



Negotiation of Co-Management Agreements That Solidify Fair, Balanced, and Long Lasting Hospital Relationships

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The future of healthcare involves clinical integration between hospitals and physicians, including between hospitals and radiologists. Clinical integration includes a focus on coordination of patient care through quality care, improved efficiencies, and demonstrable outcomes. Market forces and payors (including self-insured employers) are driving integration.

There has been a paradigm shift toward outcomes measurement and evidence-based medicine, which will require radiologists to have not only a diverse array of service offerings, but the financial strength and breadth of management and technological capabilities to analyze and demonstrate outcomes. Providers will need to prove to government payors, commercial payors, ACOs, and self-insured employers that they can provide high-quality care at a lower cost. Therefore, identifying, measuring, and possessing data will be crucial for providers to survive and thrive.

There has also been an increase in regulatory scrutiny of financial relationships between physicians and hospitals, focusing in particular on fair market value and commercial reasonableness of such compensation arrangements. The core tenet for these relationships is that compensation is not made as payment for referrals. Whenever a provider receives compensation in exchange for providing professional services to or on behalf of a hospital, the provider is deemed to have a financial relationship with the hospital. The relationship is subject to the Stark and anti-kickback laws, the False Claims Act, as well as other federal and state laws. The Stark law prohibits a physician from making a referral for certain designated health services that are covered by the Medicare program if the physician has a financial relationship (including a compensation relationship) with the provider of the services, unless an exception applies. The Medicare and Medicaid anti-kickback law and the law's safe harbor

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regulations prohibit the payment, receipt, offering, or solicitation of remuneration in exchange for the referral of services or items covered by the Medicare or Medicaid programs. The key to compliance with the Stark and anti-kickback laws is not to be considered a referring provider or to fit into an exception or safe harbor. Providers must avoid any indication of fraud or abuse in these clinically integrated relationships.

Co-management agreements can align incentives between hospitals and radiologists to improve the operations of a particular hospital department or service line through the outsourcing of department or service line management to the radiologists. They are intended to recognize and reward, in a legally compliant manner, the efforts and accomplishments of the radiologists in implementing, managing, and improving the quality and efficiency of a department or service line. The agreements can cover inpatient and/or outpatient services and apply to one or multiple locations.

The co-management model may involve a company, jointly owned by the hospital and the radiologists, that manages the day-to-day operations and participates in the long-term planning for a specific department or clinical service line. However, there are no requirements for the hospital to be an owner or employer of the manager, but it provides another level of alignment. Importantly, co-management arrangements do not require the formation of a new entity and can be achieved through a contractual relationship between the hospital and radiologists. Successful co-management arrangements require the development of joint governance and management, as well as the creation of joint accountability and joint benefit and risk sharing.

Financial alignment in a co-management arrangement occurs through the compensation paid to the manager, with the compensation including both a base component and a component tied to the performance of predetermined incentives. The performance component drives the radiologists to make clinical and operational changes that improve hospital performance, even if such decisions would have traditionally been perceived to be counter to the benefit of the radiologists. Physicians are motivated to focus administrative and management efforts on achieving objectives, enhancing the clinical quality, improving operational performance, and developing and complying with evidence-based clinical protocols. The inclusion of a cost savings component for any performance fee arrangement is challenging, as it could be construed as an incentive to deny necessary care.

Structuring the arrangement to mitigate this risk is critical. There are many services that may be part of a co-management arrangement, including the provision of:

- Administrative services
- Management services
- Medical director services
- Strategic/business planning
- Budget development and oversight
- Development of clinical standards and service protocols
- Development of physician and other clinical personnel credentialing standards
- Development of staffing levels
- Call coverage services

The co-management arrangement should be set forth in a contract that is compliant, balanced, comprehensive, and concise on rights and obligations with as many terms as possible established up front and not subject to future modification by the hospital. The terms of the agreement should not have any ability to negatively impact clinical judgment, and should not unduly shift risk to the radiologists. Radiology group employment contracts and independent contractor agreements need to coordinate with and support the obligations of their physicians under the arrangement—primarily the duties and responsibilities provisions, the compensation provisions, and the termination/remedies provisions.

For employment arrangements, the compensation policies must be kept consistent within a service line and across service lines, and must include specific objectives. Transparency is critical, and compensation must include a quality-driven, variable component and show meaningful variation based on relative performance. Lower compensation should not be the only consequence of non-compliance; other remedies and consequences will be included.

As part of clinical integration, data should be collected and measured on protocols, utilization, patient scheduling, patient quality perceptions, and patient and physician workflow. The data must be transparent and shared in an efficient and accessible manner. The medical staff and administration must cooperate in the development of strategic objectives and the development of the legal, clinical, operational, and financial framework. Changes should be implemented in reaction to the data, and quality improvements and cost reductions should be visibly demonstrated to colleagues, partners, and payors.

In financial relationships between hospitals and physicians, IRS requirements, Stark and the anti-kickback laws and regulations require that compensation be consistent with fair market value (FMV) and be commercially reasonable. It is critical that the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals. There are different methods used to reach a fair market

value determination, and an independent valuation can determine the best approach for the specific arrangement.

The contracting process starts with an end in mind that has been specifically defined, then the terms are refined and agreed to. Contracts need to support the arrangements and their objectives while at the same time protecting the respective interests of the parties. Process, time frame, deliverables, and responsibilities should be set in advance and must be framed by balance and mutual respect. Unilateral imposition of terms or aggressive negotiations would be inconsistent with collaboration and clinical integration. The contract should also include a process for regular communications and meetings among the parties. Organized intraparty communications involving a multidisciplinary team (so all key stakeholders participate) are critical to the success of a co-management arrangement.

Clinical integration between hospitals and physicians provides the opportunity to collaborate and coordinate patient care, manage quality, and respond to market forces in healthcare. Independent physicians and ancillary service providers must become a conspicuous presence within their healthcare system. They need to proactively pursue

opportunities to meet with hospital administration, let healthcare systems know that they want to work on a new alignment model, and provide management that assists with the design and implementation of a high-quality, low-cost clinical program that functions system wide. ■



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