

# SOUTHWIND BULLETIN

NOVEMBER 2006

## NEW SAFE HARBOR RULES FACILITATE PHYSICIAN ALIGNMENT STRATEGIES

New safe harbor exceptions for the donation of EMR technology to physicians by hospitals have paved a new path in physician alignment strategies.

JOHN A. DEANE & BOB VERNON

**O**n August 8, 2006, the Centers for Medicare and Medicaid Services (CMS) issued new rules which provide a safe harbor from fraud and abuse statutes – commonly referred to as Stark rules after their key proponent Congressman Pete Stark of California – which allow hospitals to donate electronic prescribing (e-prescribing) and electronic medical record (EMR) technology to private practicing physicians.

The rules allow:

- Donation of 100% of the value of software, hardware & training devoted solely to receiving and transmitting e-prescribing information
- Donation of 85% of value of software and training (including “help desk” but not hardware) used predominantly to create, maintain and transmit electronic health records.

The upshot, particularly due to the latter rule, is a significant new physician alignment strategy for health systems across the U.S.

As regards the Stark regulations, these new safe

harbor rules relate specifically to:

- Physician referrals to health care entities with which they have financial relationships; and
- An exception to physician self-referral prohibition.

Even with certain limiting conditions described below, this impetus to disseminating EMR technology is likely to significantly impact hospital/physician collaboration, physician adoption of the technology, and the vendors that provide the technology.

The new safe harbor regulations support the Administration’s goal of achieving widespread adoption of interoperable electronic health records in the U.S. The hope is that broad dissemination of the technology will improve health care quality through the reduction of medical errors, and efficiency through productivity gains – while maintaining security and privacy for individual patients.

The immediate cause for the rule changes can be traced to Medicare Part D, the prescription drug benefit for seniors. To improve the accuracy and ease of use of the new Medicare benefit, the Administration sought to facilitate the rapid distribution and implementation of e-prescribing technology among physicians and pharmacies.

The rules governing the donation of e-prescribing technology are fairly straightforward. However, the EMR safe harbor rules are more complex. And their impact is likely to be far-ranging, particularly as they affect physician/hospital alignment strategies.

Let’s examine some of the details.

### What systems qualify under the safe harbor rules?

Stand alone EMR systems would of course qualify, subject to certification by CMS, discussed below. More importantly, donated EMR systems may also include traditional physician practice management functions like scheduling, registration, billing, collection and accounts receivable management, as long as the system is predominantly an EMR system.

This facet of the regulations is very likely to result in changes in product design by IT vendors. Their incentive now is to package, price and promote their practice management/EMR products in such a way that allows a hospital to take full advantage of the ability to provide additional value to affiliated physicians. In our initial discussions with IT vendors it is clear that both marketing and product development are positioning products to respond to the rules changes.

Another very important facet to consider is that a system in which practice management and EMR capabilities are intertwined, such that the EMR is not available without the practice management capabili-

*Continued on other side*

## REASONABLE & FAIR MARKET VALUE COMPENSATION

Randy Gott

### The evaluation of reasonable compensation

for a hospital employed physician requires a determination that the compensation represents fair market value for the services provided. The IRS defines fair market value as follows:

*“reasonable and true compensation is only such amount as would ordinarily be paid for like services by like enterprises under like circumstances”*  
[IRS Treasury Regulations Section 1.162-7 (b) (3)].

One of the key principles underlying much of the “Stark regulations” – so called after the original Congressional proponent – is that compensation arrangements between a physician and a hospital must be at fair market value.

The Stark regulations do include a safe harbor applicable to hourly compensation for services personally performed by a physician – an example of which would be a medical directorship stipend. This safe harbor outlines two methodologies for determining whether such compensation is at fair market value:

1. Hourly payments shall not exceed the average hourly rate for emergency department physicians in the market (the market must have three hospitals providing emergency services); or
2. Hourly payments shall not exceed the 50<sup>th</sup> percentile of national compensation amounts by specialty using several approved national surveys. (When using this option, annual income amounts are to be divided by 2000 hours to determine an hourly rate).

The regulation also allows hospitals to use methodologies other than those described above to determine fair market value. However using one of the two defined methodologies provides the best assurance that the compensation rates meet the fair market value test.

It is important to note that these methodologies apply *specifically* to hourly payments made to physicians and *not necessarily* to the appropriateness of physician salaries or income guarantees. In our next Southwind Bulletin, we will discuss determining fair market value compensation for physician salaries and income guarantees.



**Also in this issue:**  
Jim Burks, revenue cycle and operations management specialist, joins the Southwind management consulting team as Director.

**How can we help you?**  
Please contact:

Bob Vernon, Director  
(615) 620-5165  
bvernon@  
SouthwindHP.com

**Southwind  
Health Partners**  
210 25th Avenue North  
Suite 1112  
Nashville, TN 37203  
Phone: (615) 385-2126  
www.SouthwindHP.com

**Safe Harbor Rules** – *Continued from other side*

ties, will qualify for the exception under the rules. Certain vendors and products may already have an edge in this regard, while others position themselves to take advantage as well.

One key restriction to note is that a donated system cannot replace a “functionally equivalent system”, i.e. the safe harbor is not intended to help physicians simply upgrade from one system to another. However, it is reasonable to conclude that the willingness on the part of a physician to pay fifteen per cent or more of the cost of a new EMR system makes this new system, by definition, not functionally equivalent to the current one. The reasoning goes that a physician is unlikely to pay a fifteen per cent premium for a capability he already owns.

The donated system must meet CMS standards for interoperability. CMS is developing a certification process for the technology to take some of the uncertainty out of the current technology qualification rules. These “certificates of interoperability” will be issued to qualified system vendors. Until the process has been defined and implemented, legal counsel advises that is safe to proceed with major vendors who are committed to pursuing and obtaining certification.

### Who is eligible to receive donated technology?

Because CMS is interested in broad and rapid distribution of the technology, rules about who is eligible to receive the technology are broad. A health system can donate qualifying systems to any provider, not necessarily one on the hospital’s medical staff.

A hospital need not treat every provider equally. Health systems may discriminate among providers receiving the technology as long as the criteria used to determine which providers receive the technology are not based on patient referrals to the health system. Factors such as geography, specialty, solo vs. group practice, and the size of a practice can be determining factors in the selection of recipients by the hospital.

### What are the economics of the deal?

The foundation of the economics of allowable EMR donations is the “15% rule”. The recipient physician practice must pay fifteen per cent of the total value of the goods and services provided, including software, training, upgrades, and patches. Leasing arrangements are treated similarly. Remember contributions of hardware are not eligible for EMR donations. Loans from the health system to cover all or part of the physician’s share of the cost are prohibited.

It is important to note that a health system could opt to pay less than the eighty-five per cent maximum established in the rule. Some, for instance, may opt to share the cost on a more co-equal basis.

The rule states that the recipients’ share of the cost need only include health system corporate overhead that is directly attributable to EMR software and training. As a result corporate overhead allocations that would significantly increase the cost to the physician – and make the offering less attractive – can be avoided.

Further, the indirect costs of the existing practice management infrastructure that supports the EMR may be allocated differently between employed and independent physicians. It is logical to assume that the allocation of such costs to employed physicians would be higher on the reasoning that employed physicians consume more time and other resources from the hospital’s practice management infrastructure. This may enhance the attractiveness of the strategy as it relates to non-employed affiliated physicians, with whom the hospital is seeking closer alignment.

### Conclusions and Next Steps

With the regulations less than four months old as of this writing, it is impossible to predict with certainty how this ability to align technology interests with physicians will impact health systems. However, at Southwind we believe that the new regulations at the very least represent an opportunity for health systems to collaborate in new and fruitful ways with affiliated physicians. The end result is an opportunity to advance the health system’s ability to provide higher quality and more efficient health care for patients in the community.

Some key items for consideration or questions to ask include:

- How does the ability to donate new technology fit into the hospital’s current alignment strategy and affect the expectations of affiliated physicians?
- What is the competition’s strategy as far as it can be ascertained?
- How will the regulations affect the hospital’s current EMR strategy?
- How are the hospital’s current technology vendors approaching the new rules?
- What are the costs to be borne by the hospital and physicians and are they reasonable?

Southwind practice management consultants would be pleased to discuss these issues with you and discuss the impact on your health system. Please contact Bob Vernon, Southwind Director, at (615) 620-5165 for more information.

Southwind Health Partners® is a physician practice management firm that provides long term management, interim management and consulting services to health systems, hospitals, academic medical centers and large, independent medical groups.

## REVENUE CYCLE, OPERATIONS SPECIALIST JOINS SOUTHWIND

**James Burks**  
*Director*



James Burks is a Director at Southwind Health Partners specializing in revenue cycle and operations management, analysis and turn around projects. Jim has over thirty years experience in health care, first as a clinician, and for the last twenty-six years in medical group practice and hospital management. At Southwind, Jim is helping to meet the growing demand for experienced revenue cycle management expertise among our hospital sponsors of physician practices.

Prior to joining Southwind, Jim was a revenue cycle and clinical assurance consultant for McKesson Corporation. In that capacity Jim collaborated with hospital and medical group personnel to develop, implement and monitor best practice standards in patient access and billing and collection processes. He also contributed to medical practice billing service process redesign.

Prior to McKesson, Jim was responsible for all financial, personnel and administrative functions for a chain of seven urgent care clinics in Nashville managed by Occupational Health Plus Rehabilitation. Over his career, Jim has held clinic operational positions of increasing responsibility at PhyCor, Inc., Southern Sports Medicine & Orthopaedic Center, Saint Thomas Hospital, Orthopaedic Surgical Associates and Surgical Care Affiliates.

Jim began his health care administration career with HCA in Louisiana and Tennessee, following work as a respiratory therapist in Metairie and New Orleans, Louisiana. Jim holds a Bachelor of Science degree from Our Lady of Holy Cross College and Master of Healthcare Administration from Tulane University.



**SOUTHWIND**  
HEALTH PARTNERS, L.L.C.®  
A PHYSICIAN PRACTICE MANAGEMENT  
AND CONSULTING COMPANY

**For More Information Contact:**

Bob Vernon, Director  
(615) 620-5165  
bvernon@SouthwindHP.com

Southwind Health Partners  
210 25th Avenue North, Suite 1112  
Nashville, TN 37203  
www.SouthwindHP.com