THE BLUEPRINT
NOTES FROM THE "BUILDING THE MEDICAL HOME" INNOVATION COLLABORATIVE

Attorney interview: The "Primary Care Institute" as a contractual framework for hospital-physician PCMH support

By Amanda Berra on October 13, 2010 2:07 PM | Permalink | Comments (0)

Hospitals struggle with the issue of how to support independent practices in the PCMH model without running afoul of the law. From the viewpoint of Squire, Sanders & Dempsey L.L.P. attorneys John Kirsner and John Wyand, the essential starting point is letting go of the idea that it is OK to provide significant operational support to physician practices "for free" under the banner of quality improvement.

This collaborative has explored the question of the legal parameters for supporting PCMH practice transformation in a couple of different ways lately -- in particular, please see the recorded webconference "Building the Ship While Sailing: Legal Issues for Hospitals Exploring Medical Home Models." In follow-up to that webconference, this interview with John Kirsner and John Wyand touches on why it may be necessary to create a legal structure for hospital-physician support, and provides greater detail on their suggested model: A co-management-based primary care institute.

ASB: John and John, can you recap why you think it is problematic for hospitals to provide extensive support for the creation and maintenance of PCMHs among independent primary care practices without a contractual framework for those services? In other words, why can't hospitals just give this support away?

JK/JW: Amanda, PCMHs that involve hospitals and physicians can invite scrutiny by the OIG and others under Stark and AKS. When a hospital and a physician have a financial relationship, Stark concerns are raised when a physician refers a patient to that hospital for a number of services including inpatient and outpatient services. Similarly, AKS concerns are raised because of the possibility that the financial relationship is intended to induce physician referrals. Most quality-related services are generally available to all members of a medical staff, but when shifting resources toward supporting services for a select group of physicians, both the hospital and physicians should make sure to enter into a written agreement meeting Stark and AKS exceptions.

ASB: Is there a dividing line, say in financial or number of FTE terms, between what is OK to give away versus what needs a contractual or legal affiliation?

No. There are no de minimis exceptions to the financial relationships under Stark and AKS. Stark is a "strict liability" law where the exceptions are structured to clearly distinguish permissible arrangements. We tell our clients it's like running a red light -- you either did or didn't, and there's no in between. AKS is different because it's intent-based and when an arrangement does not fit squarely within a safe harbor, one makes a subjective assessment of the risk of an enforcement action. We advise our clients whose arrangements don't meet all the elements of a safe harbor to stay within a low risk level and away from arrangements where there is moderate or high risk of enforcement action under AKS.

ASB: In Advisory Board research, we have seen hospitals using various contractual approaches to this problem, including employment, clinically integrated PHOs, or even fair-market value (FMV), management-services-organization-type centralized support . We had yet to see a "primary care institute" until you introduced the concept to us. Can you outline what it is?

JK/JW: Sure Amanda, the concept is straightforward. There are two parts to a PCMH-Institute, the Institute and a co-management arrangement. A hospital and the physicians who are advancing the PCMH model form a legal entity (the "Institute") that will manage the development of the PCMH services and infrastructure. The Institute is owned by the hospital and the physicians who purchase ownership interests in the company. The hospital then engages the Institute to provide management services to the hospital through the physician members of the Institute who have the expertise and capability to manage the Institute's services. Because the hospital and the physicians are providing the services through the Institute, you have co-management arrangement.

ASB: What services would physicians provide?

JK/JW: Physicians can provide a variety of services including medical direction, designing the clinical and quality aspects of an ACO and positioning the hospital to receive shared savings payments, and designing the clinical structure that will position the hospital to receive bundled payments.

ASB: How would the hospital pay the Institute and the physicians?

JK/JW: The Institute is paid by the hospital for meeting specific quality and operational initiatives. Separately, the Institute physicians are paid by the Hospital for the time spent providing medical director and related administrative services. Any profits earned by the Institute are distributed to the hospital and physician owners in proportion to their ownership interests.

ASB: What would be the key legal and regulatory issues related to this model?

JK/JW: To fit within Stark and AKS exceptions, the co-management agreement and the agreements with the physicians must meet a number of requirements, a critical element being that the payments must be consistent with fair market value and necessary to accomplish the commercially reasonable business purpose of the services.

It's important to point out that under Stark and AKS, payment is defined broadly and includes in-kind services. Because of that, the nature of payments between a hospital and a physician can be made with in-kind services as long as the in-kind services meet the requirements of the Stark/AKS exception. For example, a physician's management and related administrative services could be considered in-kind payment for the hospital-provided medical home services such as in-office clinical pharmacy or case management services to the physician's patients.

ASB: Thinking about the pros/cons of different models, especially with the long view toward large-scale PCMH or accountable care organization contracting, I think many in the industry believe that the most scalable solution will be full employment or use of a clinically integrated PHO. But maybe a co-management-based primary care institute would be a good "stepping stone" for markets or practices where other options are not currently feasible, e.g., if physicians had negative experiences with employment or PHOs. What do you think about that theory?

JK/JW: Well, it sounds very familiar, Amanda -- there are a lot of options. However, it's important to note that hospitals have enjoyed success with co-management based cardiovascular and orthopedic institutes for a number of years now. We are extending the model to primary care and PCMHs. If you're looking for a way to allow physicians to maintain independence because that is how they choose to practice, this is a better way

than simply supporting them without a contractual or legal structure - because, again, Stark and AKS are real issues and the OIG has a renewed mission to seek out and pursue all avenues of fraud and abuse. The PCMH-Institute is also a way for hospitals and physicians to go into business together while allowing the physicians to maintain an autonomous practice.

More information

- Building the Ship While Sailing: Legal Issues for Hospitals Exploring Medical Home Models here: http://www.advisory.com/members/new_layout/default.asp?contentid=92203&collectionid=904&program=1
- SSD memo "The Development of a Primary Care Institute"
- Attorney contact information: John Kirsner can be reached at jkirsner@ssd.com (or 614.365.2722) and John Wyand can be reached at jwyand@ssd.com (or 202.626.6676)
- The Medical Home Innovation Collaborative's main page is here
- Contact the Medical Home Innovation Collaborative by e-mailing Amanda Berra at berraa@advisory.com.

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