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# Hospital Review

**BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP**

June 2011 • Vol. 2011 No. 5

## 13 Legal Issues for Hospitals and Health Systems

By Leigh Page and Rachel Fields

Here are 13 legal issues affecting hospitals and health systems in 2011.

**1. Lawsuits against the mandate to buy health insurance.**

Since Congress is unlikely to repeal healthcare reform in the face of President Obama's veto, any repeal in the next two years would have

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## Private Equity Funds Are Changing the Face of U.S. Hospitals

By Leigh Page

Private equity funds roared into many hospital executives' consciousness last year with two huge purchases of non-profit hospitals, and they are continuing to make their presence felt.

The private equity fund Cerberus Capital Management bought Cari-tas Christi in Boston for \$900 million and Vanguard Health Systems bought Detroit Medical Center for \$1.5 billion, backed by two large funds, Blackstone Group and Morgan Stanley Capital Partners.

Then in March of this year, HCA's initial public offering, backed by KKR &amp; Co., Bain Capital and Bank of America, became the biggest private equity-backed offering ever, raising about \$3.79 billion.

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## As Denials Rise, Hospitals Working Harder to Fend Off RACs

By Leigh Page

With Medicare recovery audit contractors racking up more claims denials, hospitals are being forced to put more time and energy into improving their claims-processing track record.

It was a relatively easy 2010, but "hospitals will be stretched for resources in 2011," says Dennis Jones, director of compliance services for CBIZ KA Consulting Services, based in East Windsor, N.J. "It's going to be really tough."

## RAC activity 'about to explode'

Though RACs started their work 18 months ago, they made more than half of their recoveries just from January to March of this year, according to a recent report from CMS. Of a total of \$313.2 million collected since the permanent RAC program started in Oct. 2009, \$162 million was collected in the last three-month period, CMS reported.

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# 13 Key Questions for Hospital-Physician Relationships — Assessing Legal Compliance

By Scott Becker, JD, CPA, and Molly Gamble

Hospitals pursuing financial relationships with physicians must be focused on legal compliance. The following 13 questions can be used as barometers to help assess legal compliance from a Stark Act, Antikickback and Tax Exempt entity perspective. The core laws apply whether the physician is to be employed, co-managed or integrated with the hospital through other affiliation models.

1. Is the relationship truly needed? E.g., is a medical director necessary for the position? What value will this position add? Has the position been manufactured as an excuse to provide compensation to physicians?

2. Is the position and payment wholly unrelated to referrals or the intent to retain business? If any one purpose of a payment is in exchange for referrals, it can be deemed unlawful.

3. How comparable is the position to other positions in the hospital when it comes to specialties of lower financial value? I.e., is a position only funded because it relates to high value or volume specialties?

4. How comparable is the position to those at competing hospitals?

5. Is the payment fair market value? If so, what evidence supports this? Is there a third party valuation or objective, external evidence to defend this value?

6. Has the relationship between the hospital and the physician been approved by internal parties who are unrelated to the outside parties involved? I.e., is the physician who will receive such payment not part of the committee or board receiving such payment?

7. Does the relationship meet a Stark Act exception and an Antikickback safe harbor? If a non-employment arrangement, is the relationship set to pay a fixed aggregate amount per year and not vary per the year? Many safe harbors require that aggregate payments be set in advance.

8. Can a rebuttable presumption under the Internal Revenue Code be obtained that the relationship doesn't create private inurement or excess benefit?

9. Has the hospital's compliance officer, or legal counsel, approved the relationship?

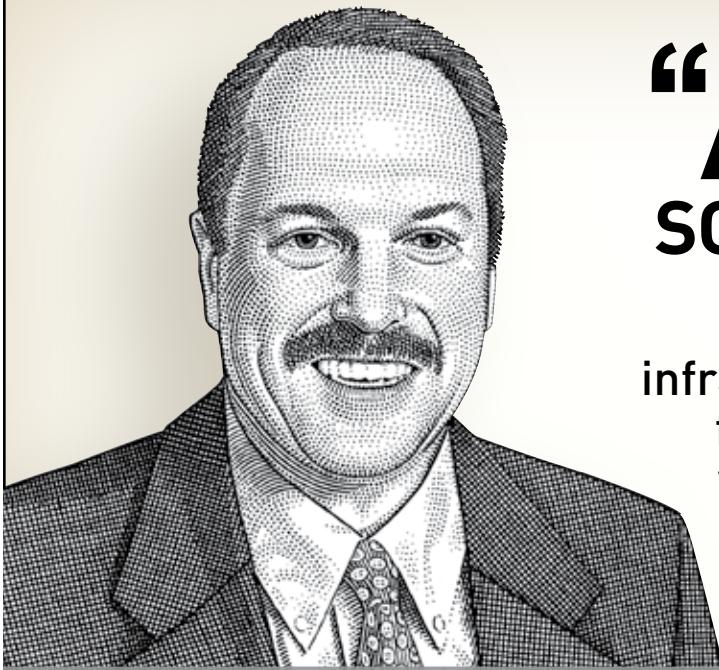
10. Is there a contracting file with legal and valuation approval? Has there been a comprehensive and detailed review of legal concerns?

11. Will the relationship be viewed in the context of an organization that has a culture of compliance?

12. Is there a short memo that supports the true need for the relationship?

13. Can this relationship be considered standard for the system, or is it highly creative and unusual?

These are a number of the questions that ought be asked about each financial relationship. For more information, please call Scott Becker, JD, CPA at (312) 750-6016 or email him at sbecker@mcguirewoods.com. ■



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## **As Denials Rise, Hospitals Working Harder to Fend Off RACs (continued from page 1)**

Part of the reason collections are rising is that appeals of RAC decisions at the initial stage of the program are now running out, says Elizabeth Lamkin, CEO of Pace Healthcare Consulting in Hilton Head, S.C. But another reason, she says, is that RACs are switching from automated reviews, which glean relatively small amounts of money, to comprehensive reviews, which are thirteen times more expensive. The latest RACTrac survey by the American Hospital Association valued automated denials at \$399 per claim and complex denials at \$5,281 per claim.

Now that RACs are fully launched and all their systems are in place, "volume of recoveries is about to explode," Ms. Lamkin predicts. "They have all their systems in place now and I think they're going to escalate all of their reviews."

CMS reported that two of the top issues for RACs so far have been "Ventilator Support for 96-plus hours" and "Extensive Operating Room Procedure Unrelated to Principal Diagnosis." RACs are now moving to probing the medical necessity of an admission or procedure. If they can deny the medical necessity, the dollar value of the case goes from the full amount to zero.

### **Hospitals are summoning up resources**

With more volume and more money on the line, hospitals are summoning up resources to take on the RACs. Half of hospitals reporting to the latest RACTrac survey said administrative costs have increased due to RACs and nearly a quarter reported hiring a utilization management company or other consultant to improve billing compliance. A recent survey of healthcare compliance professionals by Compliance 360 showed the same trend, with 40 percent saying their budgets were increasing in 2011, partly due to stepped-up activity by RACs.

RACTrac reported that \$1.7 billion in Medicare payments was targeted for medical record requests through the fourth quarter of 2010. "The volume of claims and coding for Medicare alone is just unbelievable," says Gloryanne Bryant, regional managing director of HIM and co-chair of the RAC Committee for Kaiser Northern California. "With these levels, how can providers not make mistakes?" Therefore, hospitals have to be all the more careful in how they handle claims, she says.

### **RACs are here to stay, and grow**

RACs are likely to be a permanent fixture for hospitals and get even more intensive in the coming years. At a time when federal debts are expected to stretch into the long-term future, RACs provide a welcome source of new income.

CMS has been loosening the reins on RACs to enhance their money-collecting abilities. For hospitals with more than \$100 million in Medicare payments per year, CMS recently raised the number of medical records RACs could request from 300 to 500 in a 45-day period. The agency also recently stated that RACs could review the same claim for multiple problems, contradicting many providers' assumptions of the rules.

Now a new wave of RACs is on the way. The healthcare reform law authorizes new RACs for Medicaid and for Medicare Part C payments for Medicare Advantage plans. Medicaid RACs were supposed to start in each state on April 1, but in February CMS postponed the start-up date so it could discuss details with state Medicaid offices further. The agency will announce the new implementation date when it publishes a final rule for Medicaid RACs later this year. There is also no start-up date for Part C RACs. Even the proposed rules for Medicare Advantage RACs are not expected for several more months.

In addition, RACs may soon be passing their findings on to other government agencies.

In a 2010 finding, the HHS Office of the Inspector General urged CMS to report hospitals with significant RAC collections to Medicare fiscal intermediaries. The reasoning was improper payments could be stopped before they are made, rather than the more expensive route of "pay and chase," said Mr. Jones, director compliance services for CBIZ KA Consulting Services, based in East Windsor, N.J.

The OIG is also urging CMS to report hospitals with significant RAC collections to the Department of Justice. "CMS wanted to move these hospitals to an education track, but the OIG wanted more," Mr. Jones said. Growing pressures to collect more income for federal agencies may force CMS to do this. More money is at stake because the Justice Department has a much longer lookback period than RACs have to recoup money from hospitals, Mr. Jones said.

### **Keep up on new issues**

Not getting dinged by a RAC means closely monitoring postings of new issues on its website. Under federal rules, before a RAC can pursue a certain issue, it has to explain its strategy and win approval from CMS. Then it posts the issue on its website. But hospitals have been finding that it is difficult to track approved issues on the RAC website. For example, some RACs do not post issues in chronological order, says Jennifer Colagiovanni, an attorney at Wachler & Associates in Royal Oak, Mich. And when a RAC updates an issue, it may simply rewrite the text without indicating the text has been changed, she says.

Connolly Consulting, known as the most aggressive RAC and the one that other RACs often emulate, has been posting hundreds of new issues on its website. Connolly, which covers Region C, mostly in the South, posted 35 new issues in September, 77 new issues in January and an omnibus issue in March that dealt with 309 MS-DRGs and 141 ICD-9 diagnosis codes. Since the postings frequently refer to ICD-9 codes, it takes some detective work to figure out what DRGs might be involved and precisely what the RAC is looking for in each DRG, says Ernie de los Santos, chief information officer for eduTrax.

"The RACs do not want to show you their hand," Mr. de los Santos says. "If they explained exactly what they are doing, hospitals would be prepared for them and they wouldn't make any money." He says RACs are essentially "bounty hunters," getting a contingency fee of 9-12 percent on any overpayments.

### **Learn how RACs think**

A good way to deal with RACs is to learn to think like them, says Paul Spencer, compliance officer for Fi-Med Management in Wauwatosa, Wis. "Ask yourself, 'If I were a RAC, what targets would you focus on?'" he says. RACs don't want to mess with hospitals that are highly compliant with claims and coding rules because they'll find little money to recoup. "When a RAC starts coming up with nothing at a particular hospital, it will move on to easier opportunities," Mr. Spencer says.

Put another way, RACs are always looking for easy prey, Mr. de los Santos says. In addition to focusing on big-ticket claims that can offer a big payout, they look for claims that have greater chances of being denied, such as a claim linked to only one ICD-9 code. "All the RAC has to do is knock down that one code and it might be able to get the whole payment denied," he says.

### **Basic ways to protect against RACs**

Ms. Lamkin says the chief way to protect against RACs is to move resources from the back of the operation to the front. That is, instead of waiting until the claim is sent out, carry out concurrent monitoring at the hospital admissions department, in case management and in the medical records department, she says.

The case manager examines charts and works with physicians and, if the hospital has one, the physician advisor. "The case manager keeps his eyes

on the admitting physicians and bed placement," Ms. Lamkin says. "You have to have a gatekeeper because you have to act quickly." The hospital has only 24 hours after admission to change a patient's billing status.

Hospitals should also appeal RAC determinations. "Any healthcare provider who feels that they have grounds for a RAC appeal should file an appeal," Mr. Spencer says, noting that the RAC Demonstration Project yielded a successful provider appeal rate of 64.4 percent, which is impressive.

One of the most basic ways to protect against RACs is to make sure physicians adequately document charges in the medical record, says Leo Paul D'Orazio, who directs the Healthcare Services Group in the New Brunswick, N.J., office of WithumSmith+Brown. "Hospital claims are based on medical records created by physicians, but since physicians are under a different reimbursement system, they do not have a direct financial incentive to help hospitals with RAC demands," he says. ■

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## **Private Equity Funds Are Changing the Face of U.S. Hospitals (continued from page 1)**

Private equity funds appear to be in acquisition mode. Seattle-based Pitchbook reported in its annual Private Equity Fund Breakdown that “one of the more notable trends that developed during the year was an increase in appetite for larger deals, which was driven by the increased availability of leverage.”

These funds are developing a strong interest in the healthcare sector, including hospitals. A Pepperdine University poll at the end of last year found that 11 percent of private equity executives polled said they planned to invest in healthcare, up from 4.8 percent in summer 2010. “There will be aggregation of existing hospital companies, diversification into outpatient sectors and more jostling among companies to pick up larger positions in local markets,” Scott Mackesy, a general partner with the private equity firm of Welsh Carson Anderson & Stowe, told the *Wall Street Journal* last year.

### **Conditions are ripe**

Private equity firms are jumping into the hospital arena because of a growing need for their money. Hospitals require funding to invest in IT and prepare for healthcare reform, but “traditional financing is harder to get,” says Trey Crabb, president of Health Strategy Partners in Nashville, Tenn. “Banks pulled back from loans in the credit crunch. Now, the most favorable terms are only available to the larger healthcare companies.”

In addition, “Hospitals are not performing as well as they used to, so it is harder for them to get the loans they need from the traditional sources,” says David O. Neighbours, a partner at Waud Capital Partners, a healthcare private equity firm in Chicago. “Hospitals that used to have 3 percent operating margins are now breaking even or losing money. When that happens, no one wants to lend you money.”

Well-managed hospitals, on the other hand, see an opportunity to buy distressed hospitals, but they first need the funds to do so. “Without private equity, hospitals can’t get enough money to go out and buy other hospitals,” Mr. Neighbours says. “That’s why Vanguard needs Blackstone’s capital.”

Hospitals that might once have resisted for-profit takeovers are now rushing into the for-profits’ arms. In Dec. 2010, when Holy Cross Hospital in Chicago signed a definitive agreement to join Vanguard, Sister Immacula Wendt, representing the Roman Catholic order that owned Holy Cross, stated, “Vanguard’s stewardship will remove the financial clouds that have threatened the hospital’s future and our new partner will invest a significant amount in sorely needed infrastructure improvements.”

### **What private equity firms provide**

In return for pumping large sums of money into healthcare, private equity arrangements demand a higher rate of return than can be found in more traditional investments like the stock market. In addition to their fees, PE firms keep 20 percent of the proceeds. That means fund managers have to

ensure significant profits. These can be found in struggling hospitals where there is a great opportunity to make money in a turnaround.

Private equity investments are typically committed for a 10-year period, in which the firms have six years to use the committed funds, called a “use it or lose it” provision. Private equity investors are “a fairly patient lot,” says Adley Bowden, managing editor of Pitchbook. “They go for the long haul.”

They are patient but also daring. “They’re not afraid of doing turnarounds and jumping into underserved areas,” says Linda Klute, national healthcare practice leader at Tatum, an executive services firm in Atlanta. They even have the temerity to go after bankrupt hospitals. For example, IASSIS Healthcare, backed by TPG Capital, JLL Partners and Trimaran Fund Management, recently agreed to buy a majority stake in St. Joseph Medical Center in Houston, as part of Chapter 7 bankruptcy of the hospital’s majority owner.

“When the private equity funds take up a struggling hospital, their aim is to add value to it,” Mr. Bowden says. “They are going to make a great deal of money with hospitals that do well.” The key, of course, is to improve efficiency. “The firms go in there and improve revenue cycle, introduce process improvement, and launch a service line or product lines,” Mr. Burkhardt says.

An excellent management team is critical to making this work. Private equity firms are able to recruit the very best management in the business because they pay top dollar. “Without a private equity fund, do you think a hospital in bankruptcy would be able to hire a high-caliber management team?” Mr. Neighbours says. “These firms are bringing in a whole different system of accountability.”

### **Partnering with non-profits**

Private equity is not just available to for-profit companies, but can also be tapped into by large non-profit systems. In February, for example, Ascension Health formed a joint venture with Oak Hill Capital Partners with the expressed goal of buying Catholic hospitals so that they would not be sold to for-profit organizations.

Sensitive to non-profit hospitals’ resistance to for-profit takeovers, some private equity companies are allowing hospitals to keep their management and governance in place. For example, LHP Hospital Group, backed by CCMP Capital Advisors and Canada Pension Plan Investment Board, recently entered into a joint venture with Saint Mary’s Hospital in Waterbury, Conn., valued at \$135 million. LHP is the majority owner but the governance structure will be equally shared and local control and hospital leadership of the hospital are protected.

Mr. Neighbours says in such an arrangement, the hospital’s management team would have to be well regarded for the private equity firm to agree to keeping it on. He adds that hospitals in such deals may be doing relatively well but may need extra cash for projects like acquiring other facilities or putting in an electronic health record.

### **Turning into permanent companies**

The effect of the current huge infusion of private equity funding will be to create new, mostly for-profit hospital systems. On a set date, private equity funds want their money back, requiring the hospital company to raise the funds needed to pay them. If they have been turned around, it will be easier to borrow the funds or raise money in the stock market. This switchover will eventually impact systems with large private equity backing like Vanguard or RegionalCare, a Brentwood, Tenn.-based system that was formed by a \$300 million infusion from the private equity firm of Warburg Pincus in 2009.

Private equity has the opportunity to do “a whole lot of good” for U.S. hospitals, Mr. Neighbours says. The work that such funds put in is “not a quick flip,” he says. “They will be improving the profitability of the hospital. They will make it better for patients, the doctors and the community. Without private equity, many of these hospitals would have had to close.” ■

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# Overcoming Healthcare's Most Pressing Challenges: Q&A With Methodist Health System CEO Stephen Mansfield

By Rachel Fields

**S**tephen Mansfield, PhD, FACHE, president and CEO of Methodist Health System in Dallas, discusses his outlook on healthcare for the next several years, including the need to improve access, the process of integrating independent physicians and the American expectations that are crippling hospitals.

**Q: What do you see as the top challenges for your hospital over the next few years?**

**Stephen Mansfield:** I think the big challenge that I see is continuing to improve quality while taking cost out of the system and trying to maintain access. To me, that's the ultimate conundrum for healthcare, because historically, the thought has been that you could do any two of those but not all three. In other words, you could improve quality and lower cost, but the only way to do it was to deny access or have rationing. Or you could lower cost and have access, but in that scenario, the quality suffers. But that's the pressure we're under — to try and deliver on all three of those metrics: better quality, better value and sufficient access.

I would also say hospitals are wrestling with how they best align their resources in order to perform well under healthcare reform metrics. That can translate to different imperatives for different people, depending on where you are. If you're behind the curve on IT, that means committing a lot of capital to information technology over the next few years. It may mean growing the size and scale of your physician enterprise, if you need that in your market and can't figure out how to get your ACO strategy to work without it. For us, we are in Texas, and I think because commercial reimbursement for physicians has been a little higher here than it is in some parts of the country, we have a lot of physicians who are still independent and in very small groups. We have very few large groups in primary care or specialties. [This requires] figuring out how you integrate with those independent physicians in a meaningful way to increase quality and decrease cost. It's not going to be the same in every market, or even within one market. We've got to find a way to align with independent physicians because in Dallas, 85-90 percent of physicians are unaffiliated with an IPA or health system.

**Q: That number is surprisingly high, considering all the talk about hospital employment. Are you promoting hospital**

**employment to those independent physicians, or do you think it's more practical to assume they will stay independent?**

**SM:** We've shifted our focus recently. My position is that the independent physician model is one of the greatest entrepreneurial success stories in American history. As long as physicians can make that work for them, I like that. I think it's good for patient care and good for them in many respects. We're saying, "We want you to remain independent, but if you get to a point where you just can't anymore, we can provide MSO services that take the headache out of running an office practice away but still leaves you independent. We can also do an employment arrangement."

We've shifted to a belief that we need more scale in our physician enterprise. To effectively accomplish the ACO project well and the medical home project well, we are more proactively approaching physicians to ask, "Would you like us to talk to you about what employment or alignment might look like?" We don't want to wake up some morning and read that a competitor has aligned with a physician group we've had a long-standing relationship with, and when we talk to them, they say, "You never talked to me." We're shifting to educating physicians about the model and encouraging primary care physicians to consider it.

**Q: Assuming the majority of that 90 percent want to remain independent, how do you accomplish integration without employment?**

**SM:** There are two groups that are not employed that are critical to the hospital, and I think you have to approach those differently. There's the group that are not employed but are in the hospital every day, and they're very involved with the hospital. Those are largely your specialists — your neurosurgeons, cardiologists, gastroenterologists, etc., who still do a lot of work at the hospital.

[First, let's discuss] the harder group. With the advent of hospitalists, more and more primary care physicians, family practice and pediatrics and internal medicine physicians just don't come to the hospital anymore. Many of them don't even have privileges at the hospital anymore. They don't attend your medical staff meetings, aren't part of your committee structure and communicating with them requires a whole extra level of effort. Each hospital [in the Methodist Health System] has a program whereby they call on their primary care physicians periodically just to make sure we



are providing them with what they need. That takes a lot of time. It's kind of guerilla tactics, but it's a growing group that no longer has to have a practice at the hospital in order to have a viable outpatient practice and communicating with them requires a different approach.

Going back to specialists that do work at the hospital, we're in the early stages of working with them on a clinical integration program that would allow us to share resources with them, even though they're independent, around our success in implementing best practices and care pathways. Those are things that take cost out of the system and elevate quality. If we meet both of those metrics, there's a financial incentive for doing so for those physicians. The biggest changes in trying to put together those structures in an intuitive way is the healthcare laws that have not been rolled back to be integrated into ACO models.

**Q: How do you ensure your independent physicians know about and are following standardized practices, which are an important part of ACO models?**

**SM:** We try to do it through our independent medical staff structure. We're fortunate that we have great doctors and really outstanding leadership on our medical staff. That's why I'm a proponent of clinical integration: We've got to figure out a way to compensate physicians for time they spend out of the office or surgical practice working with you to implement and ensure there's compliance with best practice protocols. We've done that through voluntary effort

of medical staff up to this point. If we're going to take that to full implementation, we've got to have a structure that compensates them.

It [also] has to be physician-led. I think the health system can do a lot to manage the menial aspects of that work, but the thought leadership has really got to come from your medical staff. First they must convince themselves that there is a best practice, and then you begin systematically taking variation from that best practice out of your system. It's a little harder if you don't have your physicians in some kind of clinical integration.

#### **Q: Where is your hospital in terms of EHR and IT implementation?**

**SM:** Well, I've only been with Methodist for four and a half years, and when I arrived, they were ahead of the curve nationally in terms of implementation of EHR. We've employed a systematic approach, and in fact, we're rolling out computerized physician order entry next week in our emergency rooms. The challenge with that is there's a massive learning curve. Because we've been on EHR inside the hospital for some time, we're being impacted now [as we implement outside the hospital]. As we're automating office practice for physicians in our employed network as well as independent physicians, they are saying it affects productivity negatively. Physicians may be able to see 90 percent of the patients they saw before. We need more productivity, not less.

We're seeing the efficiency of the billing process is better, and you do take cost out of the system through EHR just by eliminating charts [and] the person who spends their time trying to find charts. There is a savings there, but in actual physician time, it pinches the cost savings a lot through the learning curve. We're debating on when you start to use scribes to help physicians with that component of their office. The challenge is that every physician's office has some nuances of difference in the ways they do their paperwork. When you take them and put them on an automated system, it allows for little varia-

tion in the way it's used. You have to change the way you think and the way you document and the way you code to its methodology and algorithms. It just takes some time. Clearly the use of IT in healthcare is a must, but getting from here to there is very expensive from a capital standpoint and very impactful to physician productivity. On the front end, you have to acknowledge it will have an impact and build systems for physicians during that transition.

#### **Q: We've talked a lot about capital and spending — it seems that many initiatives in healthcare at the moment are draining hospital profits. How do you cut costs to offset those expenses?**

**SM:** Methodist is a health system that has a pretty good cost structure, and we have to because we're in an area with more uninsured patients than most health systems have and have been forced to run lean to compensate. For years, it's been a cultural element of Methodist that we'll try and do more with less than most systems do. We have a management group that manages resources extremely well, but you can only do so much with that. There has to be something else, and I think the real opportunity is how you align and integrate with medical staff so they can help you intuitively reduce cost. The Institute of Medicine believes that 30 percent of what is spent in a hospital adds no additional clinical value to the patient. You have to get at that through integrating with medical staff and ensuring that everything they do on the care pathway is adding clinical value.

I also really believe that for hospitals to get at their cost structure, they have to create systems that identify and treat chronically ill patients differently from acutely ill patients. Our system currently treats the chronically and acutely ill basically the same and because of that, the cost associated with treating chronically ill patients has escalated across the healthcare system. Chronically ill patients require much more longitudinal coordination, and most chronically ill patients end up in the hospital because they are not managed well

outside the hospital. That has to change, because 75 percent of our cost is related to the treatment of patients with 5-6 chronic conditions.

[Methodist] buys healthcare for employees to the tune of \$40 million a year, and we found that within our own employee group, 12 percent of our employees and dependents are driving 88 percent of our cost. We're trying to get those individuals in a different care setting and on a benefit plan that works for them. Beginning with our own employees, we're doing what has to happen at a macro level by treating chronically ill patients differently than those who have acute illness.

#### **Q: Any last thoughts before we wrap up?**

**SM:** At the end of the day, in my view, healthcare reform is largely about insurance reform and secondarily about delivery reform. We currently treat patients who are already ill and we're trying to figure out the best way to treat someone who's ill. That has to shift to a prevention/wellness focus. In my view, President Obama ... missed an opportunity during the healthcare reform debate to say, "We are unhealthy as a nation, and we're doing it to ourselves through diet and lack of exercise. We're going to be the healthiest health system on the globe by 2020 and here is how we are going to get there."

It's important to create some kind of momentum around personal accountability for health. If Methodist Health System is responsible for the health of the population around us, and the population has no accountability for their health, we will not be successful. We have to shift our focus to a focus that's further upstream. That probably starts with children: We are producing a generation of obese kids with the highest incidence of diabetes we've ever had. It's like our ancestors used to say: "An ounce of prevention is worth a pound of cure." The cost of prevention is minuscule; the cost of treatment is enormous. We've got to get Americans focused on individual accountability of health. ■

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# Creating a Growth-Oriented Hospital: Q&A With Mark Newton, CEO of Chicago's Swedish Covenant Hospital

By Lindsey Dunn

**M**ark Newton has been CEO of Swedish Covenant Hospital for 11 years, during which he helped the independent hospital grow into the largest academic community hospital on Chicago's North Side. Known for his entrepreneurial attitude in what can be a very bureaucratic industry, Mr. Newton held management roles outside of the hospital sector before he joined Swedish. At the height of the recession, Mr. Newton had to ask employees to withhold their pay increases, promising to repay the lost wages once the hospital was on improved financial footing. In April of last year, he made good on that promise, paying out \$1.5 million to employees. And in the last eight months, he has helped the hospital launch the Chicago Back Institute, a Genomics Medicine Institute and a combined medical office building and ambulatory surgery center in partnership with physicians. Here, he discusses his successes at Swedish Covenant and how he plans to lead the hospital into a new era of healthcare.

**Q: Swedish Covenant has a fairly strong market share in the very competitive Chicago market and remains an independent hospital in a time when many independents are struggling. What gives Swedish its edge?**

**MN:** I've always nurtured and focused on a growth agenda with an aggressive timeframe. Other industries have the ability to transform their service and market approach fairly rapidly, but hospitals generally take much longer to transform themselves. What we've always been focused on is trying to undertake transformation at a much faster pace than what is perhaps the industry norm. To remain an independent hospital going forward, we must continue to grow by transforming, capturing new market opportunities and being an innovative thinker in the market.

**Q: In terms of implementation, how were you able to transform Swedish Covenant into a hospital focused on aggressive growth?**

**MN:** It's really centered in the management systems. [Swedish Covenant] is structured on a service-model or service-line basis. These systems are imported from manufacturing and other companies that view their enterprises in terms of product and service lines. We aim to be service-line leaders in all clinical areas. As an independent hospital, you really can't thrive on just one or two strong service lines. We have about 15, which is due to a large extent through the management systems we use.

This is an industry that's constantly reinventing itself, and we're in a geographical market that is very fluid as well, so to be successful we must be flexible and able to quickly adapt to meet the demands. The focus must maintain centered on providing the best patient experience and growing by taking calculated risks and making smart investments — and making the best of opportunities as they arise.

I've also worked to foster this type of thinking among employees to create a culture of innovation throughout the organization. For example, I ask that all service line managers run their service line as their own business — they are the day-to-day experts in their area and therefore they are in a position to determine areas for growth and areas where improved efficiencies can be realized. Any manager can come forward with a business plan for a new program or technology, and their proposal is reviewed by a committee based on qualitative and quantitative criteria.

This type of thinking is not only encouraged among managers, but among all employees: Through monthly e-mail messages, employee open forums

and regular communications, I ask all employees to think outside their daily roles to consider new ways to improve the patient experience or improve the way tasks are accomplished at the hospital.

This approach instills a sense of ownership and freedom that brings about entrepreneurial ideas, which our executive team then supports with the necessary resources as appropriate. There are numerous examples of how such unique ideas have truly made a difference, and I believe this is one way Swedish Covenant has set itself apart and been able to grow and transform over the past decade.

**Q: Swedish Covenant recently launched the Chicago Back Institute and the Genomics Medicine Institute and also recently gained approval for a ambulatory surgery center and medical office building. What was the strategy behind these recent projects?**

**MN:** All three are representative of strategies to get ahead of a transforming market and where the consumer is going. Minimally invasive approaches to back care is increasingly gaining consumer attention, as is genomics. An ASC itself isn't a novel thing, but it's part of a strategy to align physicians as well as to open up space in our main OR, which is currently congested from increased volumes in our neuro and robotic surgery lines.

We want to lean toward change instead of falling away from it or just waiting for it to happen. As a community hospital we are rare in our ability to provide many of the advanced clinical services, renowned physicians and high quality care that can be found at academic medical centers. We strive to provide this level of care, paired with our patient-centered focus, to give our patients everything they need under one roof, right here in their community.

In addition to these service line and campus expansions, we've also recently invested in several new technologies — including the latest generation of da Vinci robotic surgery technology and the newest Siemens CT scanner — to further enhance our abilities to provide advanced clinical services. Our clinical expertise has been recognized through various achievements in the past year, including Magnet recognition for nursing excellence, Chest Pain Center Accreditation from the Society of Chest Pain Centers, and recognition as a Distinguished Hospital for Clinical Excellence by HealthGrades — placing us in the top 5 percent of hospitals in the nation for clinical performance.

Other growth strategies we've implemented include expanding our medical residency program and strengthening our partnership with our affiliated medical fitness center, the Galter LifeCenter, to further integrate our services. These efforts are especially important as the healthcare system moves toward an increased focus on wellness and prevention and the concept of bundled services.

Lastly, with an eye toward meaningful use and healthcare reform, we continue to invest in electronic medical records technology. We have been recognized as national leaders in implementing EMR and have achieved HIMSS Stage 6, placing us in the top 3 percent of hospitals in the U.S. for healthcare informatics. We recognize the important role EMR technology will continue to play in healthcare, and we plan to stay ahead of the curve.



**Q: What do you think will be the biggest challenge for the hospital this year or in the next few years? How will you confront it?**

**MN:** I think the biggest challenge is trying to understand not just hospital involvement, but individual involvement, in healthcare reform. I'm trying to look at healthcare reform from the vantage point not just of the hospital but also of the average person on the street. How are they going to seek care and get coverage? How will consumer behavior in response to reform play out? The answers to these questions will drive the nature of the delivery systems we put in place. Our plan is to remain very flexible, allowing us to participate in multiple types of delivery systems. Some hospitals are vertically integrated — they want to control every piece of the delivery system. While that is one approach, our response as an independent hospital is that we need to cater to individual physician needs and maintain a high degree of flexibility to adapt to how doctors and patients want to relate to hospitals.

**Q: Healthcare reform has brought about many changes for hospitals, and one that has been making headlines recently is the accountable care organization. Does Swedish have any plans to develop or join an ACO?**

**MN:** We have to maintain a lot of flexibility. We're at a point where we have a PHO (physician-hospital organization) already in place, and we already accept capitated payments, assuming financial risk. We have these structures in place and can build upon them. There are a number of questions about how ACOs will work — how will consumers be assigned? Will they be informed of their assignments? Who will tell them? People travel, people move. How do we keep them within the ACO?

Personally, I am more excited about growing the use of bundled payments for episodes of care. [Under these payments], hospital and physicians have an incentive to lower cost and improve quality of care. Delivery systems will need to understand the implications though, such as the importance of bringing physicians to the table for bundled payment. There are also implications for patients. The nature of these payments reduce consumer choice.

**Q: You entrepreneurial attitude is somewhat unique for the hospital industry. What made you realize you wanted to enter healthcare administration?**

**MN:** What I find most rewarding about healthcare is that the people I'm privileged to work with are here because they have a fundamental drive to help people, not to increase stock price. That is a very powerful motivator, but it has to be balanced with business intelligence. Many people who work in healthcare have not worked in a corporate environment, and because of this, risk-taking, conflict resolution and accountability to meet performance goals are often management challenges for hospitals. If you put in place a leadership team that is focused on the hospital's mission but has additional skills in these areas, it is very exciting. That for me is the most rewarding part.

I would also say that running a hospital is the most complex management task of any industry I've had exposure to. One might argue that a \$1 billion corporate enterprise is more complicated, but that's really a matter of scale, rather than a matter of complexity. For example, in the airline industry there are maybe three key standards of success, but what's the standard of success for hospitals? There are many.

**Q: Throughout your career what has been the most important thing you've learned about leading a hospital successfully?**

**MN:** You really have to in some extent be a judge. You have to have the ability to look at two different perspectives and come up with a resolution that's fair. This is an environment where there are many countervailing trends and motivations. You really have to have the ability to look at a situation and determine "what is the right thing to do?" This has kind of been a guiding force for me. If you're doing the right thing, it requires sacrifice and compromise but that is part of running a hospital with a sense of mission.

**Q: Any other advice to impart to others on how to be a successful hospital leader?**

**MN:** One of the things I've learned is you have to have a culture of transparency in the organization. If I create a culture of transparency and involvement that means leaders have to check their egos at the door. I encourage employees to call me by my first name, and myself and all hospital executives make rounds throughout the hospital regularly.

What we're really trying to do here [at Swedish Covenant] is grow on multiple levels. And you need transparency and accountability to create a growth-oriented organization. ■

## The Challenge of Non-Profit Status in an Era of Accountable Care

By Steve Ronstrom, CEO, Western Wisconsin Division of Hospital Sisters Health System

**N**on-profit hospitals like my own now face a more skeptical regulatory environment, challenging whether we give back enough to our communities to justify our tax-free status. While some of the criticisms of non-profits have been unfair, this is basically a healthy trend. It reaffirms our age-old commitment to care for the poor and support of the community. It brings us back to our roots.

Many of our institutions were founded in the 19th century by Catholic and other religious groups who cared for the poor and were deeply committed to their communities. There are stories of Catholic sisters arriving in frontier towns with just a few dollars in their pockets and

founding a rough-hewn hospital soon crowded with the poor. These hospitals are now sprawling behemoths worth hundreds of millions of dollars, but their connection to the original mission has frayed a little.

### How we got here

In the mid-1950s, the IRS recognized the charity mission of non-profit hospitals as an explanation for not paying taxes. To qualify for a 501(c)(3) tax exemption, the hospital had to be "operated to the extent of its financial ability for those not able to pay for the services rendered," the agency stated. That meant providing free care for the poor, but when Medicare and Medicaid came along in 1965, many of those patients



were now paid for, reducing non-profits' obligations to the poor. The two new federal programs also began doling out disproportionate share hospital payments to all hospitals in exchange for providing charity care, which helped narrow the difference between non-profit and for-profit hospitals.

To reflect these changing circumstances, the IRS in 1969 formalized a new way for non-profits to earn their tax-exempt status. They were required to provide community benefits such as running clinics, providing other services and educating physicians and other healthcare personnel. However, there was very little enforcement of this requirement.

Then came the rise of large, investor-owned hospital systems. These organizations applied business principles, focused on making profits, that many non-profit hospitals adopted as well. I don't want to disparage that aim, because it has helped make the entire healthcare industry more efficient, but it is certainly a different aim from treating the poor and serving the community. Non-profits took on many of the practices of the for-profits, such as investing in expensive service lines to make money, instituting revenue cycle management and selling patient debts to collection agencies. Reports began circulating of some non-profit hospitals charging uninsured patients higher rates than the insured and aggressively pursuing patients who didn't pay.

### Tightened obligations

Many people began to feel that non-profit hospitals had strayed from their mission and values. This led to a backlash against non-profit hospitals in Congress, federal agencies and the courts. In late 2007, the IRS rewrote the Form 990 for tax-exempt organizations and added Schedule H, where tax-exempt hospitals now have to report the total amount of charity care and community benefits they provide.

In 2009, Sen. Chuck Grassley (R-Iowa) called for legislation to clarify requirements for hospitals' tax-exempt status. Many of Sen. Grassley's provisions ended up in the healthcare reform law. Starting in March 2012, non-profit hospitals must conduct a community health needs assessment every three years. Those that don't comply may have to pay a \$50,000 fine and risk losing their tax-exempt status. Also, patients who are uninsured or on financial assistance cannot be charged more than levels for insured patients. And non-profits must make "reasonable efforts" to determine whether uninsured patients qualify for financial assistance before they can begin "extraordinary" collection practices, such as slapping liens on patients' homes.

On the local level, non-profits still are free from paying property taxes, but this could change. Even non-profits who don't give back anything to the community still have access to police, fire and other services, a situation that local governments, with their tax revenues shrinking, may want to change. In the future, there may be more cases like a local tax board's action against Provena Covenant Medical Center, a non-profit Catholic hospital in Urbana, Ill. The hospital lost its local tax exemption because it allegedly did not provide enough charity care, and in March 2010, the Illinois Supreme Court upheld the local board's decision.

Requiring non-profit hospitals to justify their tax-exempt status is basically a good thing, if done fairly. The recent government actions have resulted in more sharply defining the community benefit that non-profits have to provide. Many hospitals, such as my own, already leverage their resources to help the community. We host a free clinic and we bus patients there when it's cold. We also assist a medical group in running a large dental clinic. And we host several programs that do not have a direct connection to healthcare but aid the community, such as meals on wheels and an "adopt a family" program.

### Non-profits will find their own path

Despite all that has been said about non-profit hospitals becoming more like their for-profit counterparts, a lot of differences remain. I believe they will become more pronounced in the future. I'm not implying there's any-

thing bad about for-profit hospitals, but the non-profits will be taking a different route.

One big difference is the nature of management. At for-profits, management is beholden to the shareholders, while at the non-profits management is beholden to the community and the common good. Teaching and research, usually not a profitable service line, are almost entirely in the non-profit world. And while the amount of charity care does not differ that much between these two species of hospital, non-profit hospitals still tend to see more Medicaid patients and they also tend to have lower margins.

For religious-based non-profits, aiding the community also gets into the value of the Gospel. The first Beatitude in the New Testament states, "Blessed are the poor in spirit, for theirs is the kingdom of heaven." For-profit organizations have been buying up non-profit hospitals, even religion-based institutions. While the profit motive has a place in healthcare, we need to make sure that non-profit hospitals, with their dedication to the community and to service to the poor, remain a viable force in U.S. healthcare.

To this end, Ascension Health, the largest Catholic healthcare system in the country, is using private equity money — the same funding fueling the for-profits' acquisitions — to keep Catholic hospitals connected with their mission. In February, Ascension Health formed a joint venture with Oak Hill Capital Partners to buy Catholic hospitals so that they would not be sold to for-profit organizations.

The status of non-profit hospitals is going through many changes. I believe it is time for us to ask ourselves a number of questions. What is our responsibility as a kind of social services agency for the community? What is our responsibility to ourselves? And what accountability do we have? ■

*Stephen F. Ronstrom has more than 25 years of hospital leadership experience, having served for the past 12 years as an executive in the Hospital Sisters Health System. He is currently president and CEO of the Hospital Sisters' Western Wisconsin division, which comprises 344-bed Sacred Heart Hospital in Eau Claire and 193-bed St. Joseph's Hospital in Chippewa Falls.*

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### 13 Legal Issues for Hospitals and Health Systems (continued from page 1)

to come through the courts, and that prospect is becoming more likely. A federal judge in Florida became the first to reject the whole law, rather than just its highly unpopular mandate to buy insurance. He concluded the law is not “severable,” meaning if one part is removed, the rest would have to go, too. That’s a legal concept, but it is also an apt description of the interlocking nature of the law’s provisions. Keeping the popular protection for people with preexisting conditions, for example, requires that everyone have insurance. Without such a mandate, people would have no reason to buy coverage until they got sick.

The core case against the mandate rests on Constitutional law, which President Obama used to teach, but Constitutional law has some slippery concepts. The Commerce Clause grants Congress the authority to regulate “activities that substantially affect interstate commerce,” which courts have interpreted to mean Congress cannot regulate “inactivity.” Obama administration lawyers argue not buying insurance is an active decision, because if people without insurance get sick, they still need care and will crowd into EDs to get it for free. But the lawsuits — and there are about 20 of them, including the Florida case, which includes 26 states — insist that no matter what the administration says, not buying insurance is still “inactivity.” As of Jan. 17, 2011, lower courts that have heard these cases have come down on different sides regarding the mandate’s constitutionality, according to an article published in the Feb. 2011 edition of *AHLA Connections*. Those finding the new law constitutional include a Michigan District Court (*Thomas More Law Center v. Obama*) and a Virginia District Court (*Liberty University v. Geithner*). On the other side, a Virginia District Judge (*Commonwealth of Virginia v. Sebelius*) found that the individual mandate violates the Commerce Clause. As expected, Secretary Sebelius and the Obama administration disagree that the mandate is in violation of the Clause, arguing instead that Congress has the “constitutional authority to enact laws that are necessary and proper to achieve the goal of providing health services at a reasonable cost to those who cannot obtain or afford it under the current system,” according to the *AHLA* report.

Aside from potential issues with the Commerce Clause, the Obama Administration also argues it has the authority to tax individuals who decide not to purchase qualifying coverage. District Judge Henry Hudson, the Virginia District Judge who found the individual mandate in violation of the Clause, also rejected this argument. He found the “tax” imposed on individuals who chose not to purchase coverage is in fact a penalty, based on the use of the word “penalty” in the minimum essential coverage section of the statute. He argued that the distinction between a tax (intended to raise funds) and a penalty (intended to regulate behavior) is constitutionally meaningful, according to the *AHLA* report.

Everyone expects the Supreme Court to ultimately decide the issue, which could take as long as two years. The high court’s five-member conservative majority may well hold together. Rulings on these cases have been stubbornly partisan so far, with two Democrat-appointed judges in favor of the law and two Republican-appointed judges against it. Also, the Constitutional issue involves an expansion of federal authority, an issue that can get a conservative jurist’s blood boiling. Never before has Congress required purchase of a private good or service, wrote a Virginia judge ruling against the mandate. The Supreme Court could strike down the individual mandate or it could go all the way and repeal the whole law. The high court generally shies away from this, not wanting to be seen as usurping the powers of Congress. But the healthcare reform law could be an exception.

## 2. HIPAA and data breaches.

Breaches of electronic data have become a major problem, as more providers switch to electronic systems. In addition, interoperability of systems is expected to create yet more breaches, as information is traded between networks. Laptop theft is the most common type of data breach, account-

ing for 24 percent of reported breaches, according to HHS. Desktop computers were involved in 16 percent of breaches and portable devices such as smart phones were involved in 14 percent.

Almost all the states have developed their own data-breach laws. California enacted the first such law in 2003, and 46 states quickly followed. However, the laws vary on what counts as personal information, how notice of the breach has to be made and the amount of fines for noncompliance. In Nov. 2010, California levied a total of \$792,000 in fines against six hospitals and a nursing home for failing to prevent unauthorized access to confidential patient information.

In Sept. 2009, HHS implemented notification requirements for breaches of unsecured protected health information. Affected patients must be notified in writing within 60 days of discovering the breach, and if more than 500 people are impacted, local media outlets must be alerted, and the breach must be posted on the HHS website. If a breach affects fewer than 500 individuals, the provider can notify HHS on an annual basis. And if the data is encrypted in accordance with HHS guidances, an organization is exempt from notification because the information is unusable by unauthorized individuals.

On Feb. 23, 2011, HHS issued its first monetary fine for a privacy violation: \$4.3 million to Maryland-based Cignet Health. The notice followed a finding by HHS’ Office of Civil Rights that the health system failed to provide 41 patients with copies of their medical records. Cignet also allegedly failed to respond to requests from the Office for Information on the complaints. The second monetary fine followed the next day, as The General Hospital Corporation and Massachusetts General Physicians Organization, representing Massachusetts General Hospital in Boston, agreed to pay the U.S. government \$1 million to settle allegations that the hospital violated the HIPAA privacy rule. The allegations involved the loss of documents — a patient schedule containing names and medical record numbers for 192 patients, as well as billing encounter forms containing the name, date of birth, medical record number, health insurer and policy number, diagnosis and name of providers for 66 of those patients.

Cignet Health’s settlement underscores the necessity of cooperating with OCR investigations. In Cignet’s case, failure to cooperate with the agency’s investigation spurred a \$3 million fine — almost 70 percent of the total penalty.

## 3. Antitrust issues and ACOs.

Federal antitrust laws will likely have to be reinterpreted to make way for accountable care organizations. ACOs present a new legal problem because competing hospital systems would be able to come together and share pricing information, which could be viewed as “per se” illegal under Section One of the Sherman Act. The possibility that ACOs could be a means for hospitals to raise prices runs counter to the basic concept of ACOs, which is to bring hospitals together to lower prices, but it could happen.

CMS, which is currently drafting proposed regulations for ACOs, doesn’t have a direct concern with antitrust. Raising prices due to market dominance is not an issue for Medicare, because it sets prices unilaterally. However, private payors, who are beginning to create their own ACO-like relationships with hospitals and physicians, are exposed to market forces and have a strong interest in ensuring strong antitrust regulations for providers — even as insurers themselves enjoy wide exemptions from antitrust laws under the McCarran-Ferguson Act. The two federal antitrust agencies, the Federal Trade Commission and the Department of Justice’s Antitrust Division, also want to keep antitrust enforcement strong. These agencies, in separate branches of government from CMS, do not have a direct interest in making sure ACOs work. And yet the FTC and DOJ joined CMS last October in co-hosting a listening session to get feedback from stakeholders on how ACOs should be regulated.

As a basis for allowing ACOs to operate, antitrust lawyers cite a 1996 joint FTC-DOJ guidance on clinical integration. But it is not a perfect fit

and antitrust agencies are expected to provide more guidance. In a recent joint workshop held by the Federal Trade Commission, the Department of Health and Human Services Office of Inspector General and CMS, stakeholders raised concerns about existing antitrust laws, according to the *AHLA Connections* report. Some stakeholders suggested that without advice and support from antitrust agencies, ACOs — as well as other integration strategies — might pose an insurmountable risk for providers. The agencies have the option of setting up new “market power” safe harbor for ACOs, but more likely, they might provide recognition of allowable ACO activities. For example, the agencies might decide CMS’ designation of Medicare ACO status to competing providers is evidence they are committed to clinical integration and reducing costs, rather than creating an unlawful combination to raise prices.

#### **4. False claims and whistleblower suits.**

The False Claims Act is a federal law that covers fraud involving any federally funded contract or program, including Medicare or Medicaid, allowing healthcare providers to be prosecuted for various actions leading to the submission of a fraudulent claim. The primary activities that may constitute violations under the False Claims Act include:

- Knowingly presenting to the federal government a false or fraudulent claim for payment.
- Knowingly using a false record or statement to get a claim paid by the federal government.
- Conspiring with others to get a false or fraudulent claim paid by the federal government.

- Knowingly using a false record or statement to conceal, avoid or decrease an obligation to pay money or transmit property to the federal government.

The Patient Protection and Affordable Care Act will expand the government’s reach under the FCA with requirements aimed at enhancing fraud-fighting and increasing penalties for submitting false claims. Starting in 2012, physicians must return known overpayments to the government within 60 days of discovering an error.

Another issue affecting false claims is the empowerment of whistleblowers under reform. Under PPACA, whistleblowers may initiate false claims actions based on information publicly disclosed through federal criminal, civil and administrative proceedings in which the government or its agent is a party, as well as federal reports, hearings, audits or investigations. While state proceedings no longer qualify, following Congress’ revision of the statute to apply to only federal sources, news media reports are still considered public disclosure. In other words, a whistleblower no longer has to be the actual source of the information. Both critics and proponents say this measure will make it easier for whistleblowers to bring cases against healthcare organizations, though opinions differ on whether the increase in cases will help or hurt the industry. False Claims Act investigations of hospitals have come under fire recently from the American Hospital Association. In a letter to the Committee on Oversight and Government Reform, the AHA said, “The Department of Justice and certain Assistant United States Attorneys are abusing their authority by initiating False Claims Act investigations of hospitals upon the discovery of a mistake or overutilization.” The AHA said FCA cases pose a great risk to hospitals in terms of monetary and administrative sanctions, and the threat of FCA liability “leads hospitals to incur massive expenses in retaining specialized council and outside forensic accountants.”



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Over the course of 2010, many hospitals, health systems and pharmaceutical companies were targeted by the federal government for their roles in submitting false claims. More than 700 False Claims Act issues were alleged by the federal government in 2010, and from 2009-2010, the government recovered nearly \$7 billion under the False Claims Act. Of that recovery, healthcare providers and pharmaceutical companies represented over 75 percent of the total payment. In May 2010, the Health Alliance of Greater Cincinnati and The Christ Hospital in Mount Auburn, Ohio, agreed to pay \$108 million to settle claims they violated the Anti-Kickback Statute and False Claims Act. In November, St. Joseph Medical Center in Towson, Md., agreed to pay the United States \$22 million to settle allegations under the FCA that it paid kickbacks and violated Stark Law when it entered into a professional services contract with MidAtlantic Cardiovascular Associates.

## 5. Anti-Kickback and physician-hospital issues.

The Anti-Kickback Statute governs a hospital's financial relationships with physicians. To avoid being stung by the law, a hospital first has to make sure its physician relationships are not just a way to pay physicians for referrals. The statute prohibits knowingly offering or receiving payment to induce referrals of items or services. The law is similar to the Stark self-referral law and, indeed, one transaction can violate both laws at once. An Anti-Kickback violation is also expensive. It is a felony offense carrying criminal fines of up to \$25,000 per violation, imprisonment for up to five years and exclusion from government healthcare programs.

Healthcare organizations can run afoul of the Anti-Kickback Law by providing free services or staff to a practice, paying for unneeded services, providing discounts to practices and paying physicians different amounts than what had been contracted. Recruitment arrangements could also violate the statute. To comply, payments to physicians have to be at fair market value and be commercially reasonable.

The health reform law makes it clear that starting in 2012, Anti-Kickback Statute violations can spur false claims liability. In addition, the government no longer has to prove an individual had "actual knowledge" of the Anti-Kickback Statute in order to violate it; instead, a conviction requires proof that the defendant knew his or her conduct was illegal, according to the *AHLA Connections* report. Previously, the Ninth Circuit's holding in *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir. 1995) interpreted the Statute's "knowingly and willingly" standard to mean that the government must provide evidence a defendant knew of the Statute and aimed to disobey it. Under the current law, a violation of the AKS is enough to pursue conviction.

The year 2010 presented its fair share of major anti-kickback cases. In January, the former owners of Los Angeles-based Angels Medical Center paid \$10 million for paying illegal kickbacks to patient recruiters for the recruitment of homeless patients. In November, Towson, Md.-based St. Joseph Medical Center paid \$22 million to resolve a lawsuit that alleged the hospital paid kickbacks to MidAtlantic Cardiovascular Associates, under the guise of professional services agreements in return for the group's referrals to the medical center. Christiana Care Health System in Wilmington, Del., agreed to pay \$3.3 million to settle a whistleblower kickback lawsuit in March; according to the charges, the system overpaid physicians for in-hospital readings of EEGs allegedly as a "reward" for referring patients to the hospital.

## 6. Impact of Stark Law on physician-hospital relationships.

The Stark Law was enacted to prevent referral sources — namely physicians and physician extenders — from inappropriately profiting from referrals. Under Stark, a physician may not refer a patient for certain services to be reimbursed by federal healthcare programs to an entity with which the physician has an ownership interest or compensation arrangement. There are some exceptions to the law: Stark regulations allow nonmonetary compensation (not more than \$300 per year) to physicians from a referred-to

entity; preventive services are exempted as long as they meet CMS' relevant frequency limits and are reimbursed based on a Medicare fee schedule; and hospital incidental benefits are permitted if they meet a variety of requirements (described in greater detail in a report by the American Academy of Family Physicians here).<sup>7</sup>

The broadest exception to Stark Law probably exists in the concept of "fair market value." According to the AAFP report, compensation is permitted as long as it meets the following criteria:

- Compensation be written down and must cover only specific identifiable items or services.
- The time frame — which can be less than a year as long as the compensation remains the same for each period within a year — must be specified.
- When compensation is fixed for at least a year, it must be stated specifically in advance, must be consistent with fair market value and must not take into account volume or value of referrals.
- The transaction must be commercially reasonable and further legitimate business purposes of the parties.
- It must meet a safe-harbor regulation under the Anti-Kickback Statute, be explicitly approved by the Office of the Inspector General under a favorable advisory opinion or must not violate the Anti-Kickback Statute.
- The services must not involve the counseling or promotion of a business arrangement or other activity that violates state or federal law.

The various exceptions available under the Stark Law also include rental of office space, rental of equipment, physician recruitment, charitable donations from physicians, retention payments in underserved areas, isolated transactions (e.g., one-time sale of property), personal service agreements, risk-sharing arrangements and various other situations.

The complicated nature of Stark means hospitals must be very careful about compensation arrangements with physicians. Intent is not required to violate the statute, so violations occur frequently. While violation of Stark — unlike violation of the Anti-Kickback Statute — is not a criminal offense, violations may result in penalties such as denial of payment for services, repayment of reimbursed services and monetary penalties up to \$15,000 per violation and \$100,000 per arrangement or scheme. A knowing Stark violation can result in exclusion from federal healthcare program participation. The PPACA mandates that the Department of Health and Human Services establish a voluntary self-referral disclosure protocol to allow providers to report alleged violations of the Stark law. This mandate reverses a decision by the Office of the Inspector General in March 2009, when disclosures involving Stark-only violations were prohibited.

Examples of Stark Law penalties are all over the healthcare industry. In July 2010, a federal judge signed an order stating Tuomey Hospital in Sumter, S.C., must pay the U.S. government more than \$49.4 million for violating the Stark Act. Federal prosecutors alleged that beginning in 2004 the hospital violated federal healthcare law by offering part-time and other employment contracts for its Outpatient Surgery Center to physicians.

## 7. Recovery audit contractors.

Recovery audit contractors, private companies that audit providers for overpayments and get a share of what they find, are just beginning to establish themselves for Medicare payments and will soon spread to Medicaid and Medicare Advantage payments. Hospitals and practices can appeal RAC determinations, but they must choose their fights wisely because appeals are expensive and time-consuming. That said, providers have good chances of winning an appeal against a Medicare RAC if they can show their claim filings met CMS payment criteria, RAC advisors say. Several federal court

decisions have held that CMS payment criteria must be used when evaluating claims for Medicare payment.

The AHA estimates it costs a hospital an average of \$2,000-\$7,000 to file an RAC appeal. And if the appeal is lost, the hospital must also pay interest of 12 percent a year on the sum owed. In the RAC Demonstration, providers appealed more than 22 percent of adverse determinations and won about one-third of those appeals. But hospitals that appeal must be patient. They don't usually win the first two levels of appeal: a "redetermination" filed with the Medicare administrative contractor and a "reconsideration" filed with the qualified independent contractor.

Appeals start to be overturned at the third level, overseen by an administrative law judge, who is an attorney working for HHS. And if that fails, providers can go to the Medicare Appeals Council, which may either modify or reverse an administrative law judge's ruling or return the case to the ALJ for a second hearing. Even at this stage, RAC experts say providers should refrain from using legal or procedural arguments and focus on adherence to CMS payment criteria. If all else fails, providers then have the option of going to federal district court.

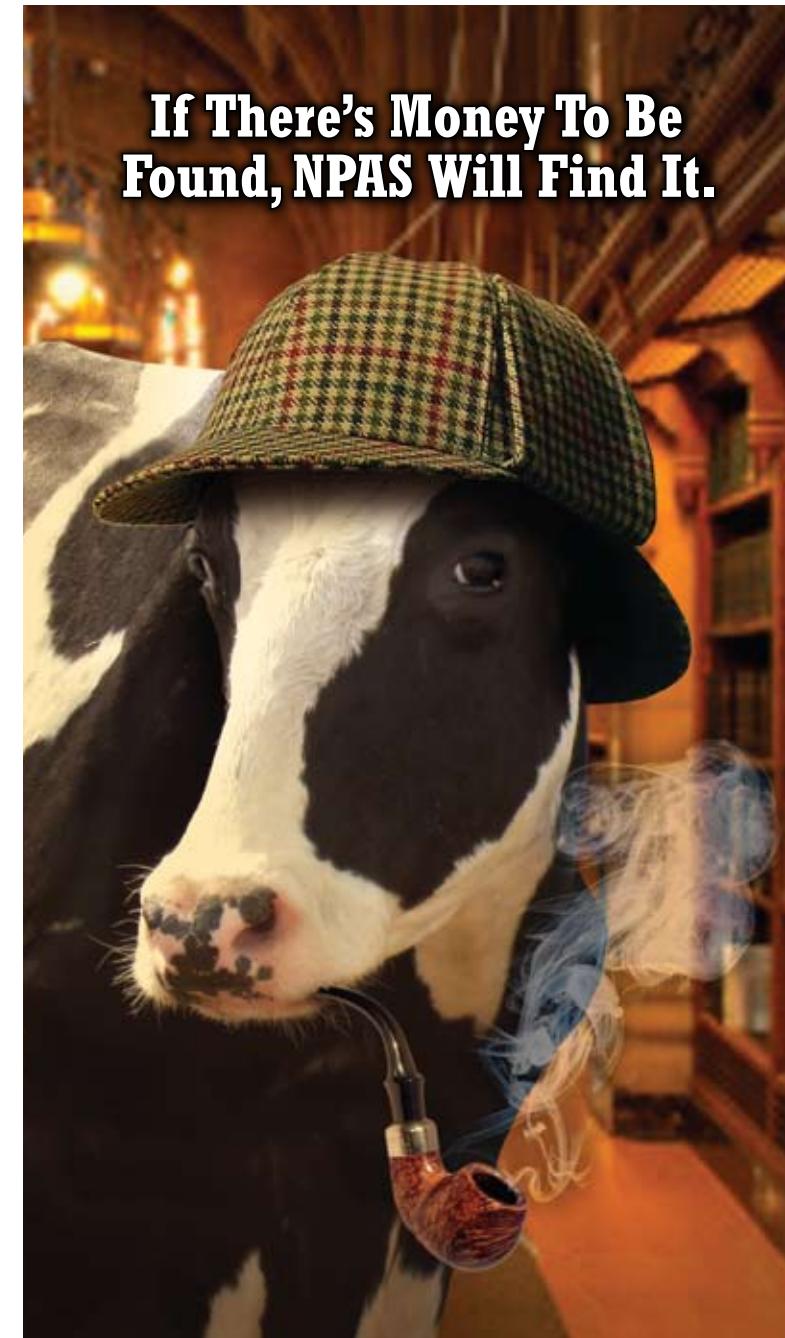
## 8. Compliance requirements for tax-exempt hospitals.

The Patient Protection and Affordable Care Act contains specific requirements for hospitals that wish to receive or maintain tax-exempt status under section 501(c)(3) of the Internal Revenue Code, changing the "community benefit standard" upon which tax-exempt hospitals have been judged for 40 years.

On March 18, 2010, the Illinois Supreme Court decided to uphold the Illinois Department of Revenue's determination that Provena Hospitals, an Illinois non-profit corporation that owns and operates Provena Covenant Medical Center, was not entitled to a charitable or religious exemption from real property taxes. The director of the Illinois Department of Revenue denied the exemption saying that Provena did not demonstrate eligibility as an institution of public charity that owned property used in an exclusively charitable manner. The director determined Provena could also not claim eligibility by using the property exclusively for religious purposes. The decision came on the eve of the enactment of healthcare reform legislation, signaling an era of change for requirements of non-profit hospitals.

The new requirements for tax-exempt hospitals include:

- **Community health needs assessments.** In order to maintain status as a tax-exempt hospital, each facility must conduct a "community health needs assessment" at least once every three years, as well as adopt a strategy to meet the community's identified needs. Hospitals that fail to conduct the assessment and report the strategy on Form 990 will be subject to an excise tax totaling \$50,000.
- **Written financial assistance and emergency care policies.** Healthcare reform also requires tax-exempt hospitals to establish a financial assistance policy and an emergency care policy. The financial assistance policy must detail the eligibility criteria for financial assistance at the hospital, including whether that assistance includes free or discounted care. The policy must also show the basis for calculating amounts charged for patients, the application process for financial assistance, measures to publicize the financial assistance policy in the community and steps the hospital may take to address non-paying patients. The emergency care policy — designed to prevent discrimination against patients ineligible for financial or government assistance — must require the hospital to provide care for emergency medical conditions without discrimination.
- **Limitation on charges.** Under healthcare reform, the amount a tax-exempt hospital charges for emergency or other medically necessary care for patients eligible for financial assistance may not



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exceed the amounts usually billed to insured patients. According to a Joint Committee on Taxation report, “the amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rate.”

- **Limitations on collections policies.** Collection actions may not be undertaken until the hospital has made reasonable efforts to determine whether the patient is eligible for financial assistance.

In addition to these four new requirements, tax-exempt organizations must include several new items in their Form 990 reports to the IRS, such as an explanation of the results of the needs assessment and audited financial statements that will be open to public disclosure. In Feb. 2011, the IRS delayed the filing season for non-profit hospitals, giving facilities three months of extra time to file their 2010 Form 990. The changes were granted to complete implementation of changes to IRS forms and systems required to reflect the additional requirements for non-profit hospitals under healthcare reform. The IRS has asked that hospitals wait until July 1, 2011, to file the form.

## 9. Co-management arrangements.

Co-management arrangements, under which a hospital pays physicians to fulfill defined duties and meet performance objectives, are a way for hospitals to create alignment with physicians and could a stop on the road to bundling and accountable care arrangements with physicians. Co-management arrangements can be utilized at the general hospital, physician-owned hospital and surgery center level and generally involve a fixed fee and an incentive to meet pre-determined objectives. But co-management can also create legal issues under antitrust, Anti-Kickback, civil monetary penalties, physician self-referral prohibitions, tax exempt organization requirements and Medicare laws and regulations. For example, the Anti-Kickback Law prohibits accepting cash or any item of value for referrals of health services.

These arrangements can be structured to meet many objectives, such as lowering hospital costs, achieving operational efficiencies, improving quality and outcomes, adherence to evidence-based medicine and increasing profitability, patient satisfaction, physician recruitment and even emergency call coverage.

However, each component of the fee must be based on fair market value and this needs to be documented. Compensation cannot be related to the value or volume of referral needs. Duties cannot overlap with what others are doing, and the hospital should review its compensation arrangements to make sure this is not happening. Responsibilities have to be clearly defined and determined in advance. They should not include easily attainable goals, such as showing up on time.

## 10. Changes in reimbursement.

Reimbursement rates have shifted under PPACA, significantly lowering reimbursements for some providers while increasing rates for others. As far as increases, Medicare will grant primary care practitioners a 10 percent bonus effective in 2011, and general surgeons practicing in health professional shortage areas will receive a 10 percent bonus on top of the existing HPSA bonus, according to the *AHLA Connections* report. Hospitals in the bottom quartile for risk-adjusted Medicare spending per beneficiary will also receive rewards.

As far as decreases, hospital reimbursement rates for inpatient services will decrease in fiscal year 2011 by approximately \$440 million. Another 3 percent cut will take its toll on providers and hospitals as CMS attempts to recoup payments made in previous years that arose from certain documentation and coding changes. Starting in 2015, physicians who fail to demonstrate cost-effective and high quality performance will be penalized through a value-based payment modifier; similar payment penalties begin in 2015 for hospitals with high rates of hospital-acquired conditions and high readmission rates for specified conditions.

At the end of 2010, Congress and President Obama blocked a 25 percent reduction in physician reimbursement rates that had been scheduled for Jan. 1, 2011. Current funding levels will persist through Dec. 31, 2011, at an estimated cost of \$14.9 billion, according to the *AHLA Connections* report. Similar blocks to the sustainable growth rate cuts were enacted in 2010 and the years prior, meaning future reductions are steadily growing as Congress delays the cuts.

Out-of-network profits continue to decrease for hospitals across the country, a shift from the historical advantage of using out-of-network to increase profits or improve negotiating position.

## 11. Labor and employment issues.

In the coming years, hospitals may see more age discrimination claims related to termination, as well as more requests for accommodations from employees with disabilities. In April 2010, a physician sued Thomas Memorial Hospital, claiming he was replaced by “younger, less experienced surgeons” and that the facility discharged him because of his age; in March, a former Lee Memorial Health System employee, age 67, filed an age discrimination suit against the hospital system, alleging she was rejected for more than 14 positions for which she was qualified. In September, a 63-year-old man filed suit against West Houston Medical Center, saying his diagnosis of diverticulitis and hypertension, as well as his age, led to his abrupt replacement by a 30-year-old colleague.

Hospitals wishing to avoid successful legal action from disgruntled employees should implement formal, written policies on employee dismissal. Job descriptions should also be kept accurate and up-to-date to prevent discrimination claims.

Hospitals may also see an increase in unionization efforts, even in states where hospitals have traditionally remained union-free. While unionization works for many facilities and provides a sense of security to employees, it can also present difficulties for hospital administration. For example, in a unionized environment, if an employee has a concern, he or she must go through a union representative and consult the union contract rather than speaking directly to a supervisor. Several hospitals and health systems have been stymied by employee strikes in recent months: the service workers union at Pocono Medical Center in Pennsylvania approved a one-day strike in February over unfair labor practices, while union nurses at Eastern Maine Medical Center in Bangor held a one-day strike in November, citing poor patient-to-nurse ratios. Strikes — especially those affecting a significant portion of hospital employees — can paralyze hospital operations or force facilities to use more-expensive agency help to fill vacated positions.

On the other side of the unionization dispute, some organizations are taking measures to allow employees to unionize without objection. Hospital chain HCA signed a neutrality agreement with the Service Employees International Union and California Nurses Association last April allowing the unions to organize workers at 20 HCA hospitals. The year-long agreement allows union workers to organize workers at the specified hospitals in Florida, Texas, Missouri and Nevada without objection from the operator. HCA has agreed to provide the unions lists of employees and allow them on hospital property. Labor experts say such agreements may come to fruition as unions look to grow membership and hospital operators look to provide stability.

## 12. Mergers and antitrust law.

Hospital mergers are heating up and so are concerns that some of them violate antitrust law. Merger and acquisition volume for the third quarter of 2010 was 20 percent higher than for the third quarter of 2009. Enforcement agencies have been leery of hospital mergers, suspecting that market power, rather than increased efficiency, is the real motivation behind them.

In addition to the Sherman Act, the Federal Trade Commission and the

Antitrust Division of the U.S. Department of Justice enforce the Clayton Act, which forbids mergers that harm competition. But enforcement actions by these agencies have had frequently been overruled by the courts in recent years. Hospitals have won lawsuits against enforcement actions by pointing to a larger market area than the government alleged, showing evidence of improved efficiencies from the merger, and, in some cases, showing that the merged entity can better serve the community.

One of the most recent merger cases is the FTC's antitrust challenge against Toledo-based ProMedica Health System for its acquisition of 198-bed St. Luke's Hospital. The FTC claimed the acquisition reduced competition and would contribute to higher prices. But as part of its argument, ProMedica said the FTC should go easy on enforcement because hospitals are trying to integrate to prepare for accountable care organizations and other payment arrangements. The lawsuit is "inconsistent with the integration and coordination that healthcare reform both encourages and requires," ProMedica said in a statement. The FTC, however, claimed it had "business documents" showing that "a principal motivation for the acquisition was for St. Luke's to gain enhanced bargaining leverage with health plans, and the ability to raise prices for services."

### **13. Medical malpractice and tort reform.**

In January's State of the Union address, President Obama said he was willing to consider proposals designed to eliminate "frivolous" medical malpractice lawsuits, a move that some say could significantly impact

hospitals. Currently, nearly all states require that physicians have liability insurance, and even in states that don't, physicians usually have to have insurance coverage in order to gain hospital privileges. Hospitals and other healthcare facilities purchase their own insurance separate from physicians and physician practices, and hospitals that directly employ physicians generally buy policies that cover both the hospital and its medical staff.

Physician malpractice premiums are priced differently from hospital malpractice premiums. While physician premiums are priced according to specialty and geographic location, hospital premiums are priced according to location, clinical services offered and the hospital's claims experience.

President Obama's statement followed the introduction of a tort reform bill by Reps. Phil Gingrey, MD (R-Ga.), David Scott (D-Ga.) and Lamar Smith (R-Texas) on Jan. 24 that would cap noneconomic — or "pain and suffering" — damages in malpractice cases at \$250,000, similar versions of which have been introduced on a regular basis by House Republicans since 2002 and have repeatedly failed to pass in the Senate. Proponents of tort reform say medical malpractice costs are an unnecessary expenditure for an already-struggling healthcare industry. According to an AMA report, medical liability premiums in the United States grew by nearly 950 percent between 1976 and 2009, though specific figures on premiums were not provided. ■

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# Physician-Hospital Contracting: A Compliance Approach — 11 Key Concepts

By Scott Becker, JD, CPA, and Lainey Gilmer, JD, MBA

The federal government has greatly increased its regulatory efforts related to investigating, prosecuting and combating healthcare fraud.<sup>[1]</sup> This focus, combined with the movement of physician providers into employment, medical director or other compensation relationships with local hospitals, has led to an increased focus and scrutiny on hospital-physician financial relationships and contracting issues. Further, a number of recent cases based on alleged improper physician compensation arrangements demonstrate that significant settlements or damages may occur if an improper arrangement is alleged or prosecuted. The magnitude of potential damages has placed physician arrangements on the agenda of U.S. Attorneys and private citizens with the potential to recover a portion of the damages or settlement.<sup>[2]</sup> In response, hospitals and providers have become proactive in analyzing existing physician compensation relationships, developing the procedures and templates for establishing new relationships and initiating internal investigations of current arrangements. Such internal investigations allow the entity to address and correct any potential liability areas and consider self disclosure if necessary.<sup>[3]</sup>

The concepts and recommendations contained in this article are aimed at assisting hospitals and providers in analyzing and evaluating their current physician compensation arrangements, as well as presenting a number of best practices used to standardize physician contracting within an organization and to increase compliance with both the Anti-Kickback Statute and the Stark Law.

**1. Financial relationship sign-off.** A specific person, preferably from the hospital compliance department or a specially-formed compliance group (a “Compliance Committee”), should sign off on each direct and indirect financial arrangement between a hospital and a physician, including all employment agreements, management agreements and medical directorships. Ideally, an individual not involved in negotiating the arrangement between the hospital and the physician would be responsible for the sign-off. Similarly, the Compliance Committee should be comprised of individuals who are independent from the contracting parties and others invested in the potential relationship.

Further, when an arrangement is above a certain dollar threshold, or in the case of highly compensated management agreements or other types of agreements in which a physician provides purely management or administrative services, the hospital should consider greater levels of approval and sign-off on the relationship. Here, the approval of both a chief compliance officer and another individual or committee (i.e., a special compliance subcommittee), along with the general counsel’s office, may be required. The committee would review and evaluate the fair market value nature and the commercial reasonableness of the compensation, document such determinations and present its findings to the chief compliance officer and the general counsel’s office.

Finally, when a hospital enters into highly compensated, unusual or politically-charged arrangements, it is increasingly important that it develop, maintain and approve a clear record of the facts and need supporting such an arrangement. The facts, discussions, valuations and negotiations that gave rise to the agreement should all be documented and retained.

**2. Internal valuation memo.** For each hospital-physician financial relationship, including all employment relationships and medical directorships, there should be a specific valuation memorandum on file which articulates the manner in which the compensation was determined, the surveys utilized for comparison and benchmarking and whether an outside valuation

opinion was sought. The Compliance Committee should review and sign off on this fair market valuation review. In terms of timing, this fair market review should be completed prior to final negotiations of the applicable contract and prior to execution by the parties. Valuation guidance or review should be conducted on each compensation relationship between the hospital and a physician (or an organization comprised of physicians). For compensation arrangements above a certain amount, an external valuation opinion should also be sought.

CMS has historically commented that the fair market value of physician arrangements is a significant element of any relationship:

“We emphasize, however, that we will continue to scrutinize the fair market value of arrangements as fair market value is an essential element of many exceptions.

Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating fair market value. Ultimately, the appropriate method for determining fair market value for purposes of the physician self-referral law will depend on the nature of the transaction, its location, and other factors. As we explained in Phase II, although a good faith reliance on an independent valuation (such as an appraisal) may be relevant to a party’s intent, it does not establish the ultimate issue of the accuracy of the valuation figure itself.<sup>[4]</sup>”

Based on the foregoing, full reliance on an appraisal may not suffice in defending a compensation arrangement. Rather, the hospital and the Compliance Committee should ensure that a full record, including all relevant analysis, is maintained.

**3. Compensation cap.** The hospital should consider for each hospital-physician financial arrangement, especially if a productivity-driven compensation structure, or containing the potential for a significant bonus, including a reasonable compensation cap. This cap is particularly important in the cases of exempt hospitals and should be consistent with the fair market value of the services performed under the arrangement. A cap on the total compensation will be important for establishing a rebuttable presumption of reasonableness for any non-fixed payments and the compensation as a whole.<sup>[5]</sup>

**4. Employed and/or highly compensated physician in private practice.** A hospital system should take extra caution in situations where a substantially full-time physician employee, or highly compensated employee, has the right to earn outside income and in situations where a paid physician employee or indirect contractor is permitted to remain a private practice physician. The Compliance Committee, or individual responsible for signing off on the arrangement, should ensure that the services provided to the hospital are identifiable, measurable and recorded. Time and activity logs will assist the hospital in defending that the compensation paid to a physician who also engages in outside activities is consistent with the services he or she is actually providing and the time spent providing such services.

**5. Stark Act and safe harbor regulatory compliance sign-off.** As part of the compliance review, legal counsel, internal or external, should review the agreements to assure they meet a core exception under the Stark Act and a safe harbor to the Fraud and Abuse Statute. These may be exceptions and safe harbors that are related to “bona fide employees” or to personal services or independent contract arrangements. The fundamental concepts guiding many of the key thoughts in this article are based on

these applicable exceptions and safe harbors. In general, a physician contract must (i) be set forth in writing, (ii) be for commercially reasonable purposes, and (iii) provide for compensation that is set in advance, consistent with fair market value and not determined in a manner that takes into account the volume or value of referrals or other business generated between the parties. Additional requirements will vary slightly depending on the safe harbor or Stark exception being utilized, but the core requirements set forth above will generally always apply.

## 6. Job descriptions and roles and responsibilities need assignment.

All physician-employment contracts, management contracts and similar arrangements should contain a clear job description, which includes a list of the services to be provided and an approximation of the time commitment. The hospital's internal files should contain a copy of the particular job description along with an analysis and record as to why the position is reasonably needed by the system. Such file should be periodically reviewed to confirm that the position remains necessary. Similarly, in the case of newly created roles, there should be great clarity as to why such role is needed and what services it will provide. This assessment should also be placed in the contract file.

**7. Contracting checklist/contract file.** A hospital should develop, implement and maintain a simple contract checklist that can be utilized in virtually all physician compensation relationships. This checklist will provide a standard step-by-step process for creating, analyzing an implementing a financial relationship. If general, a hospital should maintain consistency throughout its physician-contracting. Each arrangement should be subject to the same type of review, analysis and documentation. If investigated, a hospital should benefit by demonstrating that it systematically analyzed each relationship in a meaningful manner. Any variations from this checklist or procedure should be documented and explained.

Similarly, a physician contract file should be maintained for each compensation arrangement. As mentioned throughout this article, the file would contain support for the services to be provided under the arrangement, the compensation to be paid, along with an explanation, analysis or valuation as to its fair market value, and any amendments or changes to the arrangement with a brief explanation as to why such modification was necessary.

**8. Review of existing compensation relationships.** When conducting an internal investigation or updating the hospital physician contracting procedures, the hospital should review each existing physician-employment agreement and each management, development and marketing agreement. This review should focus on (i) the fair market analysis of the compensation paid pursuant to the arrangement; (ii) the true need for the services provided pursuant to the arrangement; (iii) ensuring the job descriptions set forth in the agreement, if any, are properly documented; (iv) ensuring the allocation of medical versus administrative services is consistent with the services that are actually being provided by the physician; and (v) whether the full-time or part-time designation or expected time commitment is consistent with the services being provided under the arrangement and taking into account the physician's outside activities. In cases where the physician is also providing clinical services through his or her private practice and separately billing and collecting for those services, the physician employee should not be designated a full-time employee. Finally, during the course of the review, an internal analysis and record should be created with respect to each compensation relationship which documents the findings and support for each relationship and which is retained in the contract file.

The review of existing arrangements may lead the hospital to restructure, renegotiate or improve the documentation of certain arrangements. In cases in which an arrangement must be restructured, the contract file should include an internal memo or analysis which supports and justifies each resulting change. If investigated, the hospital must be in a position to justify changes and modifications made to its physician compensation arrangements and to demonstrate that such changes were not carried out on a random, unsupported or arbitrary basis to unjustifiably reward a physician.

**9. Ongoing periodic reviews.** The hospital should task the Compliance Committee (or some other specially formed group or department) with developing a schedule pursuant to which each compensation relationship is periodically reviewed on an on-going basis. In the physician-employment context, the review should focus on the services being provided and the submitted time and activity sheets. The review should also ensure that proper documentation and justification supports any changes to the relationship or compensation. With respect to other compensation relationships, the review should ensure that the parties are complying with the terms of the agreement and that the proper documentation supports the compensation and services being contracted for.

## 10. Medical director agreements and other clinical/administrative agreements.

Often, hospital systems utilize an hourly compensation arrangement for medical director or clinical administrative systems. However, when a contract for administrative or medical director services sets forth an aggregate compensation, the Compliance Committee should ensure that such amount is consistent with the time and services being provided. For example, if a physician is annually compensated thirty thousand dollars (\$30,000) for his medical director services, and there are strong arguments that the hourly rate for such services is equal to approximately two hundred dollars (\$200 per hour), the physician should be spending between one hundred (100) and two hundred (200) hours a year providing medical director services to the hospital. The hospital may employ a similar calculation to determine the appropriate compensation under an arrangement and to periodically confirm that a physician is providing both the time and the services required to support his or her compensation.

## 11. Standards for department chairs; special chairs, medical director.

For similar positions that exist in numerous departments (e.g., department chair and department vice chair), a relatively standard set of responsibilities and hours expectation should be internally established by the hospital. An hourly rate and an annual compensation should be determined for such positions, regardless of the department. Then, any variations in annual or hourly rates, as determined in contract negotiations or otherwise, should be signed off by the Compliance Committee or some other specially designated committee. There may be reasonable and persuasive justification for compensating one department chair at a much higher rate (e.g., time commitment, number of employees being managed, etc.), but when great disparity exists between similar positions throughout the hospital, and justification for such variance is not recorded or contained in internal files, the hospital may face a greater challenge in defending the compensation of certain positions. ■

[1] The Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111- 148, 124 Stat. 119 (2010), together with the Health Care and Education Reconciliation Act of 2010 (Reconciliation Act), Pub.L. No. 111-152, 124 Stat. 1029 (2010), provide over \$300 million for the purpose of fraud and abuse enforcement.

[2] See. McAllen Hospitals, located in Houston, Texas, which settled claims of "sham" transactions with physicians for \$27.5 million, with the qui tam plaintiff (i.e., the "whistle blower") receiving \$5.5 million of such settlement.

[3] While self-disclosure does not guarantee lesser damages, recent changes due to the Patient Protection and Affordable Care Act ("PPACA"), may increase the benefits of this option when a Stark Law violation is identified. Under the Centers for Medicare and Medicaid Services ("CMS") "Self-Referral Disclosure Protocol" (SRDP), CMS has authority to reduce the damages associated with a Stark Law violation based on a number of factors including: (i) the nature and extent of the improper illegal practice; (ii) the timeliness of the self-disclosure; (iii) the cooperation in providing additional information; (iv) the litigation of risk associated with the matter; and (v) the disclosing party's financial position. This potential reduction, however, does not apply to violations of the Anti-Kickback Statute.

[4] 72 Fed. Reg. 51012 (Sept. 5, 2007).

[5] See. 26 C.F.R. 53.4958-6(d)(2): If the authorized body approves an employment contract with a disqualified person that includes a non-fixed payment (such as a discretionary bonus) subject to a specified cap, the authorized body may establish a rebuttable presumption with respect to the non-fixed payment at the time the employment contract is entered into if: (i) prior to approving the contract, the authorized body obtains appropriate comparability data indicating that a fixed payment of up to a certain amount to the particular disqualified person would represent reasonable compensation; (ii) the maximum amount payable under the contract (taking into account both fixed and non-fixed payments) does not exceed the amount referred to in paragraph (d)(2) (i) of this section; and (iii) the other requirements for the rebuttable presumption of reasonableness under paragraph (a) of this section are satisfied.

# Male Physicians Still Out-Earn Female Physicians in Almost Every Specialty

By Rachel Fields

In 1980, female physicians comprised 11.6 percent of the physician workforce; by 2009, they had grown to 29.6 percent of the total physician population. According to a 2008 report titled "Gender Disparities in Physician Income and Advancement" by the American Medical Association, female physicians represented 45.3 percent of all residents and fellows in 2009, compared to 21.5 percent of all residents and fellows in 1980. The most popular female physician specialty, internal medicine, saw 54,085 total female physicians and 11,902 total female residents, representing 22 percent of the total amount.

But despite this growth in the number of female physicians, women have trailed men in advancement in the medical profession as well as salary and income levels. According to data published by the MGMA in 2010, men still outpaced women in almost every reported specialty (the exceptions being anatomic pathology and critical care pulmonary medicine). In some cases, the salary difference was minor: Male pediatricians specializing in gastroenterology earned, on average, less than \$8,000 more than their female counterparts. In other cases, the discrepancy was substantial: Male gastroenterologists earned more than \$120,000 more a year than female gastroenterologists.

A study published in *Health Affairs* in Feb. 2011 indicated that the gender gap in starting salaries for female physicians is widening, rising from a difference of \$3,600 in 1999 to \$16,819 in 2008. The *Health Affairs* report did not draw a conclusion about the reason for the widening pay gap, but acknowledged that potential reasons could include an increase in gender discrimination and the possibility that men are better at negotiating salaries than women.

In response to the study, Donald J. Harris, PhD, Research Director for Penmetrics, wrote that, "It also may be worth considering that the missing variables play a much larger role in the high-stakes subspecialty fields. One might get a handle by examining, by way of separate regressions, the magnitude of the salary disparities in the four specialties with the largest Ns: pediatrics (general), internal medicine (general), family practice, emergency medicine." He also raised the possibility that "cultural" variables, such as the prestige of training institutions or employing institutions, might play a role in the discrepancy.

In its 2008 report, the American Medical Association also acknowledged that "gender disparities in medicine can be attributed to a certain degree to gender differences in specialty choice, age/experience, practice characteristics and life style choices." But in research published by J.E. McMurray and colleagues in the *Journal of General Internal Medicine* in 2000, the researchers found a \$22,000 gender gap in income for women physicians after controlling for age and hours worked among pediatricians, family medicine physicians and internal medicine physicians. The income difference persisted among younger physicians, suggesting that the trend is not merely a holdover from a bygone era.

Evidence also shows that female physicians are paid less than male physicians even in those specialties where they come close to the majority. A report from the Center for Studying Health System Change, a nonpartisan policy research organization funded by the Robert Wood Johnson Foundation, stated in 2007 that women physicians account for 49.5 percent of the primary care workforce but earn 22 percent less than male primary care physicians. Again, this disparity may be attributed to a number of variables. In a 2006 AAMC/AMA Survey of Physicians Under 50, male physicians were found to be more concerned about career advancement, practice income and long-term earning potential. In contrast, female physicians were more interested in having the ability to balance time for family and personal

life. AMA survey data have also consistently shown that female physicians work fewer hours and see fewer patients than male physicians.

Other factors affecting the pay gap include the difference in practice ownership: in 2003, 44.2 percent of female physicians were practice owners, in comparison to 66.2 percent of male physicians, according to *Physician Income: The Decade in Review Physician Socioeconomic Statistics*, a 2003 report by C.K. Kane and H. Loeblich. Additionally, based on 2006 AMA Physician Masterfile Data, 71 percent of male physicians were board-certified, compared to 65 percent of female physicians.

The AMA concluded in the 2008 report that steps are necessary to increase the ability of female physicians to advance in their careers, demand competitive salaries and negotiate strong contracts. "Transparency in pay scale and promotion criteria is also necessary to promote gender equity," the authors wrote. Compensation and promotion rates should be reviewed regularly by hospital and practice administrators to determine whether or not discriminatory trends exist. Hospitals and practices should also work to develop mentoring and role modeling programs for female physicians. ■

## Physician Group Type, Size Affect Level of On-Call Compensation

By Rachel Fields

Providers receiving on-call compensation are more likely to be compensated daily or annually than in previous years, according to Medical Group Management Association's *Medical Directorship and On-Call Compensation Study: 2011 Report Based on 2010 Data*.

Thirty-five percent of providers reported receiving on-call compensation daily, while 21 percent reported receiving an annual payment for on-call coverage in 2010. Invasive cardiologists reported the highest median daily rate of on-call compensation, at \$1,600 per day on call. General surgeons earned a median of \$1,150 per day, while urologists clocked in at \$520 per day for on-call coverage.

Practice type and size have an impact on on-call compensation. OB/GYN physicians in single-specialty practice received on-call compensation two times higher than their peers in multi-specialty practices. Invasive cardiologists in single-specialty practices also reported higher rates than their peers in multi-specialty groups.

In some cases, groups with more physicians saw higher median rates for on-call compensation. Anesthesiologists earned \$450 per day in groups with 25 or fewer FTE physicians, compared to \$660 per day in groups with 26-75 FTE physicians.

Almost all physicians reported receiving higher holiday rates than weekend rates. ■

# Should Your Hospital Form an ACO?

## 5 Considerations

By Lindsey Dunn

**M**any hospitals are now reconsidering their options to set up accountable care organizations. Given the proposed rules and regulations, it is unlikely that many will pursue a Medicare Shared Savings Program ACO, at least initially. "The opportunity is not as attractive as initially thought and organizations will be more inclined to do commercial ACO and ACO-like alternatives," says Mike Randall, a manager at The Camden Group, a healthcare consulting firm.

While some highly integrated systems may be well poised for success under this new model, many hospitals are simply not yet ready to become ACOs. These hospitals are better served by resisting the pressure to plunge ahead and instead develop core competencies for accountable care over time, says Mr. Randall.

Although the Medicare Shared Savings Program launches Jan. 1, 2012, ACOs that aren't ready to

participate in the program can apply each subsequent year, meaning missing the initial deadline doesn't rule a group out from participating in the future.

Health systems that aren't yet fully integrated should assess the pace at which they move toward an ACO by first examining their market. If competing systems are moving toward the ACO model, a hospital may need to accelerate its efforts to ensure it doesn't lose market share. Hospitals in markets with a less integrated environment have a bit more flexibility to ensure all competencies are mature before moving forward with an ACO, thereby reducing risk, says Mr. Randall.

Before hospitals jump into ACOs, Mr. Randall advises they assess themselves against five core competencies for accountable care. If not all five competencies are present or mature, he suggests hospitals focus on building them up and

utilizing other value-based payment strategies — such as a shared savings model through Patient-Centered Medical Homes or bundled pricing — before moving onto the more complex ACO model. Self-insured hospitals may also benefit by testing their capabilities with their own ACO pilots involving employees before entering an ACO agreement with Medicare or a commercial insurer, he says.

### 5 core competencies

- 1. Physician alignment.** Alignment with physicians is the most important criteria to assess if a hospital can be successful as an ACO. As ACOs, hospitals need strong mechanisms for aligning with independent physicians, especially primary care physicians, in the market. Alignment efforts may include employing once-independent or new physicians, establishing medical homes and/or co-management, clinical integration or other arrangements.

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"[Physician alignment] is the foremost issue and includes assessing such issues as level of trust with physicians, presence or lack thereof of formal physician relationships and level of experience in tracking physician performance quality. Also important is the commitment of a cadre of experienced physician leaders," says Mr. Randall.

## **2. Ability to exchange information across sites of care.**

To be successful as an ACO, hospitals will need to exchange patient data with physician practices, post-acute care facilities and others as well as have systems in place to mine data to inform clinical decision-making.

"Many organizations are pursuing EMR development, which is absolutely critical for the future, but EMR is not the full equation if you look at the needs of accountable care," says Mr. Randall.

The "full equation" referred to by Mr. Randall includes not only EMRs but also health information exchanges, which exchange health information across providers; disease registries, which gather health information from billing and diagnostic systems and EMRs; and a central data repository to develop reports and disseminate information to providers.

## **3. Outpatient clinical care management experience.**

Because most hospitals today focus on acute care, expanding their expertise

along the care continuum will be a critical precursor for ACOs. Specifically, physicians will need to develop competencies in care management.

"Many hospitals today have clinical care management expertise on the inpatient side, with care managers, social workers and others who work closely with physicians to oversee a patient's inpatient stay and transition them to their homes or to a post-acute facility," says Mr. Randall. "On the outpatient side, you have primary care physicians who often don't have a lot of support in managing care, following up with patients or ensuring patients get regular check-ups, all of which prevent ER visits and admissions."

Typical outpatient care management teams include a medical director, outpatient clinical nurses, care managers and, in some cases, pharmacists, says Mr. Randall.

## **4. Willingness of private payers and large employers to support a value-based strategy.**

Hospitals need to ensure payors are aligned with efforts to move care away from fee-for-service to value-based models. Because the two types of models are very different, it is challenging for hospitals to work in both environments. For example, if only one payor is reimbursing on a value-based model, it may be challenging to truly change the way care is delivered. To provide a significant incentive

that truly promotes high quality, low-cost care, incentives are needed across multiple payors, says Mr. Randall.

Large, self-insured employers also present opportunities to test value-based reimbursement programs. They are likely willing to work with hospitals to design a program for their beneficiaries. "Employers are often very motivated to pursue these models because they are looking for anything to lower cost of care for beneficiaries," says Mr. Randall.

## **5. Ability to handle financial implications.**

Finally, hospitals need to ensure they can handle both the start-up costs associated with early adoption of the ACO model as well as the potential for downside risk associated with early adoption. Developing an ACO requires significant capital and resources, and early adopters may face higher costs than those who join later in the game using best practices already established by the early adopters. Additionally, participation in an ACO program may hold the ACO financially accountable if it leads to higher, rather than lower, costs — this will eventually be the case for all ACOs under CMS' program.

"Payback may take several years," says Mr. Randall. "It's unlikely to realize savings in the first year of a care management program unless the hospital already has experience managing care previously." ■

# Should Specialists Join ACOs?

By Leigh Page

**A**s hospitals and large multi-specialty group practices gear up for accountable care organizations, procedure-oriented specialists are still trying to figure out their role in them.

"Specialists are not taking the lead in the formation of ACOs," says Aric Sharp, CEO of the Quincy (Ill.) Medical Group, a 130-provider multi-specialty group. "The physicians who are interested are in multi-specialty groups or integrated models with hospitals."

This makes sense. Most specialists are focused on a particular episode of care, which is not what the ACO is all about. These new models of care emphasize the whole spectrum of healthcare, not just one episode.

## **ACOs need specialists**

Everybody agrees, however, that ACOs will need to reach out to specialists and include them in their networks. Furthermore, even hospitals with many employed specialists may have to add independent specialists to fill out their networks, says Laura P. Jacobs, executive vice president of the Camden Group in Los Angeles. "Primary care physicians in ACOs will need specialists to link up with them," she says. "They will want them to collaborate."

But as ACOs begin to reach out to specialists, will specialists respond in kind?

Some observers believe some specialists will be swept up in the general enthusiasm for accountable care and find their place in ACOs. Paul Keckley,

director of the Deloitte Center for Health Solutions, says specialists will join ACOs because "it's better to be in the room. The natural inclination of most specialists would be it's better to be a player than to be left out."

## **The financial incentives**

But what specific incentives does a specialist have to join an ACO? Mr. Keckley and other ACO experts readily admit it could take years for many ACOs to make enough shared savings to pay out significant sums of money. Indeed, these sums would have to be hefty enough to be an incentive for the wary specialist to join up.

One impediment to initially paying out shared savings might be the need to pay off high start-up costs for ACOs. In the Medicare Physician Practice Demonstration Project, the model for ACOs, start-up costs were pegged at \$1.75 million for each organization, and the costs of ACOs are expected to be higher.

Moreover, ACOs face the possibility of losing money by at least the third year, as part of the new "two-sided" risk model in the proposed regulations. But Mark Lutes, a healthcare attorney with Epstein Becker & Green in Washington, D.C., thinks that it would be up to the original investors in the ACO, and not specialists, to cover expenses like start-up costs and downside risk. "Losses would be covered by the original investors," he says.

The prospect of losses leads to another problem, the possibility that many ACOs could fail. "Clearly, we know that a substantial number of them won't be successful," says Keith Kosel, PhD, senior director of the Social

Sciences Practice at VHA Inc. "If you see 70 percent standing after three years, you might be able to call that a success. If only half survive, I'd call that a failure."

If an ACO has high chances of failure, why would a specialist want to join?

## Prospect of losing referrals

One oft-cited reason for specialists to join an ACO is the potential of losing referrals. True, many specialists have very busy practices right now, and the prospect of adding more patients at lower-paying Medicare rates may not be appealing. But if a specialist does not join an ACO, "the primary care physicians in the ACO could shift the specialist's referrals to someone else," says J. Peter Rich, an attorney at McDermott Will & Emery in Los Angeles.

It might not be that easy for primary care physicians to direct patients to another specialist, considering that Medicare beneficiaries in an ACO cannot be stopped from going to any provider they wish to, even a specialist who has no connection to the ACO. But Mr. Lutes believes beneficiaries will listen. "When your primary care physician refers you somewhere," he asks, "how many times have you refused to go?"

Even so, Mr. Kosel at the VHA thinks it could take time for primary care physicians to change referral patterns. "Changes in referral patterns may be not that significant in the short term but they may be a big issue as time goes by," he says.

## Other responsibilities

However, specialists weighing the possible loss of patients if they don't join an ACO may have to weigh that against extra responsibilities if they do join. For example, experts agree that physicians in an ACO will have to lend a hand in reporting 65 quality measures that CMS plans to require.

It is also widely assumed that specialists in an ACO would need to adopt some form of information technology system, which most specialists don't have yet. The proposed ACO rules say that half of primary care physicians in an ACO would have to be in compliance with meaningful-use provisions on electronic medical records by the second year of participation. Mr. Kosel thinks specialists would also need to have some type of EMR. "You're going to need some degree of EMR," he says. "I don't know how complex or pervasive it has to be, but something has to be there."

"Perhaps the specialist isn't ready to connect electronically, so he'll say, 'I can't do it,' Ms. Jacobs at the Camden Group says. Even so, she believes ACOs will place other demands on specialists, such as agreeing to be available to see patients. For example, they may have to agree to see patients within a week or two weeks, she says. She also thinks ACOs might ask specialists to participate in meetings, such as a quality committee or an orthopedic implant committee.

## Clinical guidelines

One mantra of ACOs is to closely monitor the cost of care. An ACO's payments to specialists could be "tied to reducing cost trends associated with volume/intensity of specialist referrals," wrote family physician L. Allen Dobson Jr., MD, in a presentation on specialists in ACOs to the North Carolina Medical Society last year.

There is the possibility that specialists who join ACOs might be expected to help create and then adhere to clinical guidelines. Would an orthopedic surgeon, for example, be required to use certain implants? "That depends on the internal workings of the ACO," Ms. Jacobs says. "Over time, they might make such requirements. But they probably won't be that prescriptive. They wouldn't be saying use this particular implant and go to this particular hospital."



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Even if specialists aren't held to clinical guidelines, widespread use of guidelines in the ACO could result in fewer referrals to specialists for procedures. For example, some clinicians argue that less invasive techniques are preferable to back surgeries.

For this reason, Mr. Keckley at Deloitte argues that specialists would want to have a hand in developing clinical guidelines. "They would want to be there to help formulate the clinical pathways of care, including such things as the risk factors and the comorbidities," he says. "The specialists need to give primary care physicians the diagnostic queries for the patient."

### Would there be a contract?

The specialist's obligations as well as the manner in which payments would be distributed could be spelled out in a contract between the specialist and the ACO, says Mr. Rich, the healthcare attorney.

Mr. Rich readily agrees, however, that not all specialists in a Medicare ACO would have contracts. Medicare beneficiaries in an ACO would be able to see anyone they want, with or without a contract. But an ACO formed with private payors could require contracts, he says.

Since a contract is not necessary in a Medicare ACO, Mr. Lutes envisions a "dialog" between the specialist and the ACO. The specialist would be asked to help hospitals and primary care physicians that run the ACO to set up a "care path" for the integrated care of the patient, the healthcare attorney says.

### Other models of care may be better fit

Some experts think ACOs may ultimately not be the best fit for specialists. Instead, Mr. Lutes says bundled payments might be a better fit because they are linked to a particular procedure, which specialists can understand. Under a bundled payment, the hospital and specialists work together to bring down the cost of a certain procedure, such as knee implants. "The specialist might have more of an incentive to improve care with a bundled payment than under shared savings payments in an ACO," Mr. Lutes says.

The Medicare Acute Care Episode demonstration project has had success with bundled payment pilots for heart, total joint and hospital-acquired infections. More providers may be added to existing bundled payment demonstrations in 2013, and HHS has been authorized to roll out five more areas of focus in 2015.

Mr. Sharp at Quincy Medical Group is skeptical of bundled payments. "From the broad policy standpoint we've got to keep in mind the key factor is coordination of care," he says. "We need to be careful not to piece-meal things out."

But Mr. Keckley at Deloitte thinks bundled payments show promise. "The concept of bundled payments has been generally well received," he says. He adds that the new Center for Medicare and Medicaid Innovation is expected to develop more models that might be even better for specialists. ■

## Post-Acute Care Networks: The Key to Success in Accountable Care

By Bob Edmondson, VP Innovation, West Penn Allegheny Health System

**E**merging accountable care organizations that are focusing extensively on primary care redesign may be overlooking a part of the care continuum that may yield the greatest benefit — post-acute care. With early payment reforms targeting hospital readmissions, success in the new world of population management will depend largely on what happens to the patient following discharge. This will demand a leading role for rehab facilities, skilled nursing and long-term acute-care hospitals. ACOs will need to affiliate with or build an organized system to provide the firepower to manage post-discharge patients, which renders the post-acute care network a key element of accountable care.

Many hospital systems already have PACN components in place. In many markets these services are provided by stand-alone, for-profit entities with historically low levels of functional integration with other members of the care continuum. The strategic question is who will take the lead in forming PACNs to drive effective population health management.

There are four major components of post-acute care:

#### 1. Long-term acute-care hospitals.

Think of LTACHs as extensions of the hos-

pital ICU. Often ventilator dependent, LTACH patients average 20-30 days length of stay. The objective is to provide a bridge from hospital care until the patient can be released to a skilled nursing facility or home.

#### 2. Rehabilitation (inpatient/outpatient).

Rehab facilities may or may not be collocated with an LTACH. A less intensive level of care is provided with focused physical rehabilitation on an inpatient or outpatient basis.

**3. Skilled nursing facility.** Long-term inpatient care often includes rehabilitation. Since the SNF is a lower-cost option, payors are now encouraging more rehab to take place there.

**4. Home care.** The preferred option for post-acute care that has the lowest cost and greatest potential for innovation. In addition to in-home visits, this element of the PACN encompasses electronic monitoring and telehealth.

Until now, these entities seldom linked with hospitals in formal contracting relationships, counting on referral streams to attract patients. An organized PACN could effectively manage patients at the appropriate level of care after leaving the hospital, reducing length of stay and lowering readmission rates. Forward-thinking PAC providers are now looking to band together to form



integrated systems that include all of the components described above.

Hospitals may be looking to build their own PACN, but with so much existing capacity in the market it may make more sense to link up with existing providers. This is a prime opportunity for rehab providers to establish a key leadership position in the era of accountable care. ■

# The Gentle Art of Listening

By Chuck Lauer, former publisher of Modern Healthcare and an author, public speaker and career coach

**L**istening is one of the most powerful communication skills around, but in this era of multi-tasking, many people forget how important it is. No one is immune to talking too much. It's only natural to want to explain your thoughts and opinions. But it's also important to hold back and listen.

When you don't truly listen, you can get out of touch with what is going on around you. People who have forgotten how to listen can become isolated and make the wrong decisions for their organization.

## Listening now viewed as important

Good listening has come to be seen as an important workplace skill. Many professions now place great emphasis on listening skills, but it took a while for this to happen.

In the sales profession, where I started, listening intently to customers wasn't even talked about until the early 1970s. You'd think listening skills would be a no-brainer for sales, but a sales person used to be judged by how they talked rather than how they listened.

In medicine, making accurate diagnoses is based on what patients are telling you. And yet listening wasn't taught in many medical schools until fairly recently. Now medical educators across the country place a great deal of emphasis on the importance of listening to patients as well as to fellow professionals. Listening carefully to what another caregiver is telling you during a handoff is now considered a key patient safety measure.

## How to listen effectively

Some people think good listening is a passive skill, but it actually takes some effort. While the normal speaking rate is about 125 to 150 words a minute, we as listeners process about 500 words a minute, leaving a lot of time for the mind to wander.

Therefore, you need to make a point of listening. Here are a few pointers on developing good listening skills.

Dedicate all your thoughts to the speaker. Make eye contact. And listen without trying to formulate a response. That can come later. First focus on what has been said.

Listen with empathy. Try to figure out what is most important to the speaker. Ask questions when you need clarification.

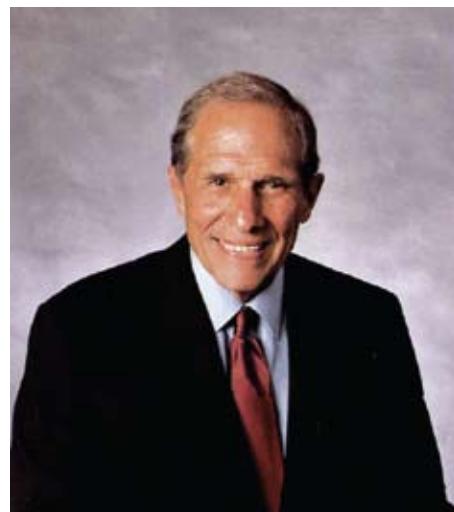
Be an active listener. Nod your head to show interest and, if you like, insert an "uh-huh" every so often to signal you are listening. If it's important to get the message right, provide feedback by paraphrasing what was said. "What I heard you saying is ..." But before interrupting, wait until the end of a sentence or a short break.

Be aware of a speaker's non-verbal communication. It has been estimated that 75 percent of all communication is non-verbal. Is the speaker's posture rigid or relaxed? Does he maintain eye contact? Does his vocal tone match the words he's using?

## What happens if you don't listen

Here is an example of what can happen if you don't listen. Years ago, a gifted sales person working for me said she was having trouble closing sales and asked me to join her on a sales trip to help her find out why. While she was making her pitch to the first client, he tried to interrupt but she just kept on talking. I asked her to stop and the client revealed he had just renewed his ad contract with us and didn't need to be sold. The same kind of thing happened again later on. It was clear that she had to brush up on her listening habits if she was ever going to regain her sales skills.

Truly listening can win you points with the speaker. A few years ago, I met with a CEO who had



turned around a major healthcare system, and I was extremely interested in finding out how he did it. As we began our conversation, though, he received a phone call from his wife and I could tell he was in some distress. Although I had spent months planning this meeting, I immediately excused myself. It was disappointing, but a week later, the CEO called to tell me his son had been in an automobile accident. He said he had appreciated my courtesy in ending the meeting and extended an invitation to meet again.

I'm sure everyone can think of a time when listening — truly listening — proved to be a real benefit. Good listening is one of those rare skills that can be applied to everything you do, from work to home to social situations. Like any key skill, you need to constantly work on it. Even if you think you're good at it, it's not a bad idea to brush up on your listening skills. ■

*Chuck Lauer (chuckspeaking@aol.com) was publisher of Modern Healthcare for 33 years. He is now an author, public speaker and career coach who is in demand for his motivational messages to top companies nationwide.*

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# Understanding Technology's Role in Accountable Care Organizations

By Molly Gamble

**W**hen the Centers for Medicare and Medicaid Services released the proposed rule for accountable care organizations at the end of March, health information technology was recognized and emphasized as a central component. Technological aspects of the proposed rule are closely aligned to the Electronic Health Records Implementation Program and HITECH. HIT will play a large role in a number of processes or concepts of an ACO.

## Requirements on meaningful users of EHR

By the start of the second ACO performance year, at least 50 percent of an ACO's primary-care physicians must be meaningful users of certified EHRs. Achieving meaningful use is an important step in HIT implementation, but providers must first overcome initial barriers that may hinder their attainment of meaningful use. Healthcare providers have demonstrated a need for assistance in overcoming barriers to HIT, such as tight financial resources to buy EHRs and a lack of technical expertise to select the proper system.

## Evidence-based medicine requires HIT infrastructure

ACOs are required to develop and implement

evidence-based medical practices and processes to coordinate care, requiring an infrastructure that allows the ACO to collect data, evaluate it and provide feedback to participants. One technological infrastructure that will perform these tasks is an integrated EHR system with clinical decision support. Furthermore, CMS has required ACOs to coordinate care through technologies such as predictive modeling, remote monitoring, telehealth and electronic health information exchanges.

## Physician quality reporting improved with EHR adoption

ACOs must meet quality performance standards to qualify for shared savings under the proposed rule. The 65 quality measures issued by CMS can be divided into five domains: patient or caregiver experience (7 measures), care coordination (16 measures), patient safety (2 measures), preventive health (9 measures) and at-risk population (31 measures).

Data may still be submitted through existing reporting programs — like the Physician Quality Reporting System, the Centers for Disease Control and Prevention National Healthcare Safety Network — but CMS has noted increased alignment with ACO measure specifications and

EHR quality measure specifications, proposing a system that necessitates increased EHR technology adoption.

## Privacy concerns and HIPAA compliance

The Department of Health and Human Services has proposed three types of medical information to be made available to ACO participants: (a) aggregated data on beneficiary use of services, (b) identification of historically assigned beneficiaries, such as name, date of birth, gender and Medicare ID and (c) Medicare parts A, B and D claims data.

A significant portion of the information ACOs are required to share qualifies as protected health information under HIPAA. In compliance with HIPAA, ACO participants may exchange protected health information under three conditions of healthcare operations: (a) both covered entities have or had a relationship with the subject of the PHI to be shared, (b) the PHI pertains to that shared relationship and (c) the recipient will use the PHI for a "healthcare operations" function, which includes population-based activities, protocol development, case management and care coordination. ■

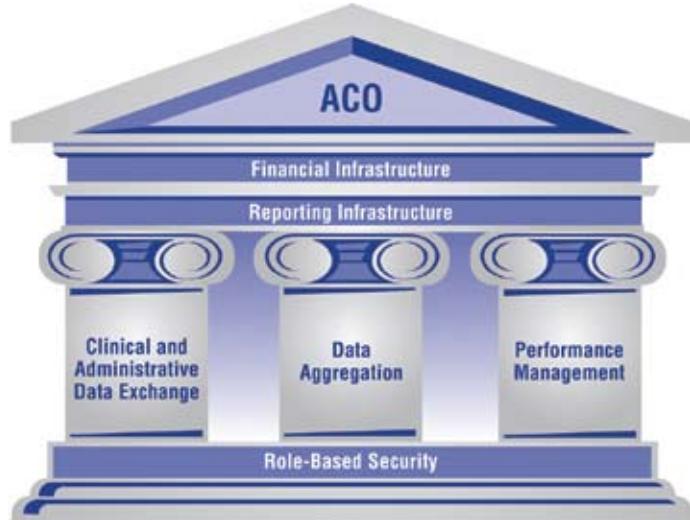
# Six Building Blocks of a Technology Framework for ACOs

By Molly Gamble

**A**ccountable care organizations continue to be a hot topic in healthcare, and with CMS' proposed rule released, many of the "why" and "what" questions regarding the model have largely been answered. However, providers are now beginning to ask what might be the heftiest question of all: how?

How do you create and operate an ACO, particularly in terms of technology? Ken Perez, who directs healthcare performance management provider MedeAnalytics' healthcare policy team and serves as the company's senior vice president of marketing, says it is a critical question that is before healthcare providers today.

"Much has been written about the goals, aims and measures of ACOs — and then you have this void," says Mr. Perez. The tone of the proposed rule was non-prescriptive, leaving many providers wondering how to create the ACO infrastructure that is undoubtedly expected of them.





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To help fill this void, MedeAnalytics performed a public policy analysis, gathered input from leading providers and payors developing ACOs and conducted extensive market research on ACO technology. What MedeAnalytics uncovered were six necessary components of technology to perform the key functions of an ACO.

"This framework is actually a description of the key building blocks required to establish and operate an ACO. It doesn't mention specific technologies — it specifies and describes the functions and roles technology needs to play," says Mr. Perez.

**Role-based security.** Role-based security is considered the foundation of ACO technology since it helps enable a critical, foundational element: trust between stakeholders. Access to data must be managed carefully to maintain confidence between hospitals, physician practices and payors. "You need to make sure there aren't inadvertent disclosures and that information is shared appropriately," says Mr. Perez. "For instance, if a hospital inadvertently shares all of its cost data with a payor, that would be devastating." When developing a technology framework, hospitals should first ensure controlled access and appropriate sharing to foster trust between the parties involved in the ACO. In addition, role-based security can ensure that access to information is also consistent with the position or role of an individual user.

**Data aggregation.** ACOs require the meaningful collaboration of data between hospitals, payors, physicians and ancillary providers to establish a holistic view of a population's health. However, ACOs may not have natural staffing for the extraction, transformation and loading of data. "Because the organizations within an ACO usually don't talk to one another, there is a need for ETL services," says Mr. Perez. "This concept of an information hub is critical, so a third party is often brought in to provide data aggregation services."

**Clinical and administrative data exchange.** The compilation and sharing of patient-, diagnosis-, condition- and procedure-specific data to aid in patient care is central to ACO success. "If you can exchange such data quickly, it can help provide the necessary care coordination as well as benchmarking and analysis," says Mr. Perez. Another critical aspect of this third step is the sharing of disease registries, particularly those that are top concerns for quality measurements such as congestive heart failure, pneumonia and diabetes.

**Performance management.** This component will make data actionable. Ideally, performance management will include dynamic score cards, dashboards and summary/detail reports. This step will also allow ACO participants to measure themselves on a daily, weekly and monthly basis. "The dangerous thing about an ACO is that the government doesn't get your report until the end of the year," says Mr. Perez. "If you wait until the end of the year, you might be in trouble." Mr. Perez compares performance management to former National Coordinator of HIT David Blumenthal, MD's analogy of healthcare as a circulatory system, consistently replenishing itself and refreshing the practice of medicine to make it more efficient. Through daily, weekly and monthly performance management, ACOs can identify problem areas and repair them before year's end.

**Reporting infrastructure.** Reporting infrastructure will allow ACOs to share performance data with stakeholders. Three groups will be interested in an ACO's clinical quality and financial performance: payors, the ACO's governing body and relevant stakeholders within the ACO. The stakeholders may vary between Medicare and commercial ACOs, but clearly, both will be concerned with clinical and financial outcomes.

**Financial infrastructure.** The last component enables the acceptance, tracking and allocation of payments tied to performance results. "The process for how ACOs will divide payments was not even mentioned in the original legislation (the Patient Protection and Affordable Care Act), but in the proposed rule, providers will have to describe the methodology or rules by which they will allocate shared savings payments in their application to become an ACO that they will submit to CMS," says Mr. Perez. "Of course, the allocation methodology should be objective and reasonable, so it should be data-driven." This may be the most difficult step of all six components due to its sensitive and complex nature. "Some people have suggested that a third party assist in this matter," says Mr. Perez.

"As with the different elements of buildings, these six technology components are interrelated and synergistic. Each one of them constitutes an essential building block of an effective ACO," Mr. Perez concluded. ■

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Technology Component	Definition	Examples
Financial Infrastructure	Ability to accept, track and allocate payments associated with performance results	<ul style="list-style-type: none"> <li>Validate budget goals based on beneficiary population</li> <li>Track performance payments received</li> <li>Administer chosen payment methodology to participating providers (distribution of the ACO's portion of the shared savings)</li> </ul>
Reporting Infrastructure	System to share performance data (e.g., clinical quality, financial) with the payer, governance team and relevant stakeholders	<ul style="list-style-type: none"> <li>Monthly performance reports</li> <li>Population management trends (disease management and case management)</li> <li>Utilization and practice variation reports</li> </ul>
Performance Management	Dynamic scorecards, dashboards, and summary and detail reports supported by proactive alerts and work lists in a collaborative environment	<ul style="list-style-type: none"> <li>Disease-specific dashboards (e.g., diabetes, COPD, CHF)</li> <li>Comparison of actual results to benchmark data and performance targets (e.g., ALOS, avoidable readmissions, preference-sensitive care, cost)</li> <li>Adherence to evidence-based medicine</li> </ul>
Data Aggregation	Meaningful joining of data from payers, hospitals, physicians and other ancillary providers to create a holistic view of a population's care experience	<ul style="list-style-type: none"> <li>Aggregation and sharing of administrative and clinical data from various disparate sources (e.g., facility and professional claims, lab, radiology, pharmacy, authorizations and census data)</li> </ul>
Clinical and Administrative Data Exchange	Compilation and sharing of patient-, diagnosis-, condition- and procedure-specific data to aid in diagnosis, treatment and/or analysis.	<ul style="list-style-type: none"> <li>Hospital shares detailed procedure information and discharge plan with patient's primary care physician</li> <li>Physician shares outpatient care history (including pharmacy, labs and radiology) with admitting hospital</li> <li>Shared disease registry that is accessed and enriched by all</li> </ul>
Role-Based Security	Secure, online environment which allows for controlled access to and sharing of data on a variety of levels between stakeholders	<ul style="list-style-type: none"> <li>Access to aggregate cost and quality trends by governance and project teams</li> <li>Secure repository for shared aggregate and detailed data</li> <li>Sharing of patient-specific clinical data between responsible caregivers</li> </ul>



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# How to Gain Stakeholder Support for Transactions

By Sabrina Rodak

**H**ospitals do not operate in a vacuum; they affect everyone in the community. Without the buy-in of employees, staff, community members and elected officials, an otherwise well-planned transaction may fail. But how can hospital leaders gain the support of so many disparate groups? Read on to find the answers.

## Communication

Clear, frequent communication is critical to gaining stakeholder support. Establishing an open dialogue from the beginning of a transaction and continuing to communicate even after a transaction is complete helps build support among key stakeholders in hospitals.

Molly Cate, of the healthcare public affairs firm Jarrard Phillips Cate & Hancock, says, "First and foremost hospitals have to start internally, because if they don't they lose the opportunity to create messengers to speak for [them]." Building support among staff, employees and board members provides a base from which support of the community and political leaders can grow. "When in transition, people's appetite [for communication] increases; people absorb it and talk about it at work, at the grocery store, at church on Sunday," she says.

Marc Halley, president and CEO of Halley Consulting Group, suggests a similar tactic for building support among staff members when a hospital acquires a medical practice. Mr. Halley says leaders should be "clear [to staff] about why they're in the business [of acquiring a medical practice] and why it's going to be successful." He says explaining the reasons for their decision can increase understanding and prevent staff from feeling threatened. Leaders should "demonstrate that they're not trying to hurt independent physicians" to build trust between the two groups, according to Mr. Halley. Another strategy for alleviating fears can be to tell staff and employees that "homework has been done," Ms. Cate says. Letting stakeholders know that thought and deliberation led to the decision to pursue a transaction can inspire trust and understanding in potential supporters.

## Dialogue

Key to successful communication to stakeholders is dialogue: hospital leaders should both dispense and gather information. Ms. Cate compares gaining buy-in for a hospital transaction to running a political campaign. As in a political campaign, the hospital CEO is responsible for discovering the wants and needs of the constituents and packaging the transaction to fit those wants and needs. "Most employees got into healthcare because they want to help people," Ms. Cate says. Thus, one way to package the transaction to employees is "helping them realize how a transition is going to impact their ability to [help people]." For example, emphasizing that a merger will help integrate service lines and possibly decrease errors may encourage employees to support the transaction because it will help them care for patients.

Hospital leaders can learn about their constituents by examining data for patient satisfaction, community perception and community needs, according to Ms. Cate. Another strategy is to create a small group representing a cross section of the constituency. The group members would "be the eyes and ears of the campaign. They can tell you what people really say, what people really think about an issue," Ms. Cate says. Simply listening to information, however, will not accomplish a hospital's goals. Leaders need to respond to stakeholders by constantly updating them on the hospital's progress and plans. In turn, leaders should constantly update themselves on the stakeholders' concerns.

## Strategy

Once leaders understand their constituents, developing a strategy of how to communicate to each group may help ensure inclusion of communication in the transaction process. "Insistence on communication since the beginning can be an easy thing to brush aside because of all the other pieces [involved in a transaction], but it's critically important," says Ms. Cate. She says one strategy for successful communication is for hospital leaders to create a vision and message about the transaction and then to be consistent in this message.

Mr. Halley says that in his consulting firm, he helps hospital leaders create a communication matrix that identifies who the stakeholders are, what likely questions and concerns they have and what the hospital's response will be. The matrix further describes who will communicate to the various stakeholders and how. Mr. Halley says there are various ways to successfully communicate to stakeholders, including using a multimedia approach, meeting face to face, sending a hospital newsletter to medical staff members and creating boards and committees, among others.

By using a variety of communication methods, leaders can reach each group of stakeholders and gain support for their transaction. ■

## Overall Healthcare M&A Spending Up, Volume Down

By Lindsey Dunn

**A** total of \$54.4 billion was spent to finance mergers and acquisitions in the healthcare industry during the first quarter of 2011, up 65 percent from \$32.9 billion in the first quarter of 2010, according to a new report by Irving Levin.

However, deal volume slipped somewhat during the same period, with a 16 percent decrease in transactions from the fourth quarter of 2010 and an 8 percent dip from the year ago quarter.

Pharmaceutical M&A spending totaled \$13.5 billion for the quarter, representing 24 percent of all healthcare M&A spending, and medical device M&A totaled \$11.7 billion, or 21 percent of spending. Hospital M&A totaled \$1.9 billion, or 4 percent of spending. M&A activity spending for physician medical groups was \$14.6 million, less than 1 percent of spending.

By deal volume, long-term care ranked first among subsectors with 27 deals. Hospitals completed 23 deals, up 156 percent from 9 deals in the first quarter of 2010 but down 4 percent from the fourth quarter of 2010 (24 deals). Physician groups were involved in 12 deals, up 50 percent from a year ago. ■

# 7 Traits of a Great Hospital CEO

By Sabrina Rodak

**C**EOs play a large role in the success of a hospital. But as the healthcare system gets more complex, CEOs face increasing demands on their time and responsibilities. What skills are most important for a hospital CEO in today's world? Several top leaders — including St. Vincent Health's Vincent Caponi, Lehigh Valley's Ronald Swinfard and Johns Hopkins' Edward Miller — share what they think makes a great hospital CEO.

**1. Servant leadership.** Vincent C. Caponi, BA, MHA, CEO of Indianapolis-based St. Vincent Health, says CEOs should be servant leaders. "A great leader, I believe, is one [where] people are doing things under [his or her] supervision because it's the right thing to do and they want to do it, not because you told them to do it," he says. The concept of servant leadership encompasses several traits, including integrity, genuineness and gratitude. Great hospital CEOs are responsive, available and keep promises, according to Mr. Caponi. "Somehow, great leaders in my experience made return phone calls in 24 hours," he says. Being true to one's image as a CEO is also important, according to Ronald W. Swinfard, MD, president and CEO of Allentown, Pa.-based Lehigh Valley Health Network. Part of being genuine is being honest and insisting on transparency. He also suggests sharing one's personal life as a way to show genuineness. Part of servant leadership is also appreciating others. "Take nothing for granted," Mr. Caponi says.

**2. Communication.** Communication is important for any leader to be successful. The structure of a hospital, however, with many departments, employees and physicians, may make communication even more important for leading the organization. Part of the CEO's responsibility is to keep employees, staff and physicians informed of the hospital's plans, including progress on key initiatives and intentions to form affiliations or partnerships. "Communicate often and clearly," says Mr. Caponi.

Edward D. Miller, MD, CEO of Baltimore-based Johns Hopkins Medicine, suggests communicating with constituents through multiple avenues, such as town hall meetings, daily emails, the hospital website, printed material, radio announcements and of course, face-to-face interactions. It is important to be "out and about," Dr. Miller says. "People need to know who you are." At Johns Hopkins, the executives, including Dr. Miller, are involved in different units. Dr. Miller, for instance, is the safety officer for the neuro-intensive care unit, where he talks with staff and physicians about their concerns and any issues related to the unit. "I think it's a little too easy to stay in your office," Dr. Miller says. "Extend your comfort zone. Get out and talk to people in the hospital."

Communication is a two-way street, however, and for hospital CEOs, listening may be more useful than talking, according to Dr. Miller and Mr. Caponi. "You need to listen more than you talk," Mr. Caponi says. "I have a great feel of the wisdom of those around us, and I seek that out as much as I can," he says.

**3. Mentorship.** "Have and be a mentor," Mr. Caponi says. "You need somebody who can unabashedly tell you where your blind spots are, encourage you and sift through some of the difficult decisions you have to make." He also suggests trying to learn something new every day, which can remind a CEO that he or she can always improve. Mr. Caponi says hospital CEOs should be humble — self-aware and willing to admit their mistakes. Furthermore, just as CEOs needed help getting to their position and need help continuing to develop skills, CEOs have a "responsibility to share wisdom and knowledge with those in the organization who are open and would want that," he says.

**4. Being a model.** As the head of a hospital, everyone looks to the CEO to gauge the state of the organization. The CEO plays a large role in setting the tone and culture of a hospital. For example, Mr. Caponi says a "can-do," positive attitude can help motivate others in the hospital to work to overcome challenges.

Dr. Miller says he purposely does not travel often because his responsibility as CEO is to be at the hospital. Being physically present in the hospital every day sets the work ethic, according to Dr. Miller. "You certainly should not see yourself as appointed king. You work for the organization, the organization doesn't work for you," he says.

**5. Connection with the community.** Mr. Caponi suggests CEOs volunteer and give back to the community. "Great leaders have a sense of community," Mr. Caponi says. Dr. Swinfard suggests networking is useful for CEOs to connect with and learn from the community. In light of healthcare reform legislation, hospital CEOs should be aware of how other organizations react to changes in the field, according to Dr. Swinfard. It is helpful to get different perspectives on changes in healthcare. Talking to board members, for instance, can provide insight because many board members have experience in businesses outside healthcare, Dr. Swinfard says.

The community includes not only the outside community that the hospital serves, but also the community within the hospital. "The people are the most important part of the equation [in the success of a hospital]," Dr. Miller says. He suggests the collective employees, staff and physicians is one of a CEO's greatest assets as a leader. Dr. Swinfard also remarks on the importance of

people and community. He says CEOs should have warmth: "the personal touch that engages [employees] in a common mission and aligns us all; we're humans, we care for one another and we care about taking care of people." Connecting with the hospital community on a basic level can help the CEO gain support and respect as a leader. "I think that sense that you are engaged in the same thing that called the employees to work in healthcare is probably what separates good [CEOs] from great [CEOs]," Dr. Swinfard says.

**6. Sense of humor.** Mr. Caponi says humor and learning to have fun are important for a hospital CEO. Dr. Swinfard also says CEOs should have a sense of humor. "People go into healthcare because of a calling," Dr. Swinfard says. "They are there because they want to serve people; they get an emotional and psychological personal return from service and giving of themselves. That's stressful work. It can take quite a drain. A little humor along the way can cut through that stress and make people feel better about themselves," he says.

**7. Balance.** Because of the varied responsibilities and concerns of a CEO, balance in one's actions is key to achieving success. Dr. Swinfard says it is important to be conscious of the importance of people in healthcare as well as the importance of a bottom line. Maintaining a balance of concern for people and finances helps the CEO not get worn down, according to Dr. Swinfard.

Mr. Caponi says one quality of great CEOs is the ability to differentiate when they need to compete and when they need to collaborate. "If [you're] always in a competitive mode, you're not going to get things done; you need cooperation from others." Collaborating in patient safety initiatives and sharing best practices, for instance, can benefit the whole. However, "competition is not a bad thing," Mr. Caponi says.

To attract and retain patients, employees, physicians and board members, the CEO may have to be competitive. Competition can also drive positive change. Benchmarking, for example, can help a CEO identify areas for improvement. Balancing security and risk is also a useful strategy for CEOs.

Dr. Miller says a willingness to take risks is important in improving the hospital. Taking risks may be particularly rewarding in times when the industry is changing, such as healthcare is now. "There is a lot of opportunity in turbulent times," Dr. Miller says. For example, Johns Hopkins took a risk by investing in home care. "We have not just stayed static; we are moving." ■



# 5 Problems That Hurt a Hospital-Physician ASC Joint Venture — and How to Avoid Them

By Rachel Fields

**P**hysicians and hospitals can both benefit significantly from a hospital-physician ASC joint venture: The hospital benefits from transferring its brand to the surgery center and building a strong relationship with community physicians, and the physicians benefit from greater leverage in payer contract negotiations, access to better supplier agreements and decreased competition.

However, joint ventures can run into problems when hospital and physician interests are misaligned or ASC efficiencies are not maintained. Luke Lambert, CEO of ASCOA, and Brandon Frazier, vice president of acquisitions and development of ASCOA, discuss five issues that cause joint ventures to fail — and how to avoid them.

**1. Lack of physician control.** Mr. Frazier says he has seen hospital-physician joint ventures run into problems when the hospital usurps all physician control and attempts to run the surgery center like a hospital.

"I think the key is setting the joint venture up so that the physicians feel like it's their center," says Mr. Frazier. He says ASCOA has found success in setting up hospital-physician joint ventures that maintain a sizeable percentage of physician ownership and divide the rest of the ownership between the hospital and the management company. Mr. Lambert says ASCOA's joint venture model is based on a concept pioneered by other ASC leaders. In this model, the hospital owns 51 percent of the joint venture between the hospital and the management company, which in turn owns 51 percent of the surgery center. This level of ownership allows the hospital to leverage strong contracts with payors for the surgery center and allows the management company to assist in improving ASC efficiency and operations.

Mr. Frazier adds that ASCOA is unique in its approach to physician involvement in ASC leadership. All the physicians in ASCOA joint venture surgery centers sit on the board of managers and attend the monthly board meetings. In addition, all officer positions are held by physicians.

**2. Poor payor contracts.** Mr. Frazier says he has seen issues with hospital-physician ASC joint

ventures when the hospital participates in the joint venture as a defensive mechanism and then fails to help negotiate strong payor contracts. "The hospital isn't proactively seeking a surgery center, but they get word that a group of surgeons is leaving to build one on their own," he says. "The hospital participates, but their heart isn't in it, and as a result, they don't use their leverage to assist with contracting." He says ASCOA has seen many ASC joint ventures fail due to poor contracts. When the same people who negotiate the hospital contracts are in charge of negotiating the ASC contracts, they are tempted to prioritize hospital contracting because the majority of the hospital's revenue is based on that reimbursement.

Hospitals and physicians can build successful joint ventures by establishing trust and expectations before any plans are finalized, says Mr. Frazier. It may be difficult to lay out in a contract exactly how the hospital will assist with payor contracts, so hospital administration and surgery center physicians must spend time with each other to assess their level of commitment. A management company can assist in this process by acting as the "middle man" between the two parties — if the physicians have a concern about the hospital or vice versa, the management company can act as the go-between without hurting the partnership.

**3. Dissatisfied surgeons.** Dissatisfied surgeons can kill a hospital-physician joint venture, as a steady stream of cases contributes significantly to ASC profitability. "When we come into centers that are failing, many times surgeons are very disgruntled," says Mr. Frazier. "As a result, they're not bringing all of their cases to the center and have lost hope that the center is going to be profitable." Once physicians reduce their case volume, the ASC goes into a "death spiral" where cases continue to decline and profitability and moral worsen, he says. This dissatisfaction may be caused by several factors, including lack of expected efficiency, issues with hospital management or several physicians burdened with bringing the majority of cases.

Mr. Frazier says fortunately, a poor surgeon attitude toward an ASC joint venture is "almost never a fatal flaw." The presence of a professional management

company, which can provide years of ASC experience, can re-build a fractured relationship between the hospital and the surgery center and increase the level of surgeon commitment.

**4. Too many physicians splitting ownership.** Hospital-physician ASC joint ventures can fail because the hospital offers ownership to a large number of its medical staff. "That potentially dilutes down any one physicians' participation to such a small level that you start to lose the inherent benefits of having physicians feel like owners," says Mr. Lambert. "If they own a quarter of a percent each, they don't care if they use expensive supplies or not." He says physicians with a greater level of ownership are more likely to care about the effect of cost-cutting efforts on their distributions, meaning they will make an effort to increase efficiency, standardize supplies and involve themselves in money-saving initiatives.

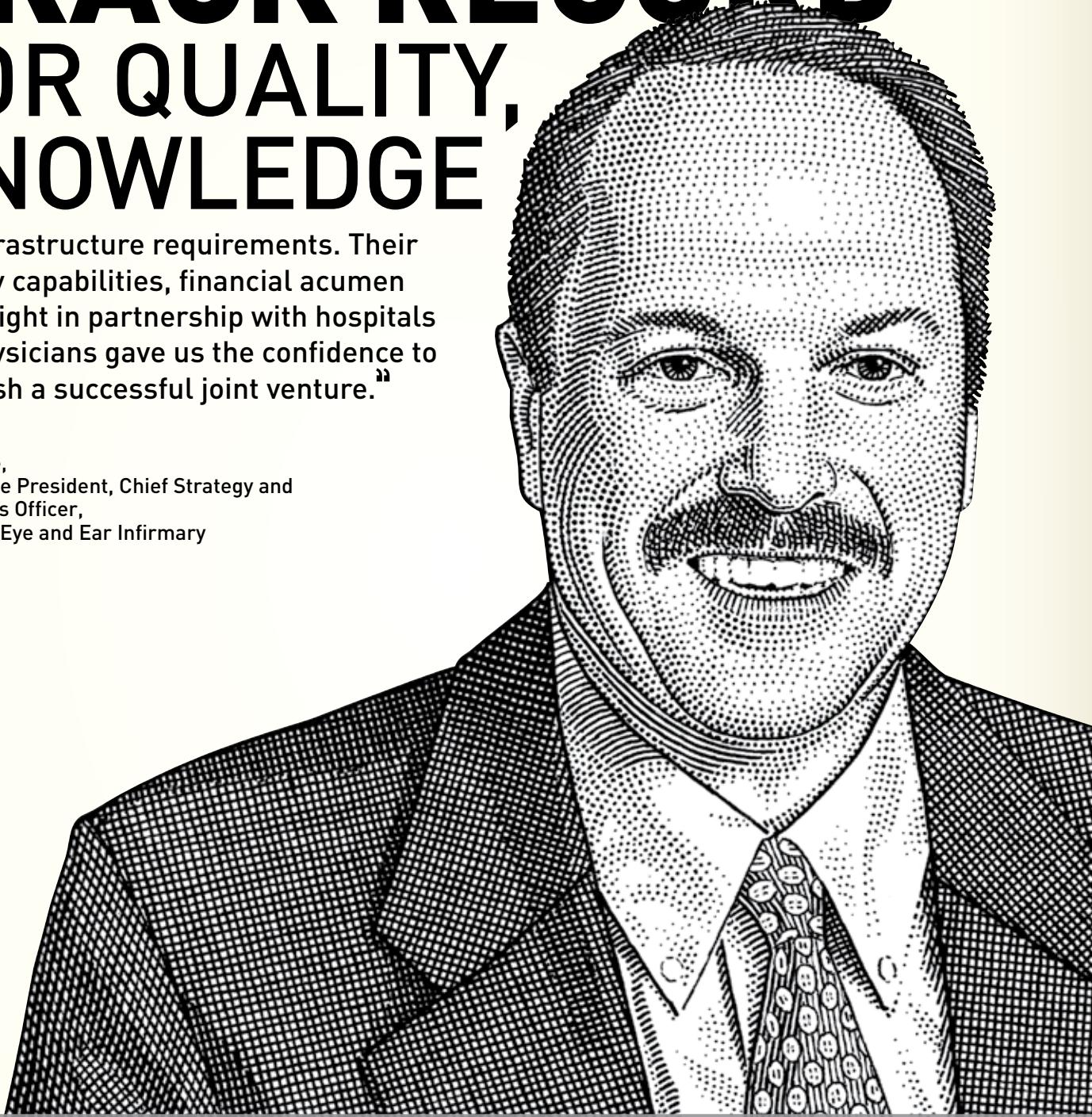
**5. Surgery center inefficiencies.** Many physicians get involved in ASC ownership because of the increased efficiencies in performing cases at a surgery center. If a hospital-physician ASC joint venture loses sight of the importance of efficiency, Mr. Lambert and Mr. Frazier agree that physicians will become disheartened and profitability will diminish. Mr. Lambert says a management company is helpful in this circumstance because the company is fully committed to the financial profitability of the center, meaning efficiency is a priority. "From the hospital perspective, we encourage hospitals to be supportive of the center and physicians, rather than trying to roll out policies from the hospital that may not ultimately be supportive of the aims of the center," he says.

For example, if the ASC has a lot of empty time or poor scheduling, the ASC is likely wasting money by staffing employees while physicians aren't performing cases — a significant problem at an ASC, but commonplace at a hospital. "What we do is compress the schedule and assign blocks of time where we're doing all the cases in a certain period of time," Mr. Frazier says. "If we're done at 3:00, we turn the lights out and go home. That's very different from the hospital mentality." ■

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# 5 Key Legal Issues Affecting Surgery Center Joint Ventures

By Scott Becker, JD, CPA, Partner, McGuireWoods

**1. Percentage of hospital ownership.** According to Mr. Becker, there are several different arguments about the necessary percentage of hospital ownership of a joint venture ASC. Generally, a hospital, whether a for-profit or not-for-profit, does not need to own 51 percent of the joint venture, though that level of ownership can help in managed-care contracting and tax-exempt concerns. Tax-exempt concerns can generally be addressed through control of management rather than ownership, he says.

"Some hospitals will say, 'We're told by our lawyers that we have to own more than 51 percent to make sure this doesn't harm us from an exempt income standpoint,'" Mr. Becker says. "The much more important issue is: Does the hospital have sufficient control to ensure the joint venture serves community/charitable purposes?" He says the IRS is primarily concerned with whether the hospital can exert control over the surgery center to force it to serve and prioritize community/charitable purposes.

Mr. Becker says in some cases, an ASC management company and the hospital set up a venture together that facilitates hospital control. For example, the hospital might own 51 percent of the hospital-management company venture (holdco), which, in turn, owns 51 percent of the ASC joint venture. While the hospital may only own 26 percent of the joint venture overall, the hospital attempts to maintain sufficient control of the ASC by controlling the venture through the holdco.

**2. Anti-trust issues.** A key issue is whether a hospital and ASC can jointly contract to obtain better rates from managed care payors. Increasingly, payors examine the ownership of the hospital in the ASC and the extent of clinical and financial integration between the hospital and ASC.

Under case law, it has traditionally been perceived that 80 percent or more hospital ownership makes it impossible for the hospital and surgery center to conspire with each other, while 50-80 percent hospital control may meet different determinations from region to region. A hospital that owns less than 50 percent of a surgery center must demonstrate significant control or clinical and/or financial integration if the two entities are to be able to approach payors together.

Mr. Becker also notes that payors may react very differently in dealing with managed care contracting for hospital/ASC joint ventures. "If the hospital is a core provider that works extensively with the payor, the payor may immediately be very receptive," he says. "Other payors say unless the hospital owns a large percent, the ASC and the hospital have to be treated as totally separate."

**3. Determining fair market value.** If the surgery center is being formed from an existing hospital department, the valuation placed on the new free-standing joint venture must be fair market value, Mr. Becker says. There are multiple ways of determining fair market value, but the hospital must make sure the fair market value price has been researched and can be defended. Further, as units are sold to new physicians, they also must be sold at not less than fair market value.

**4. Medical staff relations.** In forming a hospital/physician ASC joint venture, the hospital and center must determine how medical staff issues will be handled by each entity. Most joint ventures keep medical staff for the surgery center entirely separate from the hospital. Others require that the surgery center physicians take call at the hospital. According to Mr. Becker, many joint ventures use two separate medical staff but require that physicians on staff at the surgery center hold admitting privileges at the hospital so that patients can be transferred easily in case of an emergency at the surgery center. There may also be an overlap in credentialing between the two facilities.

**5. Physician acquisition and investment.** A more recent issue for hospital/physician ASC joint ventures concerns the acquisition of physicians in the local community. If the hospital starts employing physicians, will those physicians still be allowed to invest in the surgery center? "Many hospitals do not allow it," Mr. Becker says. "We believe that as long as the physician has to meet the same requirements as other physicians and isn't forced to invest in the center or helped to invest in the center, it should largely be acceptable." If acquired physicians are not allowed to invest in the surgery center, that could prove fatal for the center's business in some situations, he says. ■

## ASC Fast Facts

### 10 Most Frequently Provided Ambulatory Surgery Center Services

Here are the 10 most frequently provided ambulatory surgery center services in 2009, along with their percent of total volume, according to the Medicare Payment Advisory Commission's (MedPAC) March 2011 Report to the Congress: Medicare Payment Policy.

1. Cataract surgery w/IOL insert, 1 stage — 18.1%
2. Upper GI endoscopy, biopsy — 8.0%
3. Colonoscopy and biopsy — 5.5%
4. Diagnostic colonoscopy — 4.6%
5. After cataract laser surgery — 4.4%
6. Lesion removal colonoscopy — 4.4%
7. Injection spine: lumbar, sacral (caudal) — 3.6%
8. Inject foramen epidural: lumbar, sacral — 3.6%
9. Inject paravertebral: lumbar, sacral add on — 2.8%
10. Inject foramen epidural add on — 2.0% ■

Source: MedPAC



ASCOA – The ASC Experts

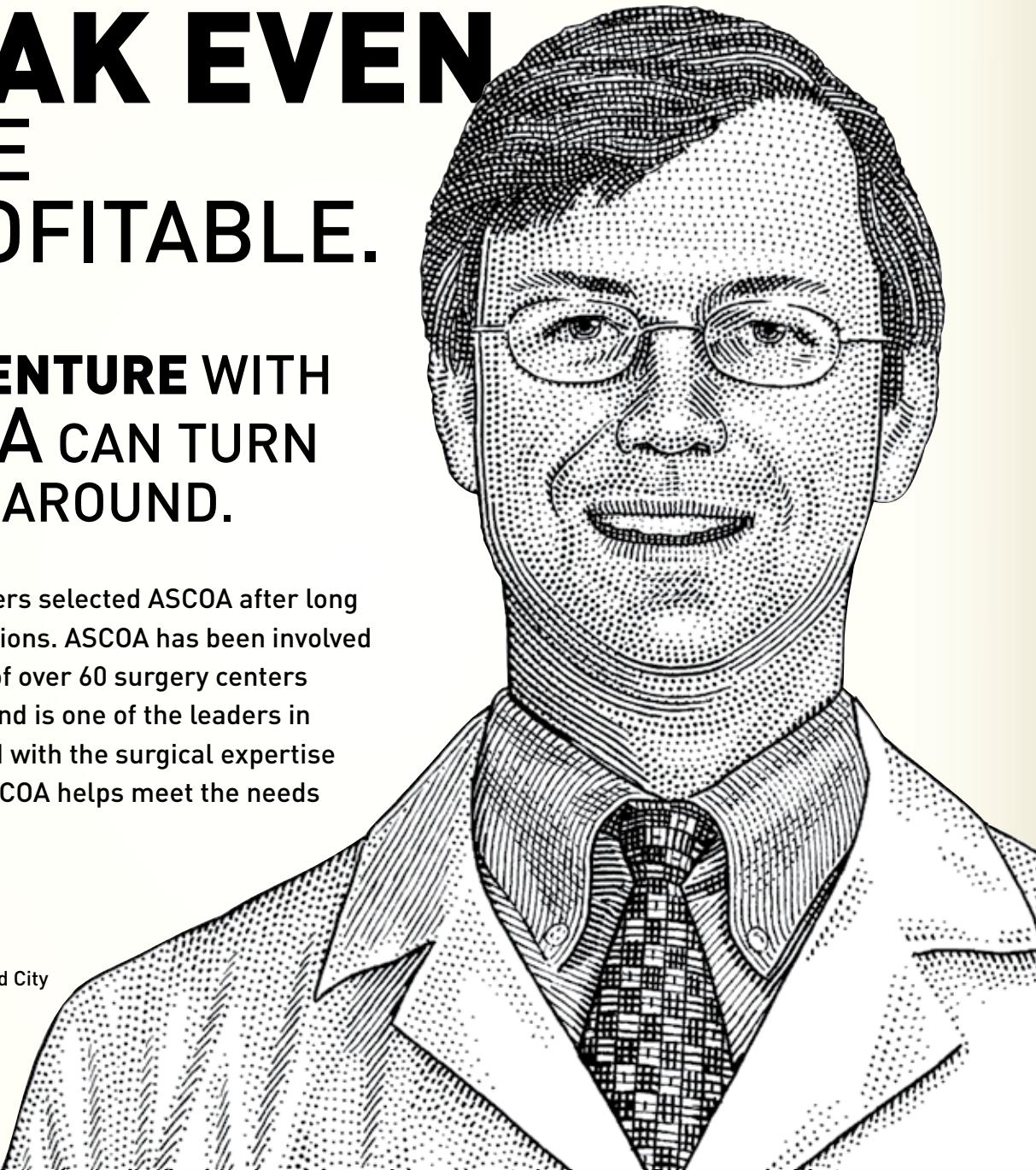
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# Hospital & Health System Transactions

Lexington, Ky.-based **Appalachian Regional Healthcare** and Wendover, Ky.-based **Frontier Nursing Service** entered into a letter of intent for ARH to acquire **Mary Breckinridge Hospital** in Hyden, Ky., and all related healthcare services.

St. Louis-based **Ascension Health** signed a letter of intent to acquire Arlington Heights, Ill.-based **Alexian Brothers Health System**, a two-hospital system.

**Baylor Health Care System** and **Select Medical Corporation** officially launched a joint venture consisting of a partnership between Baylor Institute for Rehabilitation and Select Physical Therapy Texas.

San Francisco-based **Catholic Healthcare West and Phoenix Children's Hospital** signed a definitive agreement under which Phoenix Children's will receive pediatric cases from CHW's St. Joseph's Hospital and Medical Center.

Englewood, Colo.-based **Centura Health** and **Heart of the Rockies Regional Medical Center** in Salida, Colo., signed an affiliation and services agreement. Through the partnership, Centura Health and HRRMC will develop shared programs for cardiology, stroke, spine and trauma.

**Erlanger Health System** in Chattanooga, Tenn., agreed to partner with Fort Oglethorpe, Ga.-based **Hutcheson Medical Center**.

Nashville, Tenn.-based **HCA** is planning to merge the hospital license for its newly acquired **Mercy Hospital** in Miami into **Plantation**

(Fla.) **General Hospital**. Under the license merger, all agreements for reimbursement with the federal government under the Mercy Hospital license would terminate and Mercy Hospital would be renamed Mercy Hospital, a campus of Plantation General Hospital.

Naples, Fla.-based **Health Management Associates** entered into a joint venture partnership with the current physician owners of **Tri-Lakes Medical Center** in Batesville, Miss.

New York City-based **Healthcare Management Partners** will sign agreements to manage South Carolina's **Allendale County Hospital** in Fairfax, **Barnwell County Hospital** and **Bamberg County Hospital**.

Stockbridge, Ga.-based **Henry Medical Center** chose to partner with **Piedmont Healthcare in Atlanta**. The final agreement will need to be approved by the Georgia Attorney General's office.

Stillwater, Minn.-based **Lakeview Health** and Bloomington, Minn.-based **HealthPartners** have completed a formal affiliation, bringing Lakeview Health into the HealthPartners system.

Massachusetts' Public Health Council approved the transfer of licenses for **Merrimack Valley Hospital** in Haverhill, Mass., and **Nashoba Valley Medical Center** in Ayer, Mass., to Boston-based **Steward Health Care System**.

**Milton (Mass.) Hospital** and **Beth Israel Deaconess Medical Center** in Boston have announced plans to merge in six months. The 631-bed BIDMC will oversee 80-bed Milton's opera-

tions and finances, but Milton will keep control of strategic planning and its own board of trustees.

Norristown, Pa.-based **Montgomery Healthcare System** has officially become part of Philadelphia-based **Albert Einstein Healthcare Network**.

**Owensboro (Ky.) Medical Health System** and **Kosair Children's Hospital** in Louisville, Ky., opened **Kosair Children's Outpatient Center - Owensboro**, as part of an affiliation for pediatric care. Pediatric specialists from University of Louisville (Ky.) Pediatrics and Norton Healthcare, the Louisville, Ky.-based parent company of Kosair Children's Hospital, will staff the center.

The merger between **RMH Healthcare** in Harrisonburg, Va., and Norfolk, Va.-based **Sentara Healthcare** has been finalized.

**Saints Medical Center** in Lowell, Mass., signed a letter of intent to become part of Boston-based **Steward Health Care System**.

The Sierra Kings Healthcare District board of directors unanimously approved a letter of intent confirming an agreement between **Sierra Kings District Hospital** in Reedley, Calif., and Hanford, Calif.-based **Adventist Health Central Valley Network**.

Phillipsburg, N.J.-based **Warren Healthcare** plans to join Bethlehem, Pa.-based **St. Luke's Hospital and Health Network**.

County-owned, 25-bed **White County Memorial Hospital** in Monticello, Ind., merged with Indianapolis-based **Indiana University Health**.

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# Hospital & Health System Executive Moves

Akron (Ohio) General Health System named **Benito "Ben" Alvarez, MD**, senior vice president of medical affairs and CMO of Akron General Medical Center.

After 15 years, **Peter Bastone** is resigning as president and CEO of Mission Viejo, Calif.-based Mission Hospital.

CMO **Steve Berkowitz, MD**, is resigning from Austin-based St. David's HealthCare in May to launch a healthcare consulting business.

CEO **Peter J. Betts** resigned from Johnson Memorial Medical Center in Stafford Springs, Conn., due to his disagreement with the management team about how to implement the hospital's strategic plan. COO **David Morgan** will serve as interim CEO.

Worcester-based UMass Memorial Health Care named **Douglas Brown** interim president and CEO of its Marlborough (Mass.) Hospital.

Hanford, Calif.-based Adventist Health's Central Valley Network named **Wayne Ferch** president and CEO. He will replace **Richard L. Rawson**, who was named corporate vice president of Adventist Health for Central California.

After 22 years, CEO **Tim Hanson** will retire from St. Paul, Minn.-based HealthEast Care System in January because he will reach the mandatory retirement age this year.

Greenville, N.C.-based University Health Systems of Eastern Carolina named **David Herman, MD**, president.

**Bruce Klockars, FACHE**, was named interim CEO of Saint Joseph Health System in Lexington, Ky., and senior vice president of divisional operations for parent company Catholic Health Initiatives.

San Antonio Community Hospital in Upland, Calif., named **Harris F. Koenig** president and CEO.

**Bob Lanik** is stepping down as CEO of Lincoln, Neb.-based Saint Elizabeth Regional Medical Center, part of Denver-based Catholic Health Initiatives, to become CEO of CHI Nebraska.

Sanford Health Network, based in Fargo, N.D., and Sioux Falls, S.D., named **Gordon Larson** the first CEO for its new Sanford Aberdeen (S.D.) Medical Center.

Neptune, N.J.-based Meridian Health named **Dean Q. Lin, MHA, MBA, FACHE**, president of its 281-bed Ocean Medical Center in Brick, N.J.

Miami-based Jackson Health System named **Carlos Migoya** CEO.

Memorial Health Care System in Fremont, Ohio, named **Wesley Oswald** interim CEO. He temporarily replaces **John Yanes**, who left for a position at O'Bleness Memorial Hospital in Athens, Ohio.

Boston-based Steward Health Care System has named **John Polanowicz** president of St. Elizabeth's Medical Center in Brighton, Mass.

**Rodney W. Williams, MD, JD, MS**, was named CMO of Suffern, N.Y.-based Bon Secours Charity Health System and vice president of medical affairs for its Good Samaritan Hospital, also in Suffern, N.Y.

Cleveland Clinic named **Robert Wyllie, MD**, chief medical operations officer. Dr. Wyllie replaces **Marc Harrison, MD**, who became CEO of Cleveland Clinic Abu Dhabi.

Harrisburg, Pa.-based PinnacleHealth named **Michael A. Young** president and CEO, effective in June. He will replace interim president and CEO **Philip W. Guarneschelli**, senior vice president and COO of PinacleHealth.

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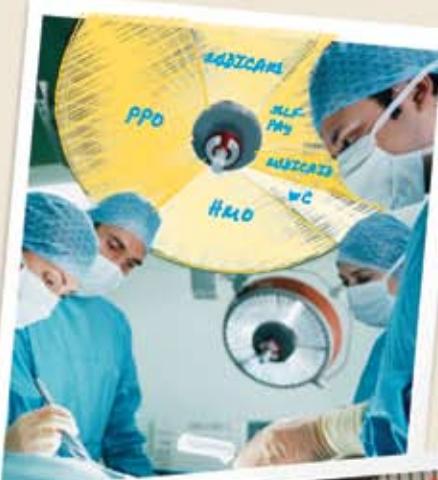
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