C-BONES ANNUAL MEETING

Thursday, April 23, 2015
1:30 pm – 2:30 pm

Strategies for Practice Sustainability:
Clinical Integration Networks and Co-Management Agreements

Presented By:

Frank E. Gamma, JD, MBA, FACMPE
Kessenick Gamma & Free, LLP
415.362.6412
fgamma@kgf-lawfirm.com

DRIVING QUALITY AND EFFICIENCY

INTRODUCTION

Purpose of Discussion

- Summarize factors that need to be assessed when evaluating organizational options
- Provide a general overview of options for physicians who wish to remain independent
- Will move through hospital affiliations quickly.

INTRODUCTION

Purpose of Discussion (cont.)

- Describe the organizing process generally
- Provide overview of legal, financial and operational issues
- Follow hypothetical market analysis

STEP ONE

Analyze Local Market Conditions and Potential Partners

- Do not create a new legal entity merely for the sake of organizing
- Evaluate single-specialty entity
- Evaluate multi-specialty entity

STEP 1: ANALYZE LOCAL MARKET CONDITIONS AND POTENTIAL PARTNERS

- Consider the facts of your particular community. (See market condition/partner analysis.)
  - Hospitals
  - 1206(l) Foundation
  - IPAs
  - Managed Care Penetration
  - Patient mix, etc.
  - ACOs

STEP 1: ANALYZE LOCAL MARKET CONDITIONS AND POTENTIAL PARTNERS

- Identify partners:
  - Compatibility
  - Financial strength
  - Operational assessment
  - Reputation

STEP TWO

Consider the Options:

- There are many resources:
  - "Medical Practice Options" – Section 1 of the Resource Manual
  - CMA ON-CALL #0200, "Medical Practice Options: Overview"
  - COA Article to be distributed
  - Initial consultation at no charge

STEP 2: CONSIDER THE OPTIONS

Some Options to Consider:

- Expense-sharing/MSOs
- Semi-integrated medical group
  - Specialty and multi-specialty IPAs
- Clinical integration “lite”
- Fully integrated medical group

EXPENSE-SHARING ARRANGEMENTS/ MANAGEMENT SERVICE ORGANIZATIONS

- Two or more physicians share expenses to obtain efficiencies
- An MSO is more formalized version, requiring a separate legal entity (C-corporation, partnership, limited liability company):
  - Can be open to additional participants
  - Can provide broader range of services, such as practice management, employee benefits/services, etc.

EXPENSE-SHARING ARRANGEMENTS/ MANAGEMENT SERVICE ORGANIZATIONS

- Practices can operate under same name
- Arrangement increasingly recognized by policymakers as an opportunity for smaller practices to increase their capacity and improve care (Commonwealth Fund, March 2011 Issue Brief)
  - Use of shared resources nearly doubles percentage of practices that have advanced HIT functionality
  - Rival or exceed participation rates of large practices in quality initiatives

EXPENSE-SHARING ARRANGEMENTS/ MANAGEMENT SERVICE ORGANIZATIONS

Potential Economies of Scale

- Joint marketing (but not managed care contracting)
- Rent/building expenses
- Staff and HR consolidation
- Joint purchasing for supplies, equipment and malpractice insurance
- Combined billing and collecting
- Practice management
- Information systems

EXPENSE-SHARING ARRANGEMENTS/ MANAGEMENT SERVICE ORGANIZATIONS

LEGAL ISSUES

- Antitrust
  - No joint contracting
- Liability
  - In the absence of a separate entity, “partners” may be liable for the acts of others
- Stark Self-referral Laws
  - Ancillary services, such as lab or x-ray, most likely would not be permissible unless all in one building
- Anti-kickback Laws
  - No payments disguised for referrals

SEMI-INTEGRATED MEDICAL GROUP

- Like MSO/expense-sharing arrangements, this model allows individual physicians to:
  - Remain in local practice settings
  - Retain autonomy over day-to-day operations
  - Achieve all of the MSO advantages with affiliated MSO
- 3 models:
  - Financially share risk (capitation, withholds, etc.)
  - Clinically integrate
  - Clinically integrate “lite”

SEMI-INTEGRATED MEDICAL GROUP

SPECIALTY IPA

(*or Depending on the market*, IPA)

- IPAs increasingly capitating specialists
- Depends on willingness of payers
- Specialty IPAs allow physicians to:
  - Negotiate jointly (where financially integrated)
  - Use a “messenger model” for fee-for-service or “clinically integrate”
  - Negotiate call coverage, global reimbursement, ACO participation, service line co-management, etc.

SEMI-INTEGRATED MEDICAL GROUP

- IPAs can also function as an MSO (if no separate MSO) and allow physicians to:
  - Share staff
  - Group purchase
  - Develop clinical protocols
  - Expand on-call coverage

SEMI-INTEGRATED MEDICAL GROUP

SPECIALTY IPA

Legal Issues

- Antitrust – Must share financial risk or be “clinically integrated”
- Requires legal structure and governance
  - Articles of incorporation
  - Bylaws
  - Buy-sell agreements
- Self-referral
  - No ancillary services

SEMI-INTEGRATED MEDICAL GROUP

CLINICAL INTEGRATION "LITE"
(or "Shared Philosophy" Model)

- Purchasers increasingly wanting measurable "value"
- Physicians increasingly needing to differentiate themselves in the marketplace
- CMS recognition in the "Innovation Center"
- IPA model can function this way and affiliated MSO critical

SEMI-INTEGRATED MEDICAL GROUP

CLINICAL INTEGRATION "LITE"
(or "Shared Philosophy" Model)

- A "shared philosophy model" meets both objectives where independent practices agree to:
  - Clinical protocols; and/or
  - Patient appointment standards; and/or
  - Joint peer review; and/or
  - Share information and coordinate care; and/or
  - Coordinate care; and/or
  - Other measures that bring value to patients and purchasers

SEMI-INTEGRATED MEDICAL GROUP

CLINICAL INTEGRATION "LITE"
(or "Shared Philosophy" Model)

- Legal restrictions
  - Antitrust
  - Self-referral - Stark

FULLY INTEGRATED MEDICAL GROUP

Physicians share revenue and expenses

- How it works (IPA or Semi-integrated group and MSO used):
  - Professional corporation or partnership of PCs
  - Most commonly single-specialty, but works with multi-specialty
  - One tax ID
  - One or more locations OK
  - Unified billing
  - Agreement among shareholders
  - Compensation income/expense formula
  - “Division” accounting

FULLY INTEGRATED MEDICAL GROUP

- Pros:
  - Economies of scale
  - Group negotiating power
  - Group purchasing power
  - Group financing power
  - Increased recruitment potential
  - Ability to attract purchasers
  - Ancillary services now possible at other locations

FULLY INTEGRATED MEDICAL GROUP

- Cons:
  - More complex operationally
  - Some autonomy given up
  - Liability issues
  - More politics to deal with
  - Physicians are their own worst enemies

STEP 3: FOLLOW AN ORGANIZING PROCESS

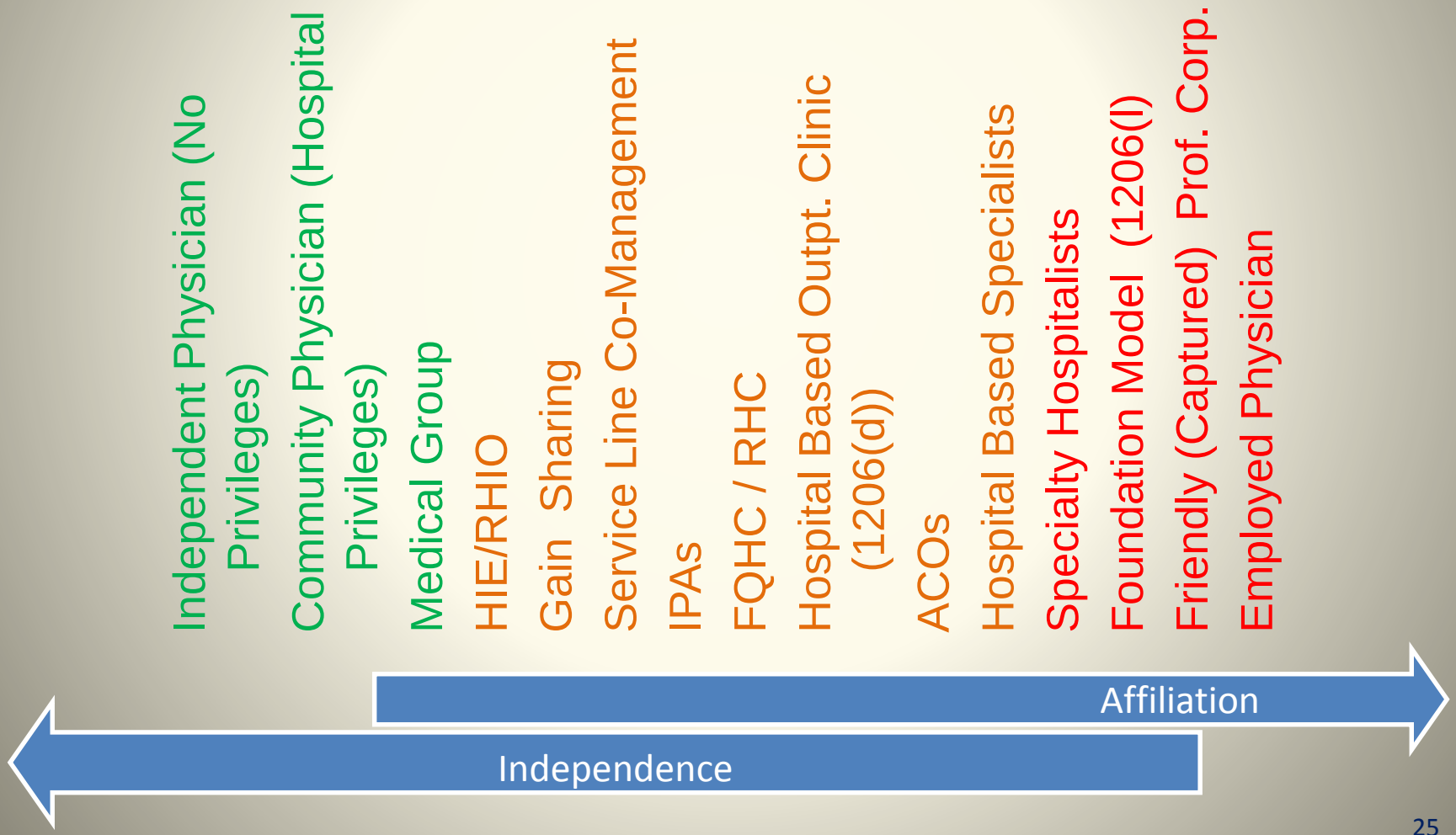
THE ORGANIZING PROCESS:

1. Identify Leaders
2. Bring Together Potential Physician Participants in Your Community – See Sample Organizing Letter in Resource Manual
3. Analyze Local Market Conditions and Potential Partners
4. Understand Your Organizational Options
5. Develop a Strategic Plan – See Sample Letter of Intent in Resource Manual

PHYSICIAN-HOSPITAL AFFILIATION:
Do Physicians and Hospitals Need Each Other?

- Many physicians need/desire the hospital's financial and other resources
- Lack of alternatives to address private practice challenges
- Hospitals cannot reduce cost, improve quality, increase patient satisfaction and coordinate care without significant physician involvement
- Is it a forced marriage, marriage of convenience or marriage made in heaven? Does it matter?

AFFILIATION / ALIGNMENT SPECTRUM



AFFILIATION OPTIONS

- Medical Director Agreements
  - Catch all contract for hospital physician services
  - Payment of Actual Services Performed
  - Fair Market Value
  - Requirement for Documentation of Time / Services
  - Covers Multiple Services Area (e.g. no pay, low pay, service line development, research, protocols and procedures, education, training, etc)
  - Legal Issues
    - Stark, AKB, and corporate practice
    - Perception of favoritism
    - Practical limitation on number of medical direction

AFFILIATION OPTIONS

- Call Coverage Agreements
  - Hospital contracts with physicians to cover ER call for unassigned, low pay and no pay physicians
  - Hospital contracts for specialty call for enhanced service line models (e.g. cardiothoracic surgery, neurosurgery)
  - Legal Issues:
    - Stark, AKB and corporate practice
    - Required to satisfy Title 22 requirements
    - Community Call versus General Call
    - May create competitive pressures / conflicts

AFFILIATION OPTIONS

- Specialty Hospitalists
  - Hospital contracts with group to provide coverage for patients requiring specialty care vs. relying on mandatory call coverage
  - Examples include intensivists, laborists, orthopedic surgeons, cardiologists, and pediatric physician
- Legal Issues
  - Stark, AKB and corporate practice
  - Alienates community physicians
  - Potential antitrust challenges

AFFILIATION OPTIONS

- Joint Ventures
  - Examples, surgery centers, imaging, cardiac and vascular, cancer, wound care, and occupational health
  - Legal Issues:
    - Stark, AKB, Antitrust, Inurement and Private Benefit
    - Reimbursement challenges
    - Governance issues

AFFILIATION OPTIONS

- Service Line Co-Management
  - Hospital contracts with hospital-MD owned entity (or MD-owned) to manage hospital service line or department
  - Hospital pays fixed fee plus performance-based payment

- Bundled Payments
  - Single payment to cover hospital, physician and other services for an episode of care (EOC)
  - EOC covers 3 days prior to admission (72-Hour Rule) and 30 days post-discharge

AFFILIATION OPTIONS

- Limited Gain-Sharing/Shared Savings Arrangements
  - Hospital gives physicians a share of reduction in hospital costs for patient care attributable to physicians' efforts
  - OIG approved examples include gain sharing for cardiac catheterization and spine fusion surgery

AFFILIATION OPTIONS

- ACOs
  - Gain sharing on a broader scale
  - ACO accountable for 5,000+ Medicare FFS beneficiaries
  - Coordinate care among Part A and Part B providers and suppliers
  - Must meet quality and other measures
  - Share with CMS savings above benchmarks
  - Non-Medicare ACOs

AFFILIATION OPTIONS

- Management Companies
  - Hospital owned or hospital and physician owned company manages group practice
  - Group may sell its non-professional assets to the management company
- Leasing Companies
  - Physician owned entity leases equipment to hospital
  - Rental fee must be compliant

AFFILIATION OPTIONS

- Physician-Owned Vendors
  - Physician owned entity sells items to hospital
  - Examples include orthopedic implants
  - Potential compliance risks
- Centers of Excellence
  - Hospital and physicians collaborate in the development and operation
  - Examples include cancer centers, minimally invasive, bariatrics, open heart surgery

AFFILIATION OPTIONS

- Shared Marketing
  - Hospital and physicians contract to jointly market a service line such as cardiac care or occupational medicine
  - Need to share costs 50/50 for equal prominence
  - Stark and Anti-Kickback Considerations
- Pay-for-Performance
  - Physicians rewarded for meeting goals such as patient satisfaction, avoiding central line infections and reducing re-admissions

AFFILIATION OPTIONS

- Shared IT
  - Health Information Exchanges / Regional Health Information Organizations
  - Provide physicians with remote access to hospital medical records through complex shared access / EMR systems
  - Provide EHR subsidy
  - Difficulty in unwinding
  - Who gets meaningful use $'s?
  - Legal Issues:
    - Stark, AKB, antitrust, IRS, privacy issues

AFFILIATION OPTIONS

- Hospital-based Outpatient Clinics
  - 1206(d) clinics
  - Hospital provides facilities and non-physician services
  - Physicians bill for an outpatient department visit
  - Legal Issues:
    - Stark, AKB, IRS, corporate practice

AFFILIATION OPTIONS

- Hospital-Sponsored Community Clinic
  - 1204(a) clinics
  - Operated by non-profit tax exempt organization
  - Sliding Fee Scale
  - Provides for broad based non-specialty licensed services
  - May employ physicians
  - Regulated by CDPH
  - Legal Issues:
    - Stark, AKB, IRS, employment, corporate practice

AFFILIATION OPTIONS

- “Friendly” / “Captured” Professional Corporation
  - Hospital-friendly physician (may be an executive) nominally owns the PC
  - PC employs physicians
  - Hospital manages the PC
  - Alternative to a medical foundation
  - Legal Issues:
    - Stark, AKB, IRS, Antitrust, corporate practice, fee splitting
    - Has survived several court challenges

AFFILIATION OPTIONS

- IPA-Hospital shared risk pools and other coordination
  - For capitated IPAs and medical groups
  - Contract defines budget for hospital care of HMO patients and sharing if below budget
  - Potential role for FFS patients? (see ACOs)
  - Legal Issues:
    - AKB, IRS, corporate practice, fee splitting
    - OIG gain sharing opinion

AFFILIATION OPTIONS

- Hospital-Based Foundations
  - 1206(l) foundation
  - Non-profit hospital owns an outpatient clinic
  - Clinic contracts with group of 40+ physicians in 10 board-certified specialties, at least 2/3 of whom are full-time
  - Clinic owns facilities, hires non-physician personnel, and contracts with payers
  - Legal Issues:
    - Stark, AKB, fee splitting, corporate practice, medical staff, antitrust, IRS
    - Governance limitations

AFFILIATION OPTIONS

- Employment
  - Limited to staff model HMOs (Kaiser is a group model). University of California, governmental, health care districts (ltd basis), community clinics and a few others
- Above Not Mutually Exclusive

COMMON STRATEGIC ISSUES

- Are the parties' expectations realistic?
- Are the parties' goals shared and incentives aligned?
- What are the local market conditions?
- Have the parties performed a "SWOT" analysis (strengths, weaknesses, opportunities, threats)?
- How will control (governance and management) be shared?

COMMON STRATEGIC ISSUES

- What are the capital needs and how will they be funded?
- What are the liability concerns and how will they be handled?
- Will the hospital be involved and/or interfere in clinical decision making?
- How will protocols, practice guidelines and evidence-based medicine be developed, implemented and assessed?
- How will data be gathered and analyzed?

COMMON STRATEGIC ISSUES

- How will outcomes and performance by measured?
- How will performance be rewarded/punished?
- How will physician leaders be indentified and/or trained?
- Are there alternatives to the hospital (other physician organizations, entrepreneurs, government grants)?
- Is there an exit strategy?

COMMON CONTRACT NEGOTIATION ISSUES

- Control
- Money
- Duties
- Term and Termination
- Exclusivity
- Restrictive Covenants
- Exculpation and Indemnity
- Unwinding
- Dispute Resolution

HOW TO MAKE YOUR BEST DEAL

- Understand your goals
- Have realistic goals and aligned incentives
- Have shared goals
- Understand your (and hospital's) strengths and weaknesses
- Be sensitive to compliance issues

HOW TO MAKE YOUR BEST DEAL

- Hire your own advisors
- Be organized and prepared
- Understand local market conditions
- Understand and maximize your leverage
- Work to increase trust and “win-win” approach
- Consider starting small

HOW TO MAKE YOUR BEST DEAL

- If possible, have 2 or more hospitals compete to align with you
- Be willing to trust hospital (this must be reciprocated)
- Be willing to do things differently
- Pursue physician buy-in
- Identify and empower physician leaders
- Adopt interoperable EMR technology

SUMMARY

- Questions and Answers

- Frank E. Gamma, Esq.
Kessenick Gamma & Free, LLP
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