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10 Key Concepts from OIG's Favorable Opinion on Co-Management Arrangements

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On Jan. 7, 2013, the Office of Inspector General (OIG) issued [Advisory Opinion 12-22](#) providing a favorable review of a co-management arrangement between a hospital and a group of cardiologists that included performance-based compensation for patient and employee satisfaction, quality and cost-savings measures. Clinical co-management arrangements, as they are commonly referred to, involve an agreement between a hospital and a group of physicians who agree to assist the hospital in co-managing the clinical and operational activities of a hospital-based service line in exchange for a management fee, which typically includes a fixed payment amount, as well as some form of performance-based incentive fee.

This is the first time the OIG has specifically addressed a co-management arrangement of this nature, but the OIG's analysis mirrors concepts from other Advisory Opinions regarding gainsharing and performance-based compensation arrangements.¹ In Advisory Opinion 12-22, the OIG concluded that the hospital's co-management arrangement with the physician group would *not* incur sanctions under the Anti-Kickback Statute (AKS) or the Civil Monetary Penalties Law (CMP).² While the Advisory Opinion is based upon a nuanced factual background, the factors that the OIG considered in making this conclusion are instructive for other hospitals contemplating similar co-management arrangements with performance-based compensation. This article reviews the significant features of the co-management arrangement, summarizes the OIG's analysis and identifies key concepts for hospitals considering developing a similar arrangement.

SIGNIFICANT FEATURES OF THE CO-MANAGEMENT ARRANGEMENT

The Advisory Opinion reviews a cardiac catheterization co-management arrangement ("Arrangement") between a large, rural acute care hospital and a group of cardiologists. Under the Arrangement, which has a term of three years, the physician group is obligated to provide certain management and medical direction services³ for the hospital's four cardiac catheterization laboratories ("cath labs") located on the main campus of the hospital and operated as provider-based departments. The hospital, which is located in a medically underserved area, operates the only cath labs within a fifty (50) mile radius of its campus.⁴ In exchange for performance of the management and medical direction services, the hospital pays the physician group a guaranteed annual fixed payment amount ("Fixed Fee") and a potential annual performance-based bonus amount ("Performance Fee").

The Performance Fee consists of four components for evaluating the operation of the cath labs: (1) employee satisfaction; (2) patient satisfaction; (3) improved quality of care; and (4) implementation of cost-reduction measures. The hospital assesses these component measures by: comparing physician

¹ The OIG previously reviewed proposed gainsharing arrangements in 14 separate Advisory Opinions since 2001 (see, e.g., Advisory Opinion 01-1), and it reviewed a performance-based compensation arrangement based upon quality and efficiency measures in 2008 (Advisory Opinion 08-16).

² The CMP penalizes any hospital that knowingly makes a payment, either directly or indirectly, to a physician to induce that physician to limit or reduce services provided to patients who are beneficiaries under Medicare or Medicaid. 42 U.S.C. § 1320a-7a(b). The AKS makes it a criminal offense to knowingly offer, pay, solicit, or receive any remuneration to induce or reward referrals for services reimbursable under a Federal health care program. Liability attaches to parties on both sides of an impermissible transaction. 42 U.S.C. § 1320a-7b(b).

³ Physician group services included (1) overseeing the lab operations; (2) providing strategic planning and medical direction services; (3) developing the hospital's cardiology program; (4) serving on medical staff committees; (5) providing staff development and training; (6) providing credentialing for the lab personnel; (7) recommending lab equipment, medical devices and supplies; (8) consulting with the hospital regarding information systems; (9) providing assistance with financial and payor issues; and (10) providing public relations services to the hospital.

⁴ This is a critical fact in the OIG's analysis. The OIG expressly identifies this as a factor reducing the likelihood that the compensation under the Arrangement creates an incentive to refer business to the hospital as opposed to a competitor. The physician group does not provide cardiac catheterization services at any other location.

performance to national standards; reviewing quality and cost-savings measures with multiple levels of peer and utilization review committees; and reviewing hospital employee and patient feedback. The quality and cost-savings components incorporate three achievement levels that trigger payment: if the physician group meets the baseline achievement, it receives 50% of the available compensation for that component; the middle benchmark, 75% of the available compensation; and the highest benchmark, 100% of the available compensation. If the physician group fails to achieve the baseline for a given component, then it will not receive any bonus amount for that component.

OIG'S ANALYSIS

In analyzing the Arrangement, the OIG noted that performance-based compensation is “designed to align incentives by offering physicians compensation in exchange for implementing strategies to meet quality, service, and cost savings targets.” The potential danger with such compensation, however, is that it can induce physicians to limit or restrict patient care, increase referrals to a particular facility, steer sicker patients to other facilities that do not offer such arrangements, and encourage unfair competition between hospitals. Given the presence of these risks under the Arrangement, the OIG analyzed the components of the Performance Fee under the CMP and AKS to determine whether the Arrangement would incur penalties or sanctions.

The OIG found that the employee satisfaction, patient satisfaction, and quality components of the Performance Fee did not implicate the CMP, but that the cost-savings component potentially did. Yet, in evaluating a number of factors, including specific measures to prevent the risk of limiting or reducing patient services, the OIG ultimately concluded that the Arrangement would not result in sanctions. The OIG's analysis of the cost-savings component of the Performance Fee under this Arrangement is largely in line with its long list of prior Advisory Opinions in which it reviewed similar cost-savings or “gainsharing” compensation agreements.⁵

With respect to the AKS, the OIG stated its concern that the Arrangement could be used to disguise illegal remuneration and considered whether the safe harbor for personal services and management contracts could apply.⁶ Although the OIG concluded that safe harbor protection would not be available because the aggregate compensation to the physician group is not set in advance, it nevertheless stated it would not impose sanctions because of the manner in which compensation is structured and various measures that the hospital certified were taken to prevent violations of AKS.

KEY CONCEPTS FOR CO-MANAGEMENT ARRANGEMENTS

There are several key takeaways that can be gleaned from the Advisory Opinion for hospitals considering co-management arrangements with performance-based compensation:

- 1. Base compensation (both fixed and performance-based) on fair market value for a specifically defined set of services.** The OIG relied on the hospital's certification that the compensation provided to the physician group in the form of Fixed Fee and Performance Fee is fair market value based upon an independent, third-party valuation. The OIG also noted that the physician group provides substantial services in exchange for the compensation. As such, hospitals should obtain an independent third-party valuation to verify the fair market value of all compensation amounts paid under the arrangement, particularly as it relates to the specific services

⁵ See Advisory Opinions 09-06, 08-21, 08-15, 08-09, 07-22, 07-21, 06-22, 05-06, 05-05, 05-04, 05-03, 05-02, 05-01, and 01-1.

⁶ 42 C.F.R. § 1001.952(d).

to be provided by the physicians. Furthermore, the services identified in a co-management agreement should be substantial, specifically defined, and actually performed, to ensure that compensation cannot be viewed as an inducement for referrals.

- 2. Structure compensation (both fixed and performance-based) so that it does not vary by the number of patients treated or number of patient referrals.** The OIG evaluated the structure of the compensation to ensure that the amount paid to the physician group does not increase as a result of an increase in the number of patients treated at or referred to the hospital. The OIG specifically noted that the Performance Fee is subject to an annual cap not to exceed the amount of the Fixed Fee and does not fluctuate based on the number of patients treated in the cath labs. The Performance Fee only fluctuates based upon the review of the four components for evaluation of the operation of the cath labs. Thus, it is critical that any compensation structure ensures that the total performance-based fee, as well as performance measurement under the benchmarks, will not increase based upon the number of patients treated or the number of referrals to the hospital.
- 3. Condition compensation on physician group certification that the downstream distribution of compensation from the arrangement will be done *pro rata* based upon ownership in the group rather than on individual participation in the arrangement.** In its analysis of the Arrangement under the AKS, the OIG noted that the hospital certified that the physician group would distribute compensation from the Arrangement to its member physicians *pro rata* based upon the amount of ownership interest in the group practice for each physician and not in any way based upon individual participation under the Arrangement. The OIG limited the scope of the Advisory Opinion by stating that any indication “that the [physician group] allocates ownership interests or other compensation based on an individual physician owner’s participation or performance under the Arrangement” could change its assessment of the Arrangement and possibly incur sanctions under the AKS. Even so, other structures for distribution of compensation that clearly document that the amount of compensation is not related to the volume or value of referrals likely will not violate the AKS.
- 4. Condition performance-based compensation upon the physicians *not* (a) stinting on care of patients; (b) increasing referrals to the hospital; (c) cherry-picking healthy patients with desirable insurance for treatment at the hospital; or (d) accelerating patient charges.** Co-management arrangements should be structured so that performance-based compensation is dependent upon avoiding behaviors that would cause harm to patients or induce physicians to alter their current medical practice to reduce or limit services. The OIG relied on the hospital’s certification that the above behaviors were not influenced or affected by the Performance Fee. In its AKS analysis, the OIG also referenced the relationship between the hospital and the physician group — namely, that the physician group did not provide services at any other facility because the hospital is the only provider of cardiac cath lab services in a fifty (50) mile radius. The OIG recognized that the exclusive availability of cath lab services at the hospital prevented the Arrangement from inducing increased referrals from the physician group. This somewhat limits the scope of the AKS analysis included in the Advisory Opinion and suggests that a less favorable analysis may apply where a hospital is located in a market with a choice of cardiac catheterization laboratory providers. Accordingly, hospitals located in markets with competing service lines that are considering similar compensation arrangements should include additional safeguards to prevent inducing increased referrals from physicians.

- 5. Include oversight by utilization review and performance improvement committees.** The OIG favorably viewed the hospital’s use of an independent utilization review body to review the cost-savings measures implemented under the Arrangement. Additionally, the employee satisfaction, patient satisfaction, and quality components of the Arrangement were monitored on multiple levels by a performance improvement committee, a peer review committee, the medical executive committee, and the hospital’s board of directors. Such oversight and performance review should be considered a necessary component of any co-management arrangement.
- 6. Encourage physicians to implement better management practices through cost-savings measures, but do not limit or restrict physicians’ abilities to request a certain device or address a patient’s unique needs.** The OIG noted that the Arrangement was designed to provide flexibility in physician decision-making. The cost-savings measures included in the Arrangement encouraged physicians to efficiently manage the use of supplies and products in the cath labs, and included a standardization of best practices within the cath labs based on evidence and clinical outcomes. However, the hospital did not limit or restrict the physicians’ abilities to offer patient services or have access to any supply or device that a physician considered clinically appropriate for patient care. The OIG also responded positively to the hospital’s engagement of an independent, third-party utilization review body to analyze the clinical appropriateness of procedures performed in the cath labs. Moreover, the cost-savings benchmarks are based on the “aggregated performance” of the physician group; therefore, the Performance Fee is not dependent upon meeting a specific standard for each particular patient, especially if the standard is contraindicated for that patient. Hospitals that are considering such cost-savings or gainsharing arrangements should structure them to allow flexibility necessary to protect patients from financial motives, should routinely monitor the effects of the cost-savings measures to assure that the measures are not limiting or restricting the physicians’ provision of patient services, and should review measures at the aggregate level, not the patient-specific level.
- 7. Make performance-based measures specific, objective, and, when possible, founded in national standards.** For example, the Arrangement in this case includes very detailed performance components that are based on national standards (e.g., the Joint Commission or other accrediting body standards), independent utilization reviews, and employee and patient satisfaction measures. The OIG took comfort in this, noting that it helps to ensure that the purpose of the Arrangement is to improve quality, rather than reward referrals.
- 8. Structure performance measures to incentivize improvement, not reward the *status quo*.** The OIG recognized that the physician group would not receive any Performance Fee if it did not satisfy the baseline measure for the various components and that the baseline reflects improvement over previous performance such that the physician group is not rewarded for maintaining the *status quo*. Further, the physician group could increase its Performance Fee by improving its achievement under the quality and cost-savings components (i.e., paid 50% of available compensation at baseline; paid 75% of available compensation at middle benchmark; paid 100% of available compensation at highest benchmark). Given the OIG’s focus on this tiered incentive system, a co-management arrangement should include performance-based compensation aimed toward improvement, not in rewarding the *status quo*. This could include measuring cost-savings and quality components in tiers with additional compensation to be paid at each tier.

- 9. Limit the duration and scope of the co-management incentive agreement.** In this case, the OIG commented favorably on the annual cap on the Performance Fee and its three (3) year term.⁷ Co-management arrangements that do not have a limited term or that do not place upward limits on compensation present a compliance risk for hospitals. Even so, longer-length co-management agreements may be defensible under the AKS, provided that the parties to the agreement document carefully that compensation is not intended to reward or retain referrals.
- 10. If appropriate or required, disclose incentive agreements to patients prior to the delivery of care.** The OIG specifically recognized that the hospital notified patients and their families in writing of the Arrangement prior to patients receiving services in the cath labs. Hospitals with similar arrangements should consider whether these types of disclosures are necessary or required.

The OIG's favorable analysis is an indication that clinical co-management arrangements, when properly structured, can be useful tools for hospitals in building clinical and operational management schemes that are effective and beneficial to the delivery of patient care. If you have questions about the Advisory Opinion or if you would like assistance in developing a co-management arrangement, please contact one of the authors or a member of McGuireWoods' Healthcare Department.

⁷ The OIG noted, however, that the agreement included an automatic renewal term, and it specifically limited its Advisory Opinion to the three-year initial term and expressed no opinion on how the renewal term would affect the inurrence of sanctions under the AKS or CMP.