiding sicker patients at the hospital)
  - “quicker-sicker discharges” (discharging patients earlier than clinically indicated)

Proposed Stark Law Exception

- Key elements include:
  - Objective, independent medical evidence that measures will not adversely affect patient care
  - Quality measures derived from CMS' Specifications Manual for National Hospital Quality Measures
  - Annual independent medical review
  - Per capita distribution to pools of at least five physicians
  - No reductions in available items, supplies or devices or limitations on availability of clinically appropriate new technology linked to improved outcomes
  - Prior written notice to patients of program and participating physicians

Proposed Stark Law Exception

- Key elements include (cont'd):
  - Payment cannot reflect increased volumes of federal health care program patients or services
  - Rebasing annually or reduced incentive levels for later years
  - No length-of-stay-based incentives



Discussion

Overview of Kutak Rock LLP

- National law firm with offices in 15 cities
- Extensive health care practice with focus on physician-hospital joint ventures
- Counsel in joint venture transactions in over 40 states, including cardiovascular, advanced diagnostics, surgery, orthopaedics, endoscopy, cancer, whole and specialty hospital
- Counsel for clinical co-management programs for cardiac, vascular, surgery, orthopaedic and spine service lines

- Chairperson of health care practice of Kutak Rock LLP for 15 years
- Practice focus on physician/hospital joint ventures, with emphasis on project management and facilitation of planning and deal-structuring process
- Transaction counsel in numerous venture projects, including cardiology, vascular, cancer treatment, imaging, orthopaedic, spine and ambulatory surgery and endoscopy
- Business experience as founder of ambulatory center development and management company
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