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Co-management agreement pitfalls and best practices: A case study

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There has been much discussion in the healthcare industry over many years regarding how healthcare entities and providers can partner to create efficiencies and value in medical services. Some of these efforts culminated in the Department of Health & Human Services' (HHS) 2018 "Regulatory Sprint to Coordinated Care," which resulted in significant changes to the federal Anti-Kickback Statute (AKS) and the Physician Self-Referral Law (Stark Law) regulations. Another way that healthcare providers traditionally coordinate services is through co-management agreements.

The term co-management can refer to a number of practically different but conceptually related arrangements. Perhaps the most traditional example is a hospital contracting with a physician group to co-manage a service line. In this form of agreement, the hospital typically manages the administrative aspects of the practice, while the physician group focuses on the clinical aspects of the practice, particularly patient care. Another example is an arrangement between providers to co-manage different aspects of patient care. For example, a specialist may provide surgical care, and then refer the patient back to their primary care provider for post-surgical monitoring.

Co-management is a common and accepted practice, but that does not mean that it is without risk to the partnering entities. Although HHS has recognized that some forms of co-management agreements are acceptable and some state laws specifically validate the practice, this does not immunize the parties from compliance risks. The particular characteristics of a co-management arrangement may still subject the participants to scrutiny under, for example, the AKS and the Stark Law. These laws are intended to protect federal healthcare programs and their beneficiaries from the influence of money on the referral of program business, which could result in overutilization and other issues. Co-management agreements, by their nature, involve the sharing of responsibility for patient care and can be susceptible to these concerns. This article reviews HHS's general acceptance of co-management agreements in both of the contexts described above, discusses a recent federal case out of the Middle District of Tennessee that identifies certain problematic aspects of one particular co-management arrangement, and provides best practices and considerations for structuring and executing co-management agreements that fall on the right side of the regulatory divide.

HHS and state acceptance of co-management arrangements

HHS has issued guidance demonstrating acceptance of different types of co-management agreements. For example, Section 40.4(B) of Chapter 12 of the *Medicare Claims Processing Manual* provides codes and modifiers for physicians to use when billing claims for less than a full global surgery package.[1] In the example provided in the *Medicare Claims Processing Manual*, Dr. Jones bills the surgical procedure code using a -54 modifier, indicating 60 days of post-operative care, while Dr. Smith bills for 30 days of post-operative care for the same procedure using a -55 modifier. This illustrates a typical instance of patient co-management where physicians share responsibility for post-surgical care.

States too have acknowledged the propriety of patient co-management. For example, Tennessee's regulations governing the practice of optometry specifically provide for the co-management of patients following eye surgery. The regulations define co-management as "[t]he cooperative and active participation in the delivery of services and treatment to patients between optometrists and other health care providers."[2] Tennessee further provides that (1) the decision to receive co-managed care rests solely with the patient but should be made in consultation with the patient's physicians; (2) an optometrist may provide follow-up care for a patient's surgical eye problem; and (3) the optometrist should provide a report to the surgeon of all post-operative care rendered.[3]

HHS also has recognized the usefulness and propriety of co-management agreements in the hospital context. In 2012, the HHS Office of Counsel to the Inspector General (OCIG) opined that hospital co-management agreements can have "legitimate business and medical purposes" by increasing efficiency, reducing waste, and increasing profitability.[4] OCIG considered a scenario in which a large, rural hospital in a medically underserved area was paying compensation to a cardiology group based on the group's implementation of "certain patient service, quality, and cost savings measures." As part of this arrangement, the cardiology group performed services in the hospital's catheterization labs and referred patients to the hospital for inpatient and outpatient procedures. The agreement between the hospital and the cardiology group had a term of three years, and it contained two fee arrangements: a guaranteed and fixed payment per year and a potential capped annual performance-based payment (based on employee satisfaction, patient satisfaction, quality of care, and implementation of cost savings procedures).

While recognizing that hospital co-management agreements can have benefits, OCIG also expressed its concerns that these arrangements could lead to poor patient care resulting from: "(i) stinting on patient care, (ii) 'cherry picking' healthy patients…, (iii) payments to induce patient referrals, and (iv) unfair competition among hospitals." It found that the particular arrangement at issue was not illegal because (1) it had "not adversely affected patient care"; (2) the risk of a specific cost-savings measure being used in a medically inappropriate circumstance was low; (3) the financial incentive was "reasonably limited in duration and amount"; and (4) receipt of a performance fee was predicated on a physician not taking certain specified actions that are detrimental to a patient's health.

OCIG also found that there was no intent that the arrangement result in illegal remuneration. In making this determination, OCIG noted several elements of the payment arrangements that supported this finding: (1) the payments made under the arrangements constituted fair market value (FMV) for many different types of medical services; (2) the compensation paid under the agreement did not vary with the number of patients treated; (3) there were limited providers in a limited geographic area; (4) the specific measures included in the agreement indicated that the purpose was to improve quality, not reward referrals; and (5) the agreement was written and limited to a three-year period. Thus, OCIG provided some indicators of a legal co-management arrangement, without fully defining what a legal co-management agreement looks like.