Target Practice: Physician Contracting Strategies to Avoid the Fed’s Bull’s Eye

Health Care Compliance Association

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Part I - A
Foundation: Legal/Statutory Basis for FMV

- Stark Law
- Federal Anti-Kickback Statute
- Tax-Exempt Organization Regulations
- False Claims Act
- Civil Monetary Penalties Law
- Health Insurance Portability and Accountability Act (HIPAA, not HIPPA)
- Emergency Medical Treatment and Labor Act (EMTALA)
- Social Security Act
- The Sherman Act and other Federal Anti-Trust Laws

The Stark Law

- Stark
  - General prohibition
    - A physician or immediate family member who has a financial relationship (direct or indirect; ownership interest or compensation arrangement) with an entity may not make a referral to the entity for the furnishing of Designated Health Services for which payment otherwise may be made under Medicare, unless an exception applies. Additionally, the entity may not present or cause to be presented a claim for Designated Health Services furnished pursuant to a prohibited referral. [42 CFR §1395nn(a)(1)]
  - Exceptions for certain arrangements
The Stark Law, *cont’d*

- **Designated Health Services (DHS) [42 CFR §1395nn(6)]**
  - Clinical lab
  - Physical therapy
  - Occupational therapy
  - Radiology
  - Radiation therapy
  - DME
  - Parenteral and enteral nutrients, equipment and supplies
  - Prosthetics, orthotics and prosthetic devices and supplies
  - Home health services
  - Outpatient prescription drugs
  - Inpatient and outpatient hospital services

The Stark Law, *cont’d*

- **Stark Penalties**
  - Civil penalty of up to $15,000 for each bill or claim filed by the entity
  - Recoupment of payments
  - $100,000 for circumvention schemes
  - Exclusion from federal health care insurance programs
  - $10,000 per day penalty against entity for non-reporting of required information
The Stark Law, *cont’d*

**Stark Rulemaking in Slow Motion**
- 1993: Stark II [OBRA 1993, Section 13562] – designated health services

**Stark in Rapid-Fire Mode**
- Proposed and Final Changes to Stark in Medicare Physician Fee Schedule (MPFS) and Medicare Inpatient Prospective Payment System Regs (IPPS)
  - July 12, 2007 – CMS proposed changes to current policies on 11 different issues relating to the Stark regulations. [72 Fed. Reg. 38,122]
  - November 27, 2007 – CMS issued final MPFS, finalizing changes to reassignment and purchased diagnostic test rules, but delaying finalization of other proposed changes to Stark regulations. [72 Fed. Reg. 66,222]
  - April 30, 2008 – CMS proposed changes and solicited comments on four different issues relating to Stark. [73 Fed. Reg. 23,528]
  - July 7, 2008 – CMS proposed changes and solicited comments on a new gainsharing exception and the purchased diagnostic test rule. [73 Fed. Reg. 38,502]
  - November 19, 2008 – CMS issued final rules on incentive payment and shared savings programs and the anti-markup rule. [73 Fed. Reg. 69,793]
The Stark Law, *cont’d*

- **Applicable Stark exceptions**
  - Rental of office space
  - Rental of equipment
  - *Bona fide* employment relationships
  - Personal service arrangements
  - Physician recruitment
  - Fair market value exception
  - Indirect compensation arrangements

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**The Stark Law, *cont’d***

- **Stand in the shoes (SITS)[42 CFR §411.354(c)]**
  - A physician is deemed to have a direct compensation arrangement with a DHS entity if the only intervening entity between the physician and the DHS entity is a “physician organization”.
  - A “physician organization” is imprecisely defined as:
    - Another physician as employer
    - A physician’s professional corporation
    - A physician practice
    - A group practice as defined by Stark
Federal Anti-Kickback Statute

Overview of Anti-Kickback Statute

- The anti-kickback statute provides that anyone who knowingly and willfully solicits, pays, offers or receives any remuneration, in cash or in kind, directly or indirectly, overtly or covertly, to induce or in return for arranging for or ordering items or services that will be paid for by Medicare or Medicaid, will be guilty of a felony, and upon conviction will be fined up to $25,000 or imprisoned for not more than five years, or both.
- Safe harbors are available.

Federal Anti-Kickback Statute, cont’d

Anti-Kickback Statute Safe Harbors

- Investment interests in small health care joint ventures
- Investment interests in large publicly traded entities
- Space rental arrangements
- Equipment rental arrangements
- Personal services and management contracts
- Sales of practices between physicians
- Referral services
- Warranty arrangements
- Discount arrangements
- Payments to bona fide employees
- Group purchasing organizations
Federal Anti-Kickback Statute, *cont’d*

- **Anti-Kickback Statute Safe Harbors, cont’d**
  - Waivers of Medicare Part A beneficiary co-insurance and deductibles
  - Increased coverage, reduced cost-sharing amounts or reduced premiums offered by health plans
  - Price reductions offered to health plans
  - Practitioner recruitment
  - Obstetrical malpractice insurance subsidies
  - Investments in group practices
  - Cooperative hospital service organizations
  - Ambulatory surgery centers
  - Referral arrangements for specialty services

- **Anti-Kickback Statute Safe Harbors, cont’d**
  - Price reductions offered to eligible managed care organizations
  - Ambulance replenishing
Issues Applicable to Tax-Exempt Organizations

- Who qualifies as a tax-exempt organization?
  - Requirements to be operated as a religious, charitable, scientific, literary or educational organization
  - Application and approval process

- What are the benefits?
  - Exempt from Federal and state taxation
  - Tax-free bond financing

- Unrelated business income tax

- Reporting requirements
  - Form 990
  - State reporting

Issues Applicable to Tax-Exempt Organizations, cont’d

- Restrictions on exempt organizations
  - Community benefit standard
    - Charitable purpose of exempt organization also inures to entities owned by an exempt organization
    - Elements of control are important in joint ventures between exempt organizations and for-profit entities
  - Private inurement prohibition
  - Excess benefit transaction
    - A benefit that exceeds the fair market value of the goods and services for which it was provided

- Weapons at the disposal of the IRS
  - Revocation of exemption
  - “Intermediate Sanctions”
Issues Applicable to Tax-Exempt Organizations, cont’d

- Excise tax on “disqualified persons” and organization managers
  - 25 percent of the excess benefit
  - 200 percent tax if not corrected
  - $20,000 limit to organizational managers

- Who is a disqualified person?
  - A person of substantial influence over the organization

- Protecting against intermediate sanctions: The Rebuttable Presumption of Reasonableness
  - Shifts the burden of proof to the IRS

Other Regulations

- The Civil Monetary Penalties Law
- False Claims Act
- Health Insurance Portability and Accountability Act (HIPAA, not HIPPA)
- Emergency Medical Treatment and Labor Act (EMTALA)
- Social Security Act
- The Sherman Act and other Federal Anti-Trust Laws
Selected 2008 OIG Enforcement Activity

- Condell Health Network, self-disclosure and $36 million settlement over improper leases, loans and reimbursements with physicians
- Ivinson Hospital, self-disclosure and $635,000 settlement over free rent, below-FMV leases, medical director payments over FMV and excessive income guarantee reimbursements
- Spartanburg Regional Healthcare System, self-disclosure and $780,000 settlement over IT resources provided to non-employed physicians
- Bakul Desai, M.D., $1.4 million settlement over receiving a salary in exchange for referring cardiac patients
- University Health Services, Inc. d/b/a University Hospital, $137,429 settlement over athletic trainer furnished to a local orthopedic practice

Selected 2008 OIG Enforcement Activity, cont’d

- Memorial Health University Medical Center, $5.08 million settlement over compensation of physicians for teaching and indigent care services in excess of fair market value
- Lester E. Cox Medical Centers, $60 million settlement over financial relationships with referring doctors, improper billing practices and inclusion of non-reimbursable costs on Medicare cost reports
- Hardeman County Memorial Hospital, $400,000 settlement over free rent and utilities for a physician
Emerging Regulatory Activity

RAC, DFRR and 990

- **Recovery Audit Contractor (RAC) program**
  - Created by Medicare Modernization Act of 2003 as a demonstration program
  - Made permanent by Tax Relief and Health Care Act of 2006
  - Expanding to all states by 2010
  - Tennessee is part of Region C, currently assigned to Connolly Consulting Associates, Inc. of Wilton, CT
  - Tennessee is slated for August 1, 2009 or later
FY 2007 RAC Status Report
- RACs identified and corrected $371 million in Medicare improper payments during FY 2007. Over 96 percent of these improper payments were overpayments collected from providers and the remaining 4 percent were underpayments repaid to providers.
  - $357.2 million in overpayments
  - $14.3 million in underpayments
- More than 85 percent of the overpayments collected by RACs and almost all underpayments refunded by the RACs were from claims submitted by inpatient hospitals.
  - Approximately 42 percent were a result of incorrect coding
  - Approximately 32 percent were medically unnecessary service or setting

- Hospital reporting on arrangements with referring physicians
- August IPPS FY09 Final Rule
- CMS will select 500 hospitals for inquiry
- Sixty (60)-days to complete form, or $10,000 per day penalty
RAC, DFRR and 990, *cont’d*

- **Form 990**
  - Ten page core form
  - Sixteen schedules
  - Schedule H - Hospitals
    - Charity Care and Certain Other Community Benefits
    - Community Building Activities
    - Bad Debt, Medicare, & Collection Practices
    - Management Companies & Joint Ventures
    - Facility Information
    - Supplemental Information
  - Schedule J – Compensation
    - Part I: Questions Regarding Compensation
    - Part II: Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
    - Part III: Supplemental Info blank sheet with additional space for Schedule J answers

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**Target Practice:**
**Physician Contracting Strategies to Avoid the Fed’s Bull’s Eye**

- **Part I - B**
Environmental Factors Influencing Hospital-Physician Relations

- **Today’s market**
  - Increasing numbers of facilities are paying for call
  - Rising dollar amounts are paid for on-call compensation
    - From 2006 to 2008, median expenditures by trauma centers for physician on-call compensation increased by 88 percent
    - From 2007 to 2008, median expenditures by non-trauma centers for on-call coverage increased by 114 percent

Traditional Medical Staff Model vs. New Reality

- **Historically**
  - Physicians voluntarily served on the medical staff
  - Compliance with active medical staff by-laws related to emergency department (“ED”) on-call coverage was considered necessary to build a practice and was a physician’s community service
Marketplace Phenomena

- Hospital-physician integration and the downfall of traditional medical staff models
  - Hospital perspectives:
    - Elimination of competition for outpatient services
    - Expansion of services and service area
    - Improved market share
    - Community service and indigent care
    - Physician supply/demand management
    - Improved leverage with payers
    - Access to clinical leadership
    - Addressing the pay-for-call dilemma
    - Alignment of quality objectives

Marketplace Phenomena, cont’d

- Hospital-physician integration and the downfall of traditional medical staff models, cont’d
  - Physicians: competitors or employees?
  - Demise of traditional idea of medical staff privileges as necessary to build a practice
  - Demands of compensation for ED call coverage and administrative services, both once thought of as a community obligation
Marketplace Phenomena, cont’d

Hospital perspectives
- **Physician shortages**
  - Shortage of physician residents exists, particularly in certain subspecialties
  - The number of sub-specialists who limit patients, injuries, and illnesses treated is increasing
  - A growing number physicians drop out of call rotation
  - Smaller supplies of on-call doctors increase the difficulty and stress for those who remain in the rotation
- **Fewer emergency departments and increasing utilization**
  - Nationwide ED closures and other problems in access to care create an over-utilization of EDs, resulting in:
    - Increased intensity and risk in on-call coverage, and
    - Negative impacts on payer mix and physician reimbursement

Marketplace Phenomena, cont’d

Physician Perspectives
- **Tort climate**
  - A slight decrease in malpractice premiums is occurring on a national scope
  - Malpractice risk is higher for patients first seen in emergency department
  - Estimates of the annual cost of defensive medicine range from $50 billion to $100 billion
- **Uncompensated care**
  - Forty-five (45) million non-elderly persons are uninsured
  - Access to care is affected for the uninsured
  - Half of uninsured adults are four times more likely to delay or forego care
- **Quality-of-life for physicians**
  - Call rotation causes a disruption of private practice or other professional and personal activities
Marketplace Phenomena, cont’d

Physician Perspectives, cont’d
- Relief from administrative burden
- Improved leverage with payers
- Partial or perceived insulation from reimbursement and overhead pressures, including subsidized arrangements
- Malpractice premium cost control
- Access to capital for facilities, equipment and services
- Information systems and EMR
- Stability of earnings
- Other reasons
  □ “It’s not my responsibility”
  □ Resentment for not being paid for call
  □ Difficulty in enforcing medical staff by-law requirements to take call

Collaborative care
- Current health care payment system rewards inefficiencies
- “The integration of clinical care across providers, across settings, and over time” is needed to reduce fragmentation in health care delivery and improve the quality and efficiency of care. (Am. Hosp. Ass’n., Aligning Hospital and Physician Interests: Broadening the Concept of Gainsharing to Allow Care Improvement Incentives, 2005)
- “Pay for performance is one mechanism that can help transform the payment system into one that rewards both higher value and better outcomes.” (Rewarding Provider Performance: Aligning Incentives in Healthcare, Institute of Medicine, National Academies Press, 2006.)
Collaborative care, cont’d

- **P4P incentive programs** rely primarily on changed behavior via:
  - A set of targets or objectives that define what will be evaluated
  - Measures and performance standards for establishing the target criteria
  - Rewards, typically financial incentives that are at risk, including the amount and method for allocating the payments among those who meet or exceed the reward threshold

- **Disease management programs** focus on chronic conditions with an objective of improving care and reducing high-cost health care interventions

- **Clinical co-management** involves physicians as participants in the management of the hospital’s clinical operations, with an expectation of significant clinical and operational input by the physicians and the alignment of physician and hospital interests to achieve quality patient care.

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Joint ventures

- **Growth in outpatient diagnostic and therapeutic center and ambulatory surgery center joint ventures between hospitals and physicians**
  - Hospital efforts to guard against real or perceived threat of competition by physicians for better paying patients
  - Expansion or protection of service area or service line
  - Access to capital, facilities and/or expensive equipment
  - Alignment of quality objectives
  - Hedge against declining reimbursement

- **Hospitals or hospital service lines**
  - Whole hospital joint ventures
  - Clinical co-management arrangements
Part II - A

Valuation: Art-Science to Science-Art

“Valuation is not for the feint of heart”
- NACVA
Common Valuation Methods

- Cost method
- Market method
- Income method*

* Not generally applicable to physician contracts

Common Approaches & Current FMV Controversies

- Physician practice data (PPD)
  - MGMA, AMGA, Sullivan Cotter, etc.
    - Apples and oranges (geography, specialty definition, percentile points, sample size, definition of compensation, bias in sample between employed and private practice)
    - Challenge is balance between—
      - Federal interest in "consideration of multiple sources" and
      - Statistical traps of quantitative blending
- Complying with FTC/DOJ Anti trust Safety Zone for compensation surveys
- What to do about escalation of historical data to date of proposed agreement?
- When to use:
  - Cost approach to valuation
  - Market approach to valuation
- When an outside opinion is needed
Approaches & Controversies - Continued

- Emergency Department coverage market data
  - Sources:
    - Proprietary data & limited published data
    - Weak on nuances such as restricted coverage, multiple campuses, hybrid payment arrangements (stipend and collection floors)
  - How to treat no-cost coverage arrangements or “understandings”
  - How to reconcile:
    - OIG Advisory of July 10, 2007 on factors related to economic burden
    - Widely divergent or conflicting market data

Approaches & Controversies continued

- Medical direction and Administrative Services
  - Derived rates from various compensation surveys, but limited or no information on hours per year
    - Minimum & maximum hours
  - When is opportunity cost approach appropriate?
  - Variations by specialty for similar administrative services, e.g. Chief of Staff, quality, IT
Situational Analyses & Approaches

- Escalation
  - A tale of two specialties

- Contribution of multi-hospital system to survey results (anti-trust safety zone)
  - Management of the challenge

- Opportunity cost
  - Chief of heart center

- Cost approach or market approach
  - Critical care coverage

Escalation Forecast to Adjust latest Market Data to Proposed Contract Period

- Review of professional practice
  - Rates
    - 1 with method not revealed
    - 1 with no escalation (or de-escalation)
    - 2 with 3%
    - 2 with 3.5%
    - 2 with 4%
    - Unclear if there are any specialty-specific differentials
  - 6 year average, all specialties, all regions, 3.8% / year
Problems with Specialty-specific Rates

Historical trend...4% might be a good legally conservative escalation factor for a forecast

Internal Medicine Hospitalist Compensation
Annual Rate of Change
Rate Escalation Dilemmas

For neurosurgery, a study after 2006 data was released…
* Study of 5 years (4 year-over-year changes)
* Might suggest that escalation for forecast should be zero

But after release of just one new data point, an opinion based on the prior analysis might be questionable…
Median Compensation Variations

Change in Median Compensation: History and Linear Extrapolation

General Surgery
Int Med: General
Int Med: Hospitalist
Linear (General Surgery)
Linear (Int Med: General)
Linear (Int Med: Hospitalist)

Market approach or cost approach?

Business Performance of a Medical Group Matters In Valuation of Coverage Agreement
Case Study: ICU Coverage

- Community hospital with a 12-bed Medical ICU
- Coverage by Pulmonary critical care intensivists
  - 0 hours per day on-site
  - 14 hours per day on-call
- Group proposing is stipend of $1,500 per day, $547,000 per year
- Hospital, Group and valuation consultant agree staffing required is 3.1 FTE
- Group aiming for 75th percentile compensation
- Group reports practice overhead of $275,000 for 3.1 FTE
- Group reports professional collections from ICU at $961,000/year
- Survey of hospitals shows a range of $0 to $2,000 a day, with no central tendency

Important Considerations

- When to use cost method (compared to market method)
- When using cost method, competitive business practices should be modeled

Professional Fee Collections Per FTE

Cost to Provide Coverage: Highly Dependent on Collections Performance

Cost to Provide Coverage

Collections Per Year
Medical Director of Heart Center

- Hospital established a heart center in 2005
- First medical director was a well-respected non-invasive cardiologist
- Physician was paid the hospital’s standard medical director rate of $200 per hour for 15 hours per week
- After 2 successful years, this physician retired
- New director is an interventional cardiologist who wants to be paid more
- He has a full time private practice
- What is the fair market value range for the position?

Central Question:

Is it appropriate to use opportunity cost in valuation of medical administrative services?
Factors Often Considered

- Region
- Time requirements
- Specialty
- Documented shortages
- Professional fees
- Payer mix
- Restrictions on practice

Target Practice:
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Part II - B
Themes

- Justifying the Numbers
- Pitfalls of Published Data
- Managing the Process

How badly do your physician contracts hurt?

**PAIN ASSESSMENT SCALES**

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*Note: The table represents pain assessment scales with descriptive phrases for different intensities of pain.*
Justifying the Numbers

“Your physician contracts may be painful, but so is a lack of FMV compliance.”

Key Questions to Answer

1. Is this a physician arrangement that merits compensation?

2. What are the factors or characteristics that influence compensation in the arrangement?

3. What level of compensation is reasonable?

4. Is the level of compensation commensurate with expectations of the arrangement?
Merit

- Is this a physician arrangement that merits compensation?
  - What are the objectives of the arrangement?
  - Will meeting the objectives generate bona fide, value-added results?
  - What are the activities required to meet the objectives?
  - Are the activities clearly delineated?
  - Will the activities be appropriately monitored and documented?

Factors of Influence

- What are the factors or characteristics that influence compensation in the arrangement?
  - Market Forces
  - Arrangement Expectations
Market Factors

1. Physician Specialty / Compensation by Specialty
   - Survey data
   - Market comparables
2. Competitive Environment
   - Insights from other organizations
   - Trends
3. Personal and Economic Burden
   - Opportunity costs
4. Physician Supply / Recruitment Conditions
5. Payer Mix
6. Region and other Geographic Determinants

Expectations

1. Objectives of the Arrangement
   1. Relationship to organizational goals
      1. Developing / improving a service line
      2. Maintaining accreditation
      3. Responding to community need
2. Activities Required
   1. Time commitment
   2. Job description
   3. Staffing requirements
3. Physician Experience / Qualifications
   1. Often a secondary consideration
Compensation Examples

- Medical Directorship
  - Market
  - Expectations

- Call
  - Market
  - Expectations

- Employment
  - Market
  - Expectations

- Other
  - Market
  - Expectations

Pitfalls of Survey Data

“Everyone can’t be at the 75th Percentile.”
Pitfalls

- Lies, Damn Lies and Statistics
  - Know the Limitations
  - Hold your Nose

- Relate to Market Factors and Expectations
  - Is there a reasonable correlation?
  - What is the risk?

Statistics

- Know the Survey Sources
  - Representativeness
  - Bias and Sample Composition
  - Quality and Consistency

- What is your Benchmark?
  - Single or Multiple sources
    - Mitigate bias or compound the error
  - Categorical Samples
  - Percentile Rankings
  - Median vs. Average

- Establish a Consistent Approach
  - Acknowledge the limitations
Factors

■ Connecting the Dots

□ How do the market factors and expectations relate to the Fair Market Value range?
  ■ Available studies and references
  ■ Market comparable examples: validation
  ■ Reasonable judgments based on the factors

□ Is the 90th Percentile ever an appropriate benchmark?
  ■ Extraordinary, compelling circumstances
  ■ Reliable evidence
  ■ Know the risk

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■ Part III
Managing the Process

“What process?”

or

“The CEO agreed to what?”

Process

- Elements of an Effective Contract Management Program
  - Education – knowledge and training
  - Reliable Data
  - Analytical Tools
  - Corporate Standards – methods and payment terms
  - Transparency
  - Documentation
  - Oversight
Benefits

- Compliance
  - Consistency
  - Transparency
  - Responsiveness
  - Internal audit

- Cost Management
  - Minimizes special deals and range creep
  - Reduces need for outside reviews

- Timeliness
  - Reduces uncertainty
  - Speeds negotiation and decision-making
  - Decreases contracting frustration

Common Sense Approach

- Proactive Perspective
  - Anticipate physician demands

- Systematic
  - Effective in a single hospital or across a health system

- Promotes Objectives
  - Compliance
  - Business / Financial Considerations
Discussion / Questions / Dilemmas

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