

Understanding the Complexities of Subsidy Payments for Hospitals

Agreements Must Take Into Consideration a Host of Regulatory Requirements

Hospitalist programs are increasingly common at hospitals as a response to a variety of recognized needs, including patient care, teaching, research, and leadership related to hospital care. Unlike medical specialists, most hospitalists help manage patients throughout the continuum of hospital care. Most hospitalists are members of the medical staff. While hospital medicine is a relatively new phenomenon in the United States, it has many benefits, including:

- increased efficiency and reduced waiting in the emergency room;
- decreased length of stay by streamlining the care process;
- decreased cost of an inpatient stay;
- immediate availability of a physician for an emergency medical admission when a patient does not have a physician; and
- immediate availability of medical consultations with specialty physicians.

Many hospitalist programs are subsidized at least initially. Sources for a subsidy include the hospital itself, local primary care, and multispecialty groups. This article focuses on such subsidy payments. When the program is subsidized by a hospital, such payments often are viewed by the government as an additional cost of “doing business” because of contracting and economic demands made by the service providers on the hospital/health care system and as a result of the economic climate and competition for the specialty in the community.

Under the conditions of participation in Medicare and Medicaid and by licensure under the state, hospitals must have adequate medical staffs and provide quality care. They are dependent on physician providers to satisfy these requirements. Depending upon the market-



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place and other competitive attributes, it is not uncommon for a hospital or health care system to be presented by a demand that the failure to pay a subsidy will result in a physician or physician group disassociating with the hospital or health care system.

A subsidy arrangement is very similar in certain respects to an “income guarantee” that is provided by a hospital to a physician who is recruited to a hospital’s geographic area or is used as an incentive to retain a physician in the area who intends to leave. Often, a recruited physician is guaranteed a certain amount of income for a defined period of time by the hospital. In certain situations now, a hospital may provide monies to a physician to remain in the geographic area to ensure that his or her specialty services remain available to residents of the community.

The various regulatory authorities have continued to approve the use of, and need for, income guarantees in both of these situations when certain conditions are met and when certain requirements placed upon the recruited or retained physician are satisfied. Although not mandated under the Stark regulations, hospitals often will require certain commitments from these physicians, *e.g.*, provision of services to charity care patients, call coverage obligations, *et cetera*.

The Office of Inspector General (OIG) recognizes the need for subsidies under certain circumstances. Also, several “safe harbors” under the anti-kickback statute allow for compensation arrangements between health care providers and physicians if such arrangements are properly structured.

One such safe harbor is the “personal services and management contracts” safe harbor. The conditions in this safe harbor are quite similar to those found in the applicable exception under the Stark law discussed below and include, among others, that (1) the agreement be set out in writing, signed by the parties, and be for a term of at least one year; (2) the compensation paid must be “set in advance,” in the aggregate

and be consistent with fair market value in an arms-length transaction, and not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties; (3) the agreement must cover all of the services the physician will provide to the provider during the term of the agreement and any services to be provided by the provider to the physician; and (4) the aggregate services contracted for do not exceed those that are reasonably necessary to accomplish the commercially reasonable business purpose of the services to be provided.

The OIG Guidance for Hospitals states as a “general rule of thumb” that any remuneration flowing between hospitals and physicians must be at fair market value for actual and necessary items furnished or services rendered based upon an arm’s-length transaction and should not take into account, directly or indirectly, the value or volume of any past or future referrals or other business generated between the parties. Arrangements pose significant risk when the hospitals (1) provide physicians with items or services for free or less than fair market value, (2) relieve physicians of financial obligations they otherwise would incur, or (3) inflate compensation paid to physicians for items or services. In such circumstances, an inference arises that the remuneration may be in exchange for generating business.

The compliance guidance further provides that a hospital should ensure that the “services obtained from a physician [are] legitimate, commercially reasonable, and necessary to achieve a legitimate business purpose of the hospital (apart from obtaining referrals).” Furthermore, “the determination of fair market value [should be] based upon a reasonable methodology that is uniformly applied and properly documented.”

Financial arrangements that contain a guaranteed payment exist in many other settings involving the delivery of health care services, such as guaranteed payments to provide on-call coverage, locum tenens agreements, and recruit-

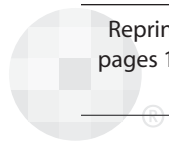
ment agreements in which there is a new or underutilized health care facility or a facility located in an underserved or underpopulated area to attract physicians to such facility. In 2007, the OIG provided, in an advisory opinion, factors to consider in reviewing such arrangements and stated that “[w]e are aware that hospitals increasingly are compensating physicians for on-call coverage for hospital emergency rooms...and we are mindful that legitimate reasons exist for such arrangements in many circumstances.”

In the last few years the OIG has provided guidance on “interim subsidies” by hospitals in the form of financial assistance to physicians experiencing limited access to, and affordability of, medical malpractice insurance. Such a subsidy is permissible when the physician is a member of the active medical staff of

the hospital, the criteria for the receipt of the subsidy are not based on the volume or value of referrals or other business generated by the physician, and the physician will pay at least as much going forward as he or she currently pays for the malpractice insurance.

With the foregoing in mind, any hospitalist agreement should stipulate in advance the “target compensation amount” in aggregate, and such amount must represent fair market value. This is to meet the Stark laws and anti-kickback statute standards. Fair market value should take into consideration independent objective compensation information, such as Medical Group Management Association compensation data. The overhead expense amount must be agreed upon in advance and evaluated against an objective reasonableness standard.

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