Business and Financial Relationships with Hospitals: Co-Management, JVs, and Employment Key Valuation Issues

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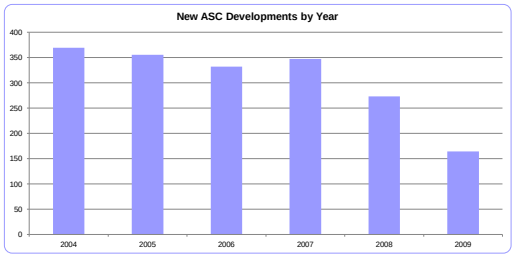
Road Map to the Presentation

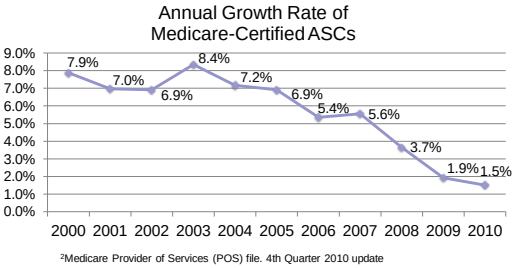
- Why is this relevant?
  - Recent trends in ASC development
  - Contributory factors and implications to existing and new ASCs
- The New Competition…
  - Renewed Physician Alignment with Hospitals in the form of
    - Employment Agreements
    - Co-Management Arrangements & JVs

Recent Changes in ASC Activity



[1]MedPAC analysis of Provider Services file from CMS, 2009

Recent Changes in ASC Activity



[2]Medicare Provider of Services (POS) file. 4th Quarter 2010 update

Contributory Factors…
Implications…not so good☹

- Hospital employment is likely the single biggest competitive threat currently faced by ASCs. In the coming years, the vast majority of primary care physicians will be employed by health systems, thus limiting the referrals to surgical specialists outside of the system.
- Specialists who become employed are often required to divest of independent ownership interests in ASCs, causing existing ASCs to lose case volume and to scramble to identify "unencumbered" alternates, which pool is steadily shrinking.

Contributory Factors…
Implications…maybe good?

- We have already seen a significant shift in behavior by hospitals, as they now increasingly look to expand their existing ownership percentage or acquire ASCs outright (*i.e.*, through 100% ownership). In many cases the goal is to convert the freestanding ASC into a hospital outpatient department ("HOPD") to take advantage of significantly higher reimbursement.
- Valuation Implications? Can hospital value your center based on HOPD rates?

Implications…maybe good?

- Conversely, the transition of freestanding ASCs to HOPDs has presented alternative opportunities for independent physicians to partner with hospitals through the creation of a co-management joint venture. The joint venture, comprised of physicians and a hospital, provides certain services to the HOPD in exchange for a FMV fee.
- Valuation Implications? Should future FMV Co-Management fee offset value of ASC?

Physician Employment

- Over half of the physicians in the U.S. are employees of groups owned by hospitals, other physicians, or foundations. Less than half of U.S. physicians own their own independent practice.[3]
- Employed surgeons may be subject to restrictive investment covenants.
  - Standard hospital employment contract more often than not prohibits ownership in ASCs.

[3] http://www.nytimes.com/2010/03/26/health/policy/26docs.html

Physician Employment

- According to MGMA 2010 survey, sixty-five percent (65%) of established physicians who changed positions in 2009 became hospital employees and nearly half (49%) of new physicians coming out of training chose hospital employment over private practice.[4]
- Medicare physician payment cuts have been delayed for more than 7 years in a row. Physician pay will be a key target of Medicare reform. This will (and has) lead more physicians to seek hospital employment out of fear.

[4] http://www.mgma.com/press/default.aspx?id=33777

Employment Agreements Overview

- Employment activity has seen a significant uptick in the past 24 months.
- Productivity-based models are in vogue; median compensation per wRVU is a widely viewed metric; however, for highly productive MDs, application of a median rate per wRVU may have risky implications.
- Employment agreements have many moving parts… the "terms and features" are critically important.

Employment Agreements Using Survey Data

- MGMA data can be misused in a variety of ways, including:
  - Cherry picking from among different tables (*e.g.,* regional data vs. state data)
  - Failure to consider ownership/ancillary profits that may be inherent in 90th percentile compensation
  - Do regional compensation differences exist?

Employment Agreements Compensation per wRVU

Example of misuse of MGMA data:

For Orthopedic Surgery: General

- 90th percentile cash compensation - $876,000
- 90th percentile wRVUs – 13,977
- 90th percentile compensation per wRVU - $103.71

Where is this going?

- 90th percentile wRVUs x 90th percentile compensation per wRVU = $1,450,000
- MGMA states that there is an inverse relationship between physician compensation and compensation per wRVU
- *Median* compensation (per wRVU) is a misnomer; no physician wants to be below the median!

Employment Agreements
"Stacking"

If you label compensation layers by different names, you can stack them higher and higher!

- Sign-on bonus
- Productivity bonus
- Medical directorship
- Co-management agreement
- Quality bonus
- Retention bonus
- Call pay
- Tail insurance
- Excess vacation
- Relocation costs
- Excess benefits

Employment Agreements
Other Issues

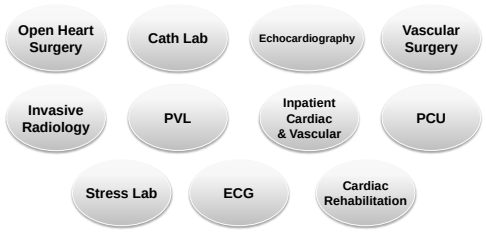
- Can physicians be "made whole" for ancillary profits?
  - Defining "normal" ancillaries
    - Oncology – chemotherapy infusion
    - OB/GYN – Ultrasound tests?
    - Cardiology – Stress tests, Echo?
    - Orthopedic surgery – MRI?
- Perils of overly complicated compensation structures
- Valuing clinical vs. administrative duties

Service Line Co-Management Arrangements

- The purpose of the arrangement is to recognize and appropriately reward participating medical groups/ physicians for their efforts in developing, managing and improving quality and efficiency of a particular hospital service line.
- Scope of service – The arrangement may cover inpatient, outpatient, ancillary and/or multi-site services.

Service Line Co-Management Arrangements

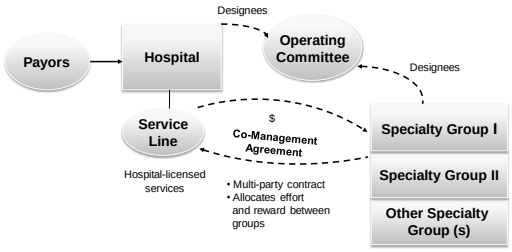
Example: Potential Scope of Cardiology Service Line



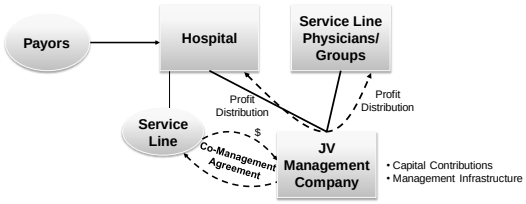
Service Line Co-Management Arrangements

- The contract may be either with one or more physician(s) / medical group(s) (or faculty practice plan(s)) or with a joint-venture entity owned by the hospital and participating physician(s) / medical group(s).

Service Line Co-Management Arrangements
Direct Contract Model



Service Line Co-Management Arrangements Joint Venture Model



Service Line Co-Management Arrangements

- There are typically two levels of payment under the service line contract:
  - Base fee – a fixed annual base fee that is consistent with the fair market value of the time and efforts participating physicians dedicate to the service line development, management, and oversight process
  - Bonus fee – a series of pre-determined payment amounts contingent on achievement of specified, mutually agreed, objectively measurable, program development, quality improvement and efficiency goals
  - Must be fixed, fair market value arrangement; independent appraisal strongly advised

Typical Features of a Co-Management Arrangement

- The agreement stipulates a listing of core management/ administrative services to be provided by the manager (for which the base fee is paid).
- The agreement includes pre-identified incentive metrics coupled with calculations/weightings to allow computation of an incentive payment (which can be partially or fully earned).
- Compensation is directed towards accomplishments rather than hourly-based services.

Valuation Process – Riskiness of Co-Management Arrangements

- Among the spectrum of healthcare compensation arrangements, co-management arrangements have a relatively "high" degree of regulatory risk if FMV cannot be demonstrated.
  - By design, these agreements exist between hospitals and physicians who refer patients to the hospital.
  - Available valuation methodologies are limited and less objective as compared to other compensation arrangements.
  - Physicians are not being compensated under the traditional "hours worked and logged" approach.
  - The "effective" hourly rate paid to physicians may be higher than rates which would be considered FMV for hourly-based arrangements (since a significant component of compensation is at risk).

What Drives Value?

- As a percentage of the service line net revenues, the *total fee* payable under a co-management arrangement typically ranges from 2% to 6% (on a calculated basis).
- The fee is fixed as a flat dollar amount, including both base and incentive components, for a period of at least one year.
  - Commonly, the base fee equals 50-70% of the total fee.
- The extent and nature of the services drive their value. Thus, the valuation assessment is the same whether the manager consists of only physicians or physicians and hospital management.
- Determinants of value include:
  - What is the scope of the hospital service line being managed?
  - How complex is the service line? (*e.g.*, a cardiovascular service line is relatively more complex than an endoscopy service line; multiple hospital campuses)
  - How extensive are the duties being provided under the co-management arrangement?

What Drives Value?

- Size adjustments based on service line revenue
  - Large programs may be subject to an "economies of scale" discount.
  - Small programs may be subject to a "minimum fee" premium.
  - Addressing poor payor mix
- Consider the appropriateness of the selected incentive metrics
  - Is the establishment of the incentive compensation reasonably objective?
  - Consider the split of base compensation and incentive compensation.
- Occasionally, certain other services (*e.g.,* call coverage) may be included among the co-management duties. (Some hospitals prefer to embed call coverage in the co-management fee to avoid a separate compensation arrangement with the physicians.)

Speaker

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