# Hospital and Physician Co-Management Agreement Will Not Result in Sanctions

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The use of co-management agreements between hospitals and physician practices has increased in recent years, and they may serve as an important component of one of the outcomes-driven programs being promoted under the Patient Protection and Affordable Care Act. If properly structured, co-management agreements can align incentives between hospitals and medical staff physicians to improve the operation of a particular hospital department or service line. The Office of Inspector General's ("OIG") Advisory Opinion No. 12-22 issued on December 31, 2012 ("Opinion") affords helpful guidance on how to structure and document those arrangements.

While co-management arrangements can result in important efficiencies and improved quality, they also can raise important concerns under a number of federal laws, including the Civil Money Penalty law ("CMP"), the Anti-Kickback Statute ("AKS"), the Stark law ("Stark") and the private inurement and private benefit prohibitions applicable to tax exempt hospitals. The CMP prohibits arrangements that improperly reduce or limit items or services provided to Medicare and Medicaid beneficiaries. The AKS prohibits payments intended to induce referrals of business paid for by the federal health care programs. Stark prohibits referrals to a hospital with which a physician has a financial arrangement unless an exception applies. Federal tax laws restrict the payment of funds by tax exempt entities to non-exempt persons such as physicians.

Based on the particular facts presented, the Opinion confirmed that OIG would not impose sanctions on the hospital or independent cardiology practice for entering into an arrangement that rewards the practice for improving efficiency and lowering costs at the hospital's four cardiac catheterization laboratories ("Labs") if certain safeguards are in place. The hospital certified that a number of important

measures would be implemented to ensure that it would not improperly result in the reduction of necessary services or induce the referral of business covered under the federal health care programs.

Under the co-management agreement, the practice would provide management and medical direction services at the Labs for a co-management fee with two components: (i) an annual fixed fee, and (ii) a potential annual performance fee (reconciled quarterly) based on measures of employee and patient satisfaction, improved quality of care and reduced costs. Both fees were supported by independent assessments of fair market value which would be updated annually to evaluate fair value and clinical appropriateness.

Among the specific duties of the practice would be to oversee Lab operations, provide strategic planning and medical direction, develop the hospital's cardiology program, serve on medical staff committees, provide training for hospital staff, credential Lab personnel, consult on the information system, assist with financial and payor issues, assist with public relations, and recommend Lab equipment, devices and supplies.

The cost saving component of the performance fee arrangement is the most challenging, as it could be construed as an incentive to deny necessary care. The parties were careful to implement measures designed to ensure that all purchasing decisions would be in the best interests of the patients and that all products would be safe and effective. As proposed, a committee of interventional cardiologists would generate the initial product recommendations based on a review of evidence-based medicine. Physicians would not be prohibited from requesting a different product where they determined that it would be better suited to address a patient's unique health needs, even if it was more expensive and not on the recommended list. Other proposed cost saving measures included the use of best management practices and measures to avoid wasting supplies.

The performance fee arrangement utilized base line measures so the incentive compensation would only be based on improvements over existing pre-agreement performance for each measure. The base line measures would be re-benchmarked after the initial three year term.

From a CMP perspective, the Opinion observed that a number of measures would be implemented to ensure against an inappropriate reduction in services, including: (i) an independent evaluation of fair value of all payments, (ii) the use of an independent utilization review firm to monitor clinical appropriateness, (iii) the unrestricted right of physicians to order any service or device that they concluded would best serve their patients' needs, (iv) detailed internal and external monitoring

processes to ensure that appropriate care is provided, that patient “cherry picking” based on health or payor source would not occur, and that accelerated discharges are avoided, and (v) advising patients of the arrangement and obtaining patient consent in advance.

From an AKS perspective, the Opinion noted that the safe harbor for personal services and management contracts would not cover the arrangement because the performance fee would not, by its nature, be set in advance. The Opinion concluded, however, that the compensation arrangement had appropriate safeguards that overcame that deficiency, including: (i) an independent determination of fair value, (ii) the compensation would not vary based on the number of patients treated, (iii) the hospital operated the only Labs within 50 miles, and the group only practiced at that facility, limiting the likelihood that the physicians would increase their referrals to the hospital, (iv) the performance measures were specifically tailored to ensure quality improvement, (v) the term of the arrangement was limited to three years, and (vi) if the arrangement continued after the initial term, the quality improvement and cost saving measures would be adjusted to avoid continued payment for improvements in prior years and to provide incentives for additional improvements in the future.

Importantly, the Opinion does not apply to the application of Stark or the IRS restrictions on private benefit and private inurement. Those limitations must be evaluated separately.

As health care costs continue to increase and as third party payor arrangements seek to encourage hospitals and physicians to collaborate better to foster successful outcomes, the Opinion provides helpful and practical guidance to physicians and hospitals on ways they may align their interests to better serve patients by creating incentives to lower costs and improve quality of care.

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