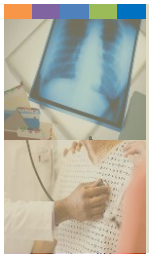

What can Be Paid for in a Co-Management Arrangement? Should You Enter Into a Co-Management Relationship?

Valuation, Quality, & Other Issues

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Introduction

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- Partner at VMG Health, a healthcare valuation and consulting firm
- Leads Professional Service Agreements Division
- Previously with KPMG's litigation department
- Former Finance professor from the University of North Texas
- Published and presented multiple times related to physician compensation and fair market value

hfma healthcare financial management association

AMERICAN HEALTH LAWYERS ASSOCIATION

ABA Defending Liberty Pursuing Justice

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Overview

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Presentation Overview

- Co-Management Arrangements
- Fair Market Valuation Guidelines
- Getting Paid for Quality

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Co-Management

Structure. Compensation. Regulations

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The Basics

Co-Management

Fixed Fee + Variable Fee = Co-Management Fee Structure

- Hospital and physicians enter into an agreement where physicians are jointly responsible with hospital for managing a defined service line
- Various arrangement types exist in the market
  - Joint Ventures
  - Contractual arrangements
- Payments contained in the agreement
  - Will vary based on services outlined
  - Should be linked to actual services and/or outcomes

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Fixed Fee Overview

Co-Management

- Fixed Fee
  - Time dedicated to meetings designed to improve the overall quality of care for a specific service line.
  - May also include
    - Medical Directorship
    - Non-physician services
      - Billing
      - Management/administration
    - Call coverage

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Fixed Fee Considerations

Co-Management

- Physician service related payments are justified by need for clinical expertise
  - Define duties
  - Time and effort expended
    - Clinical and administrative survey data considered
    - Hourly rate x meeting attendance hours
- Non-physician services
  - Hospital could benefit from experience of current administrative and/or billing staff
    - Prevent training, extra costs for integration
    - Challenge: maintain consistent policies/benefits
  - Valuing 'typical' management services
- The duties must not overlap with hospital staff

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Variable Fee Overview

Co-Management

- Variable Fee
  - Quality outcomes drive payments
  - Improvement and superior outcomes may warrant incentive payment
  - Valuation of fee typically requires understanding of
    - Historical outcomes
    - Benchmarking data
  - A note about IRS Revenue Procedure 97-13
  - A note about cost savings metrics

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Variable Fee Considerations

Co-Management

- Understand what constitutes superior quality and improvement
  - Identify key quality metrics and understand historical performance
  - Obtain industry-recognized benchmark data for the quality metrics, (average or median and top or 90th percentile)
  - Understand who is responsible for developing and implementing the strategy
  - Determine the appropriate market rates for improving and achieving superior quality care
  - Create payment tiers for incentives based on various outcomes

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Fair Market Value

Valuations. Guidelines. Regulations

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Valuation Starting Point

Fair Market Value

- Agreement Terms must be understood and are sometimes unclear at valuation stage, define:
  - What services will be provided?
  - How parties will be compensated?
  - Valuation should match the agreement
- No published standards for physician compensation valuations
- Appraisal firm should understand
  - Healthcare regulations
  - Valuation principles
- Regulatory Guidance
  - Fair Market Value
  - Data considerations
- Business valuation standards - a good place to start

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Fair Market Value Definition

Fair Market Value

- Based on the anti kickback statute, and other healthcare regulations and guidelines, any transaction between hospitals and physicians must be at Fair Market Value.
- **IRS definition** - "*the amount at which property would change hands between a willing seller and a willing buyer when the former is not under any compulsion to buy and the latter is not under any compulsion to sell and when both have reasonable knowledge of the relevant facts.*"
- Provides a conclusion which should not reflect consideration for value or volume of referrals.
- Rely upon generally accepted valuation theory – consider multiple valuation methodologies and approaches: cost, market and income approach

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Data Considerations

Fair Market Value

- Co-management likely a combination of several valuations since several services may be provided
- Multiple, objective surveys suggested
- Data should not reflect referral relationships
  - Medical Director data
  - On-Call data
  - Competing Hospitals – Extra Caution
- P4P comparables
- Multiple valuation methodologies

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Tuomey Case Lessons

Fair Market Value

- Do not pay fulltime benefits/malpractice premiums for part-time services
- Physicians paid above the 75th percentile of market data should demonstrate productivity consistent with other physicians in this percentile
- Understand arrangements where the provider is not making money
- Compensation for administrative duties should be based on significant duties
- Valuation methodology is as important as total compensation
- Creative arrangements need to be carefully constructed, the government suggests getting an OIG Opinion
- No opinion shopping, carefully choose your valuation firm

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Valuation Takeaways

Fair Market Value

- Understand agreement Terms
  - What are the services?
  - How is the compensation stated in the agreement (valuation should match)?
- Consider all facts and circumstances
  - Survey data
  - Credentials and specialty
- Use multiple valuation methodologies
- Performance payments may not be tied to service volumes, charges, or revenue
- Commercially Reasonable
  - Facility needs – overlap of services?
  - Operational assessment
  - Understand total hours

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Quality Incentives

Getting Paid for Quality

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Valuing Quality

Quality Incentives

- Hospitals critical success factors – shifting towards quality of clinical performance
- In late 2003, CMS and Premier Inc. launched the Hospital Quality Incentive Demonstration (HQID) for over 250 hospitals
  - Offering financial incentives to improve the quality of health care
  - Includes financial incentives for the top 20% of hospitals.
- Congress authorized the development and implementation of a value-based purchasing (VBP) program to replace the RHQDAPU program which reports quality (the precursor).
  - Performance (Incentives) would be based on either improving historical performance or attaining superior outcomes compared with national benchmarks.
  - Proposed ACOs include similar guidelines
- Numerous third party payors provide P4P payments to hospitals and physicians

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Results of Quality Incentives

Quality Incentives

- Hospital Quality Incentive Demonstration (HQID),
  - Raised overall quality by an average of 17% over its first four years with total payments in excess of $36.6 million.
  - Majority of hospitals improved their quality of care across the board with respect to reliable use of scientifically based practices
- In 2008, the Robert Wood Johnson Foundation and California HealthCare Foundation reported results of a national program that tested the use of financial incentives to improve the quality of health care.
  - Tested seven projects across the nation that adjusted compensation based on performance scores – hospitals and physicians.
  - Among the notable findings from the program were that:
    - Financial incentives motivate change
    - Alignment with physicians is a critical activity for quality outcomes
    - Public reporting is a strong catalyst for providers to improve care
- Less favorable findings and why

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Regulatory Guidance

Quality Incentives

- OIG & CMS guidelines provide a solid foundation regarding structuring quality care arrangements:
  - Quality measures should be clearly and separately identified
  - Quality measures should utilize an objective methodology verifiable by credible medical evidence
  - Quality measures should be reasonably related to the hospital's practice and consider patient population
  - Do not consider the value or volume of referrals. Consider an incentive program offered to all applicable providers
  - Incentive payments should consider the hospital's historical baseline data and target levels developed by national benchmarks
  - Thresholds should exist where no payment will accrue and should be updated annually based on new baseline data.
  - Hospitals should monitor the incentive program to protect against the increase in patient fees and the reduction in patient care
  - Incentive payments should be set at FMV

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Quality Incentives

- Measures of quality should include:
  - Efficiency
  - Outcomes
  - Patient experience
  - Adherence to evidence based processes
- Goals:
  - Create competition based on quality and efficiency
  - Drive improvement
  - Recognize highest quality and most efficient providers
  - Recognize improvement
  - Improve transparency

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Observed Quality Metrics

- Common co-management service lines: orthopedic surgery, cardiology, ASC ->HOPD
  - Patient satisfaction
  - Infection Rates
  - Readmission
  - Mortality
  - New metrics continually being added
- Predicting what will be incentivized and identifying support for quality payments
  - Look to current reporting measures – withholds may occur for reporting alone
  - Track what credible ASC organizations are measuring
  - Identify metrics third party payors are measuring
  - CMS metrics

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ASC Quality Metrics

- ASC organizations
  - ASC Advocacy Committee: ASC Association & ASC Coalition
  - ASC Quality Collaboration (ASC QC): Ensuring quality data is appropriately developed and reported
- CMS proposes quality reporting program for ASCs, July 2011 (6 from ASC QC)
  1. Patient burns
  2. Patient falls in an ASC
  3. Wrong site/side/patient/procedure/implant
  4. Hospital transfer/admission
  5. Prophylactic IV Antibiotic Timing
  6. Appropriate surgical site hair removal
  7. Selection of prophylactic antibiotic 1st or 2nd generation cephalosporin
  8. Surgical site infection rate
- Payment for outcomes likely next step

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Questions?