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REFORM AND HOW IT IMPACTS VARIOUS TOPICS

In this world of ever increasing complexity it is getting harder and harder to keep up with change. In the healthcare arena that difficulty is magnified with the intense debate on how to reform the system for the future. If you are like me you are inundated and overwhelmed with information and it is difficult to determine what to focus on. The American Health Lawyers Association (AHLA) does an excellent job of analyzing and disseminating information that I think is very useful in understanding what others think is going on. This month, instead of reinventing the wheel, I thought I would reproduce two excellent articles authored by other members of AHLA that give good perspective and insight to areas that many hospitals and physicians encounter more and more frequently. They are well worth reading and provide a useful resource when considering future decisions. Enjoy them and have a wonderful holiday season and a happy and healthy New Year.

September 9, 2009

Healthcare Reform Will Challenge Providers' Business Structures
By Kim Roeder*

As the debate over healthcare reform continues, the form of any future legislation remains unclear. Certain aspects of the debate, however, have raised questions about the shortcomings of the current fee-for-service healthcare delivery system that will likely persist, whether or not final legislation includes such controversial elements as a public plan option, a federally regulated health insurance exchange, and individual and employer health insurance coverage mandates. Policy positions, advocacy papers, and draft legislation have addressed a variety of proposals designed to spark changes in healthcare delivery, promoting a focus on wellness and primary care, shifting payments from a fee-for-service structure based on volume to methodologies that reward quality, and encouraging coordination of patient care across the provider spectrum through bundled payments structures and payment incentives.

Delivery System Reform

Although the ultimate resolution of the legislative debate is far from clear, a survey of the major outstanding House and Senate proposals indicates that providers would be well advised to begin some consideration of strategic options to position them for a business response to incentives and mandates as discussed in the context of a public plan, private plans operating through an exchange, or proposed Medicare and Medicaid payment adjustments. Various proposals under consideration will impact directly relationships among hospitals, physicians, and post-acute providers:

- ***Innovative and Alternative Payment Arrangements***. The House reform bill, America's Health Choices Act of 2009, specifically authorizes the public plan option to compensate participating providers under fee structures representing an alternative to traditional fee-for-service payments, including patient-centered medical home and other care-management payments, accountable-care organizations, value-based purchasing, bundling of services, differential payment rates, performance or utilization-based payments, and partial capitation.[1]

- ***Payments Based on Quality***. The House bill authorizes a number of initiatives designed to develop quality measures for payment purposes.[2] Although the Senate Finance Committee did not release a bill before Labor Day, the committee's April 2009 policy option publication includes various proposals to control healthcare costs by paying hospitals performance bonuses under the inpatient prospective payment system (IPPS) for meeting or improving upon prescribed performance measures focusing on such matters as cardiac conditions, pneumonia, surgical care, and patient evaluations of care. Across-the-board reductions in IPPS payment rates would be implemented to fund these bonuses.[3] Only hospitals scoring in the top quartile would receive the full bonus; those in the bottom quartile would receive no bonus, and those in the second and third quartile would receive a partial bonus.

- ***Bundled Payments***. The House bill directs the U.S. Department of Health and Human Services Secretary to develop a detailed plan to implement post-acute bundled payments, and expands an existing demonstration project to include bundling of payments for hospitals and post-acute providers.[4] The Senate Finance Committee's policy options include a proposal under which Medicare would pay a singled bundled payment amount for both inpatient services and certain post-acute services, including home health, skilled nursing facility, rehabilitation, and long-term hospital care, if furnished within thirty days after discharge from the acute-care hospital. The bundled payment rate would reflect savings attributed to the anticipated efficiencies achieved through improvements in the coordination of services.[5]

- ***Hospital Readmissions***. The House bill provides for adjustment of hospital payments based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for three conditions with risk-adjusted readmission measures that are endorsed by the National Quality Forum. In future years, this policy is to be expanded to additional conditions.[6] In addition, risk-adjusted readmission rates would be developed for post-acute providers, and a readmission payment system similar to the hospital system would be implemented for post-acute providers. The potential for reduction in payment due to readmissions may incentivize coordination among acute and post-acute providers.

Business Structures

Hospitals, physicians, and other providers considering a transactional response to this landscape may consider the following continuum of business arrangements:

- ***Independent contractor service arrangements*** between hospitals and physicians and among hospitals, physicians, and post-acute providers. The ability to implement coordination of care and enforce commitment to quality and other incentives may be more challenging—both operationally and legally—in structures in which providers remain independent outside the specific terms of the contract.

- ***Employment of physicians by providers*** . Even in the absence of new healthcare reform legislation, employment of physicians by hospital systems has been increasing due to a number of market pressures, including shortages of physicians; the need to plan for recruitment in certain specialties to replace retiring practitioners; reimbursement pressures that have led to demands for higher payments for call coverage and administrative services; an emphasis on lifestyle choices and less investment in the independent private practice model among young physicians; and the like. Employment may furnish a framework for developing protocols for coordination and implementing quality and patient care coordination incentives.

- ***Joint ventures for the co-management of clinical matters in certain service lines*** (particularly those that will be subject to particular scrutiny and penalties). Many such joint ventures in recent years have centered on hospital-physician joint ventures to manage certain hospital service lines. Health reform may indicate that focus should be directed to efforts promoting clinical management across a broader group of providers, including post-acute providers.

- ***Joint ventures for negotiation of payor contracts***, such as a physician-hospital organization (PHO) or a physician independent practice association (IPA). Under antitrust rules, organizations of this type have been limited to a complex messenger model involving individual responses to payor pricing unless the organization implemented substantial economic or clinic integration.[7]

- ***Joint ventures for ownership of healthcare facilities***. Co-ownership is one method for incentivizing investors in the success of the facility's operations. Joint venture opportunities involving physicians are severely limited under the Stark Law. It should be noted that House and Senate HELP bills would eliminate the Stark Law exception for physician ownership of hospitals.

- ***Acquisitions and vertical integration of providers***. Although common ownership may be a flexible legal vehicle for aligning incentives and negotiating with payors across a spectrum of providers (including acute and post providers, as well as physicians), acquisition (and subsequent integration) may be expensive, time-consuming, and require compliance with a number of change-of-ownership rules.

While these structures may provide a *framework* for the administration of global capitation and bundled payments, the successful implementation of clinical integration, patient care coordination, quality incentives, and efficiencies across previously unaffiliated providers will require innovative leadership and management.

Legal Issues

As noted above, implementation of any of the foregoing structures to respond to various reform proposals meets significant challenges under at least the following laws as currently in effect:

- ***Referral Laws***. Cooperation among providers, including physicians and providers who serve as referral sources to each other, presents basic compliance issues under the Stark Law[8] and federal Anti-Kickback Statute[9] (and their counterparts at the state level that may be applicable to Medicaid and private insurance programs). Joint venture opportunities involving physicians are limited under the Stark Law and the Anti-Kickback safe harbors; and services contracts must meet highly formalized requirements relating to documentation of the arrangement, setting compensation in advance for at least one year, limiting bonuses to regulatory criteria, and compliance with standards of fair market value payments.[10]

- ***Antitrust Laws*** . Transactions among healthcare providers that involve sharing of price-related information among healthcare providers and joint ventures for specialty health services, mergers, or establishment of physician and multi-provider networks such as IPAs and PHOs for contracting purposes, are still subject to guidelines published in the 1990s, the Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care (Joint Statements). The antitrust laws are actively enforced against providers, IPAs, and PHOs that cannot demonstrate sufficient financial or clinical integration to deal jointly with payors or that otherwise run afoul of antitrust prohibitions.[11]

- ***The CMP Statute and "Gainsharing."*** The HHS Office of Inspector General (OIG) has long taken the position that arrangements for sharing hospital cost savings with physicians incorporating certain efficiencies in their practice are at least technical violations of the statute imposing a civil monetary penalty for a hospital's payment made to a physician to induce reductions or limitations of services to Medicare or Medicaid beneficiaries under the physician's direct care.[12] Under its advisory opinion process, the OIG has approved a number of arrangements that include substantial protective measures surrounding programs such as product standardizations or pay-for-performance, under which a private insurer paid the hospital a bonus based on certain standards of quality and efficiency.[13] Reliance on the advisory opinion process to assure compliance is cumbersome and time-consuming for wide-ranging implementation of such measures. The House bill extends the CMS gainsharing demonstration project in order to further study these programs.[14]

- ***Tax-Exempt Status Regulations***. The ability of Section 501(c)(3) charitable healthcare providers to engage in business transactions with for-profit business entities is limited by tax guidance and regulations regarding their participation in joint ventures with for-profit partners,[15] and the imposition of excise taxes in connection with compensation arrangements and other transactions that are determined to be excess benefit transactions within the meaning of the intermediate sanctions rules.[16]

Planning a transactional response to healthcare reform efforts will require close attention to whether and how these principles are modified to enable providers to structure business relationships in response to incentives, mandates, and innovative payment mechanisms.

**AHLA wishes to thank Kim H. Roeder, Esquire (King & Spalding LLP, Atlanta, GA), for authoring this alert and sharing her expertise with other colleagues.*

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[1] H.R. 3200, Section 224.
[2] H.R. 3200, Sections 1441-1444.
[3] "*Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs*," Senate Finance Committee, April 29, 2009.
[4] H.R. 3200, Section 1152.
[5] "*Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs*," Senate Finance Committee, April 29, 2009.
[6] H.R. 3200, Section 1151.
[7] *See the Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care*, available on the FTC website.
[8] 42 USC § 1395nn.
[9] 42 USC § 1320a-7b(b).
[10] *See* Stark rules at 42 CFR Part 411, Subpart J; and the Anti-Kickback Law safe harbors at 42 CFR § 952.1001.
[11] *See* actions cited in *Overview of FTC Antitrust Actions in Health Care Services and Products*, Health Care Division, Bureau of Competition, Federal Trade Commission (June 2009), available on the FTC website.
[12] 42 USC 1320a-7a(b).
[13] OIG Advisory Opinion No. 08-16; OIG Advisory Opinion No. 09-06.
[14] H.R. 3200, Section 1903.
[15] *See* Revenue Ruling 98-15.
[16] IRC § 501(c)(3); IRC § 4958.

October 20, 2009

Physician-Hospital Integration as a Business Model
By Matthew Albers*

Over the past few years, the healthcare industry, specifically hospitals and health systems, have increased their activity in acquiring, establishing, and operating physician practices. Unlike a similar trend that occurred in the mid 1990s, current hospital and health system attempts to acquire physician practices are not limited to ownership of primary care and internal medicine practices. Rather, in addition to continued interest in acquiring primary care, hospitals and health systems now target specialty physician services as well, most commonly oncology, cardiology, and orthopedics. The question arises whether legislative reforms will slow or reverse the current trend toward physician employment as part of larger, integrated hospitals and health systems.

Hospital and Health System Ownership of Physician Practices: Historic and Emerging Trend

In response to the belief that the capitation payment model of managed care would take hold in the early to mid 1990s, hospitals and health systems across the country began large scale initiatives to acquire, maintain, and operate primary care, family, and internal medicine physician practices.[1] As a result, hospitals and health systems had to create complex legal and corporate structures to allow for their ownership of physician practices, especially in states maintaining a prohibition on the corporate practice of medicine.[2]

As the difficulty and cost of simultaneously managing physician practice and hospital operations began to outweigh the financial benefits of ownership, hospitals and health systems began to unwind these arrangements.[3] This resulted in the re-emergence of the independent physician practice and presented hospitals and health systems with the difficult task of identifying and implementing alignment and affiliation structures with independent physicians. Simultaneously, certain physicians and hospitals began aggressively exploring joint venture and partnering opportunities to jointly own and operate numerous types of facilities and services, including ambulatory surgical centers, diagnostic imaging and laboratory facilities, specialty hospitals, and whole hospitals. With this focus on hospital/physician business collaboration and entrepreneurship came increased regulatory scrutiny.[4]

Changes to Reimbursement

The heightened joint venture and entrepreneurial activity created increased competition among physicians and physician groups. Simultaneously, changes in the economy and government reimbursement programs began to exert financial pressure on the independent physician practice. Most significantly, from 2003-2005 physicians experienced substantial reductions in professional fee reimbursement from Medicare and most independent third-party payors.[5] With this reimbursement reduction and increasingly limited opportunities to share in ownership of ancillary and technical service revenues, physicians without significant hospital or health system subsidy or support faced a difficult financial situation. The reduction in reimbursement rates did not have as profound an impact on hospitals and other technical service providers. However, increased competition in the marketplace (including competition from physician-owned diagnostic and other surgical facility ventures) and dilution of the primary care physician base prompted hospitals and health systems to re-evaluate the benefits and disadvantages of physician employment, integration, and consolidation.

The Emergence of Hospital Employment of Physicians

In an attempt to recreate the perceived success of, among others, the Mayo Clinic and Cleveland Clinic, hospitals and health systems across the country currently are acquiring and consolidating hospital facilities and establishing large, integrated physician groups.[6] The advantages of the integrated physician hospital structure for both sides are relatively clear. From the hospitals' perspective, alignment and employment provide:

- Increased coordination of care and quality oversight;
- Additional negotiating leverage with insurance payors;
- Opportunity to better manage and control physician productivity and utilization of hospital and system resources and facilities;
- Ability to better market and brand major service lines (i.e., cardiology, oncology, etc.);
- More efficient management of call and emergency coverage schedules;
- Defense against competition from physician-owned ancillary services, surgery centers, and other facility provider services; and
- Relief from certain regulatory restrictions regarding hospital/physician relationships and prohibitions on managing physician referral practices.[7]

For physicians, employment with a hospital or health system entity provides a number of advantages, including:

- A stable financial circumstance, including, but not limited to guaranteed or fixed competitive base compensation and benefits;
- Access to continuing and reliable malpractice coverage and, in many cases, tail insurance;
- A practice environment free from the day-to-day burden and administrative tasks of operating and managing an independent practice; and
- More regular work hours and shared call responsibility.

By employing the physicians, hospitals access the flexibility of the employment exceptions and safe harbors to basic state and federal fraud and abuse provisions, and gain financial and operational control over the physicians interacting with their patient base.[8]

Impacts of Proposed Legislative Reform

Based on proposed legislation, including a version of Senator Max Baucus' (D-MT) America's Healthy Future Act of 2009,[9] which the Senate Finance Committee approved on October 13, 2009, it is reasonable to conclude that the trend of hospital/physician alignment will continue in a "reformed" healthcare economy.

The single unifying factor in all of the various proposals appears to be a primary focus on extending insurance coverage and medical services to currently uninsured or underserved populations. Interestingly, the proposals do not address the factors that contribute to decreased physician practice efficiency and increased costs--factors motivating physicians to consider hospital or health system employment or affiliation.[10] Additionally, while pending reform proposals promise no reductions in reimbursement levels for physician professional services, they do not alter the fundamental business realities that, from a pure economic standpoint, increasingly weigh in favor of institutional or hospital employment.

Finally, there appears to be a perception on the part of reform proponents that large, vertically integrated hospitals and systems are better situated to maximize efficiencies and quality care.[11] In light of this perception and because the reform proposals do not contemplate changes that would make it economically advantageous for a physician group or hospital to remain independent, the prevailing trend toward hospital and health system consolidation and physician employment is likely to continue.

**AHLA wishes to thank Matthew E. Albers, Esquire (Vorys Sater Seymour and Pease LLP, Cleveland, OH), for authoring this alert and sharing his expertise with other colleagues.*

[1] *See* John E. Hill, "Survey provides data on practice acquisition activity," Healthcare Financial Management. FindArticles.com. Oct. 16, 2009. COPYRIGHT 1995 Healthcare Financial Management Association; *see also* Casalino and November, "Hospital-Physician Relations: Two Tracks and the Decline of the Voluntary Medical Staff Model," HEALTH AFFAIRS, Volume 27, Number 5 (2008).

[2] The prohibition on the "corporate" practice of medicine states that a general business corporation may not practice medicine and may not employ a physician to practice medicine. Corporations entering into such arrangements may be engaged in unlawful practice of medicine and may be operating an unlicensed facility, depending upon the particular laws of their state. "To practice a profession requires something more than the financial ability to hire competent persons . . . . It can be done only by a duly qualified human being . . . . The qualifications include . . . honesty . . . upright conscience and a sense of loyalty to . . . patients . . . [in other words] good moral character which is the prerequisite to the licensing of any professional man . . . . No corporation can qualify."- *Dr. Allison, Dentist, Inc. v. Allison*, 196 N.E. 799, 800 (Ill. 135). Presently, a majority of states maintain some form of the prohibition, and some even prohibit direct employment of physicians by hospital entities (e.g., Ohio, California, Texas, Colorado, Illinois, and New York).

[3] *See Casalino* and *November infra*, n. i, at 1306.

[4] Notably, increased scrutiny occurred in the 2003 Centers for Medicare and Medicaid Services moratorium on physician investment in specialty hospitals as well as additional limitations on the establishment and operation of physician-owned or joint-ventured facilities and designated health service providers under fraud and abuse provisions of the Stark Law and the federal Anti-Kickback Statute.

[5] In 2002, the Medicare reimbursement increase was less than the estimated increase in physician practice costs associated with providing services, and in each of 2003 through 2005, the Medicare reimbursement rates actually decreased. *See* July 2006 Government Accountability Office Report to Congressional Committees, "Medicare Physician Services--Use of Services Increasing Nationwide and Relatively Few Beneficiaries Report Major Access Problems."

[6] *See id.* at Exhibit 1; *see also* John G. Larson, PhD, "Defense vs. Offense: Hospital Employment of Physicians," Health Leaders Media, May 2, 2008.

[7] This factor is an important one, as under both Stark and Anti-Kickback, hospitals and other designated health service providers are permitted to require referrals from their bona fide employees subject to certain limitations surrounding patient choice, insurance limitations, and appropriate care.

[8] The integrated health system and employed physician model currently dominates in a number of markets, most notably Cleveland, OH; Greenville, SC; and Phoenix, AZ; and continues to gain momentum in other large metropolitan markets across the country. These markets include, Boston, MA; Indianapolis, IA; Minneapolis, MN; Little Rock, AK; and Orange County, CA. *See Casalino* and *November, infra*, n. i, at Exhibit 1 (*citing* data from the Community Tracking Study and various GAO studies).

[9] The Act has not yet been assigned an official Senate Bill number, but the full text of the Chairman's Mark of the America's Healthy Future Act of 2009 can be downloaded here.

[10] *See* Allan H. Ropper, M.D., "Health Care Reform and Clinical Culture," New England Journal of Medicine, August 26, 2009.

[11] President Obama and Senator Baucus have specifically cited the examples of the Mayo Clinic, the Cleveland Clinic, Geisinger Health System, and Intermountain Healthcare. Jason Plautz, "Learning from Efficient Hospitals--How do They do it?," National Journal Online, October 5, 2009.

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Baratz & Associates, P.A.
4A Eves Drive, Suite 106
Marlton, NJ 08053
(856) 985-5688
Clifford Simmons, CPA

E-mail: simmonsc@baratzcpa.com

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