Valuation Primer – Physician Practice Acquisitions & Physician Service Agreements
Introduction
VMG Health - Overview

- Valuation and transaction advisory firm focused in the healthcare industry since 1995.

- More than 50 professionals and two offices in Dallas, TX and Nashville, TN.

- Clients located in all 50 states

- Services provided include:
  - Business valuation (800+ valuations per year)
  - Professional service agreement valuation (300+ valuations per year)
  - Tangible asset valuation
  - Transaction advisory
  - Real estate valuation
Overview
Physician Practice Acquisition Trends and Valuation Techniques
Colin McDermott, CFA, CPA/ABV

Physician Service Agreement Trends and Valuation Techniques
Jonathan Helm, AVA

Questions
Colin McDermott and Jonathan Helm
Physician Practice Acquisition Trends and Valuation Techniques
Overview (A Primer on Valuation)

I. Practice Acquisitions – A Look Back in History

II. Practice Acquisitions – Current Observations & Trends

III. Valuation 101: Practices & Ancillary Services
Practice Acquisitions – Past & Present
Physician Transaction History

*Physician Acquisition & Employment – A Look Back in History*

- Physician Practice Management Companies (PPMCs)
  - PhyCor (1998)
  - Typically purchased equipment, A/R, real estate
  - Provided management services for fee (% of revenue)
  - Physicians were not employees

- Hospitals Defensive Response: Integrated Delivery Network (IDN)
  - Hospital-owned
  - Typically purchased equipment, A/R, real estate, goodwill
  - Physician was gatekeeper
  - Ancillary services often included
  - Physicians were employed
Physician Transaction History

- The PPMC / IDN Bust – late 1990s / early 2000s

- Physicians frustrated with how hospitals managed practices
  - Hospital’s lack of experience in billing for physician services
  - Grew too large too quickly
  - Lack of Physician involvement in decision-making

- Hospitals frustrated with Physicians’ lack of motivation and declining productivity
  - Prices paid for practices were too high to earn adequate ROI
  - Often caused by guaranteeing Physician salaries with no recourse
  - Resulted in significant losses to hospitals

- Many PPMCs / IDNs dissolved and physicians re-entered private practice
Physician Transaction History

Physician Practice Transaction Timeline

- **1993-1995:** Number of hospital-owned physician practices tripled
- **1995-2002:** Hospital-owned physician practices suffered significant operating losses. Acquisitions slowed, divestitures increased
- **1998:** PhyCor collapses
- **2007 - Present:** “The Great Reconsolidation”
2007 to Present: The Great Reconsolidation

Driving Forces for Physicians:

- Physician desire to be shielded from market forces
- Reimbursement cuts – in some cases these have been drastic
- Increasing costs – particularly malpractice
- Increased in costly IT requirements (EMR)
- Reaction to Healthcare Reform
- Shifting physician demographics
- Shifting desire for work/life balance
2007 to Present: The Great Reconsolidation

Driving Forces for Hospitals:

- Herd Mentality
- Secure/expand referral network – defensive strategy
- Advantageous reimbursement – particularly for ancillaries (imaging)
- Addressing staffing shortages
- Need for call coverage
- Healthcare Reform – ACOs
- Need to improve and exhibit quality of care
Hospital Employed Physicians on the Rise…

Since 2000:
- Employed PCPs has Doubled
- However Employed Specialists has increased 5-fold
Fair Market Value from a Regulatory Perspective
Regulatory Guidance

Regulatory Overview

- Fair Market Value ("FMV") – the only premise of value to meet the Anti-Kickback Statute and Private Inurement Regulations

- FMV – both for-profit and not-for-profit health care providers that accept payments from government programs (Medicare / Medicaid) must be careful that exchanges between them and other providers are at FMV.

- Definition
  - The price, expressed in terms of cash equivalents, at which a property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arms length in an open and unrestricted market, when neither is under compulsion to buy nor to sell, and when both have reasonable knowledge of the relevant facts
  - FMV can consider revenue increases or cost savings to the Practice that any hypothetical willing buyer would be able to influence but not specific downstream referrals the Practice drives to a health system
Regulatory Guidance

Regulatory Overview

➢ Stark Law
  ❖ Prohibits physicians from referring a patient to an entity with which the physician (or an immediate family member) has a financial relationship, when the referral is for the furnishing of certain designated health services (DHS).

➢ Anti-Kickback Statute
  ❖ Prohibits the payment or remuneration in exchange for, or in order to induce, the referral of patients or other businesses which are reimbursed under the Medicare program.

➢ Private Inurement
  ❖ Deals with Tax-exempt entities providing excess benefits to non tax-exempt individuals or entities
Valuation Approach

Fair Market Value vs. Strategic Value

- Investment Value or Strategic Value
  - Premise of value used everyday in merger and acquisitions which are not required to meet Fair Market Value standards
  - Definition – The price, at which a property would exchange hands between a specific buyer and able seller; it is the value of a property to a particular investor

- Examples of FMV / Investment Value
  - Investment Value:
    - Adjusting the reimbursement rates for the sellers to Hospital-based (Provider-based)
    - Adjusting the cost structure to account for efficiencies or economies of scale that only a specific buyer could realize
  - Fair Market Value:
    - Adjusting reimbursement rates up to freestanding market averages
    - Adjusting the cost structure to reflect market norms for similar businesses
Valuation Primer - Practices
Types of Practice Transactions...

- Purchase in context of entire practice
  - Ancillaries may be “carved out” in valuation
  - Physician employed
    - Carved out ancillary cash flows excluded from post transaction compensation calculation

- Ancillary only Purchase
  - Physician may not want to give up control
    - Physician not employed
  - Method to Integrate with Hospital without outright sale
  - Method of liquidation/risk mitigation
Valuation Primer

Practice Valuation versus Ancillary Services

➢ Professional Practice Valuation
  ❖ Hospital will buy Fixed Assets – very little intangible value
  ❖ Acquisition Value versus Ongoing Comp Structure

➢ Ancillary Valuation
  ❖ Physician is giving up Income Stream
  ❖ Buyer will compensate Physician for this Lost Income Stream
  ❖ Many Ancillary Businesses are still Quite Profitable
  ❖ Acquisition Market is Quite Active
Components of Value…

- **Total Value**
  - Working Capital
  - Fixed Assets
  - Intangible Assets (Goodwill)

- **Retained by Physician**
  - Working Capital Less Inventory
  - Personal Fixed Assets

- **Purchased by Hospital**
  - Inventory
  - Fixed Assets
  - Intangible Assets
Valuation Primer

There are three accepted business valuation methods...

- Income Approach
  - Discounted Cash Flow Method

- Asset (Cost Approach)
  - Tangible Assets
  - Intangible Assets

- Market Approach
  - Guideline Public Company Method
  - Similar Transactions Method
Valuation Primer

Valuation – Three Approaches

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<thead>
<tr>
<th>Method</th>
<th>Professional Practice</th>
<th>Ancillary Business</th>
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<tbody>
<tr>
<td>Income Approach</td>
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<td>Discounted Cash Flow Method</td>
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<td>Cost Approach</td>
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<td>Tangible Assets</td>
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<td>Similar Transactions Method</td>
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Valuation Primer

The Asset (Cost) Approach...

- Takes into consideration the cost of replicating a comparable asset, security or service with the same level of utility.

- Typically used when the entity has historical losses or nominal projected cash flow.
The Asset (Cost) Approach...

- Typical Components...
  - Tangible Assets
    - Working capital
    - Fixed assets
    - Real estate (if applicable)
  - Intangible Assets
    - Legal title, protectable, separately marketable
      - Trade name
      - Phone number
      - Medical Chart
      - Non-Physician Trained Workforce
    - Also generate an economic return (typically based on positive Income Approach)
      - Covenants not to compete
      - Physician workforce
The Market Approach...

- Estimates value by comparing the value of similar assets, securities or services traded in a free and open market to the subject asset, security or service.

  - Similar publicly-traded companies are not comparable from a size or growth standpoint and often include practices with a variety of management services agreements.

  - Similar transaction information in the public domain is rarely useful because details on transaction structure (including post-transaction compensation and employment terms) are not included.
Valuation Primer

The Income Approach...

- Examines historical financial and production information to estimate the future level of cash flows.
  - Projection of future revenues and expenses
  - Projection of future capital expenditures and working capital requirements

- Discount future after tax debt free discretionary cash flows

- Discounted or capitalized cash flow methods are commonly utilized for healthcare entities.

Present Value of Cash Flows = Fair Market Value
Physician Service Agreement Trends and Valuation Techniques
Why the Growth in Physician Alignment?

Association of American Medical Colleges work force projections indicate the U.S. will have a shortage of 91,500 physicians by 2020.

**Non-economic Reasons**
- Security – healthcare reform, changing reimbursement
- Quality of Life – older and younger physicians, on average, working less hours

**Economic Reasons**
- Increased compensation: post employment or contracted arrangement
- Better hospital-based reimbursement
- Replace potential loss of ancillary earnings
- Investment requirements for information technology
- Participate in risk-based contracting, ACOs, quality initiatives
Physician Service Agreements (PSAs)

May be a result of joint ventures, acquisitions, employment or independent contractor arrangements

- Traditional Employment
- Physician Lease Model
- Administrative Services
- Call Coverage
- Clinical Co-management (fixed + variable)
- Management

- Professional/technical splits
- Development
- Billing and Collection
- Leasing Arrangements
- All of the above combined

Often a combination of several valuations is required for one agreement. Choose the right data / analysis to reflect each of the services.
PSA Valuation Basics

- Select a valuation expert with care – does the valuation expert have:
  - Credentials from recognized organizations (AICPA, ASA, NACVA)?
  - Experience with healthcare industry regulations and guidance?
  - Expertise on the impact of the regulations on a valuation?
  - Knowledge of relevant market survey data and its limitations?

- There are no published standards for valuing physician services and compensation.
  - Stark law indicates that fair market value is based on the facts and circumstances and reasonable methodologies should be used.
  - Most valuators start with traditional business valuation approaches (Cost, Market, and Income Approaches)

- The PSA terms must be understood prior to valuation:
  - What services will be provided?
  - How will the parties be compensated?
  - The valuation should match the agreement.
Fair Market Value (FMV) Defined

- Traditional IRS Definition:

  “Fair market value is the price that property would sell for on the open market. It is the price that would be agreed on between a willing buyer and a willing seller, with neither being required to act, and both having reasonable knowledge of the relevant facts.”

- Stark Definition:

  “The value in arm's-length transactions, consistent with the general market value. ‘General market value’ means the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement.”

Sources: IRS Publication 561 and 72 Federal Register 51012 (September 5, 2007)
Common Misconceptions of FMV

➢ Compensation data point from a single survey constitutes FMV.
   - Per Stark, reference to multiple, objective survey remains a prudent practice in evaluating FMV.
   - One survey alone may not provide enough support for FMV compensation.

➢ Any compensation rate that falls below a certain percentile (i.e., median or 75th) is FMV.
   - Median means that 50% of respondents earned less than this amount.
   - May raise a red flag if productivity is not considered (i.e., paid 60th percentile while productivity falls at 40th percentile).

➢ Compensation offers from local competing hospitals determine FMV.
   - Compensation offer may not be arms-length or consistent with FMV.
   - Per Stark, market data utilized in determining FMV should exclude referral relationships.

Takeaway: Each of the above may be considered as part of the entire FMV analysis, but should not be the sole basis for FMV.
Clinical Services - Overview

- Most commonly provided under:
  - Direct employment agreements
  - Physician leasing agreements

- What is physician leasing?
  - “Synthetic” employment agreement
  - Physicians retain ownership of the practice
  - Asset acquisition may occur (ancillary services)
  - Independent contractor arrangement with a hospital
  - Hospital bills / collects for physician services and retains revenues
  - Hospital pays compensation on a productivity basis (typically per work RVU)
  - Practice decides how to distribute compensation internally
  - Practice operating expenses may be assumed by the hospital or the practice.

- Clinical compensation models vary widely:
  - Fixed salary model (employment)
  - Revenue minus expense model (employment)
  - Percentage of collections model (employment and leasing)
  - Compensation per work RVU model (employment and leasing)
Clinical Services – Valuation

➢ Cost and Market Approaches (blended Cost-Market Approach):
  ❖ Cost to employ/contract with a physician based on market data
  ❖ Most commonly utilized method among valuators
  ❖ Simple to understand
  ❖ Benchmarking analysis that aligns compensation and productivity

➢ Compensation and productivity data are obtained from independent, published surveys:
  ❖ *MGMA Physician Compensation and Production Survey*
  ❖ *AMGA Medical Group Compensation and Financial Survey*
  ❖ *SCA Physician Compensation and Productivity Survey*

➢ Common productivity metrics include:
  ❖ Work RVUs
  ❖ Total RVUs
  ❖ Professional collections
  ❖ Gross charges
  ❖ Patient encounters

Note: MGMA = Medical Group Management Association, AMGA = American Medical Group Association, and SCA = Sullivan, Cotter and Associates, Inc.
Clinical Services – Valuation

- Benchmarking example (using the MGMA survey):
  - Solo practitioner specialized in general orthopedic surgery
  - No in-office ancillaries or mid-level providers
  - 2011 annual work RVU volume of 13,867

<table>
<thead>
<tr>
<th>Physician Work RVUs</th>
<th>25th</th>
<th>Median</th>
<th>75th</th>
<th>90th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedic Surgery: General</td>
<td>6,239</td>
<td>8,250</td>
<td>11,021</td>
<td>13,867</td>
</tr>
<tr>
<td>Subject Physician's Annual Work RVUs</td>
<td></td>
<td></td>
<td></td>
<td>13,867</td>
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Conclusion: Physician productivity falls at the 90th percentile

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<thead>
<tr>
<th>Physician Compensation</th>
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<th>75th</th>
<th>90th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedic Surgery: General</td>
<td>$372,437</td>
<td>$497,088</td>
<td>$658,842</td>
<td>$825,044</td>
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<tr>
<td>Selected Compensation (based on work RVUs)</td>
<td></td>
<td></td>
<td></td>
<td>$825,044</td>
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Takeaway: Valuators commonly benchmark multiple productivity metrics to multiple surveys.
Clinical Services – Valuation

- Common benchmarking mistakes include:
  - Including mid-level provider productivity
  - Benchmarking total RVUs to reported work RVUs
  - Benchmarking total collections to reported professional collections
  - Miscalculation of patient encounters (read the data definition of each survey!)

- Common misunderstandings of survey data:
  - Reported compensation is a definitive snapshot of current market compensation
  - Reported compensation reflects only clinical services

- Common mistakes in using the reported compensation per work RVU:
  - Per MGMA, an inverse relationship exists between work RVU volume and compensation per work RVU
  - Paying a highly productive physician the 75th to 90th percentile compensation per work RVU may result in compensation outside of FMV.
  - See illustration on the following page.
Clinical Services – Valuation

➤ Misuse of reported compensation per work RVU data
  ❖ Solo practitioner specialized in general orthopedic surgery
  ❖ No in-office ancillaries or mid-level providers
  ❖ 2011 annual work RVU volume of 13,867
  ❖ Hospital employer proposed MGMA 90th percentile compensation per work RVU

<table>
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<th>Compensation per Work RVU</th>
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<tr>
<td>25th</td>
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<tr>
<td>2011 annual work RVU volume of 13,867</td>
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<tr>
<td>Equal to MGMA 90th</td>
</tr>
<tr>
<td>Compensation per work RVU - Orthopedic Surgery: General</td>
</tr>
<tr>
<td>Times: Physician's Annual Work RVU Volume (equal to MGMA 90th)</td>
</tr>
<tr>
<td>Equals: Annual Physician Compensation</td>
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<table>
<thead>
<tr>
<th>Physician Compensation</th>
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<tbody>
<tr>
<td>25th</td>
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<tr>
<td>Total Compensation - Orthopedic Surgery: General</td>
</tr>
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Annual Physician Compensation is more than 160% of the 90th percentile!!! $1,324,021

Takeaway: Always test productivity models to ensure the selected metric and expected productivity result in FMV compensation.
Clinical Services – Valuation

Income Approach:
- Another standard valuation approach
- Considers normalized historical compensation
- Considers normalized physician practice revenues less expenses and a reasonable rate of return to the employer.
- Considers specific economic factors of a physician’s practice such as:
  - Local reimbursement
  - Payor mix
  - Procedure mix
  - Practice expense profile

Takeaway: The Income Approach often serves as a reasonableness check to the results of the Cost-Market Approach.
Historically, physicians provided call coverage to Hospital emergency departments on an uncompensated basis.
- Sometimes a condition of medical staff membership
- Sometimes granting/renewal of clinical privileges

Not anymore . . . Why not?
- Increasing number of uninsured patients
- Aging active physician staff
- Increasing cost of malpractice insurance and declining reimbursement
- Perceived increase in risk of lawsuits

According to the Sullivan, Cotter and Associates Call Coverage Survey:
- 63% of survey respondents had difficulty finding physicians to provide call
- 7% had to shut down one of more services due to lack of call coverage
- 58% employ physicians specifically to provide call coverage
- Most common payment structure is an hourly rate or stipend

First question to ask prior to valuation: Are call coverage services generally needed for the subject specialty?
Call Coverage Services - Valuation

- As noted previously, no published standards exist for valuing call coverage services.

- Regulatory guidance – OIG Advisory Opinion no. 07-10
  - Issued on September 20, 2007
  - OIG agreed not to prosecute a hospital for paying for call coverage services
  - OIG found the arrangement to be at low risk for fraud and abuse and noted the following:
    - Independent analysis was conducted to ensure compensation was FMV
    - The per diem rate was designed to compensate based on the burden of call
    - On-call physicians were obligated to provide care to ED patients regardless of the patient’s ability to pay
    - Physicians in each specialty received the same per diem rate
    - The medical center had a legitimate need for the coverage services

Takeaway: The development of a reasonable and FMV rate for call coverage services must consider the specific burden of call.
Call Coverage Services - Valuation

Cost Approach – Beeper Rate Method:
- Determines call compensation as a percentage of base compensation
- Base compensation rates are based on multiple, published surveys:
  - MGMA Physician Compensation and Production Survey
  - AMGA Medical Group Compensation and Financial Survey
  - SCA Physician Compensation and Productivity Survey
- Percentage of base ranges (or beeper rates) are based on market observations and call coverage pay rates of non-referring physicians
- Base rate may need to be adjusted for independent contractor relationship

Factors to consider in determining a Beeper Rate:
- Volume of call
  - Phone calls
  - In-person
- Response time requirements
- Ability to bill/collect
- Payor mix of patients served
- Restricted versus unrestricted coverage

Note: MGMA = Medical Group Management Association, AMGA = American Medical Group Association, and SCA = Sullivan, Cotter and Associates, Inc.
Call Coverage Services - Valuation

✔ Market Approach:
  ❖ Considers available market survey data for call coverage services
  ❖ Currently, there are two prevalent market surveys:
    o *MGMA Medical Directorship and On-Call Compensation Survey*
    o *SCA Physician On-Call Pay Survey*
  ❖ Compensation data within the surveys is reported as an hourly rate or daily stipend

✔ Limitations of the survey data:
  ❖ Based on referral relationships (physician-hospital)
  ❖ Limited number of respondents
  ❖ Can be large variances in the fees reported
  ❖ Important factors such as call volume, payor mix are unknown
  ❖ Details such as whether the physician bills/collects are unknown

Takeaway: The shortfalls of the Market Approach often limit its use to a reasonableness check to the results of the Cost Approach.

*Note: MGMA = Medical Group Management Association and SCA = Sullivan, Cotter and Associates, Inc.*
Medical Director Services – Overview

- As with call coverage, historically it was not unusual for physicians to volunteer their time to hospitals for medical director duties.

- Due to the increase in duties and demand of services, physicians require reasonable payment for their time and services.

- According to Integrated Healthcare Strategies Medical Director Survey, medical directors common provide the following services:
  - Act as a liaison between the medical staff and hospital management
  - Participate in the JCAHO accreditation process
  - Physician credentialing and peer review
  - Utilization review and quality improvement
  - Establish and implement clinical pathways
  - New program development and implementation

- Preliminary questions to ask prior to valuation:
  - Are the services needed (i.e., how many hours? How many other directors?)?
  - Do the services require a physician? A specific specialty?
Medical Director Services – Valuation

➢ Two valuation approaches:
   • Cost Approach
   • Market Approach
   • Results are typically stated as an hourly rate

➢ Cost Approach
   • Considers the cost of the physician’s time based on clinical compensation
   • Considers multiple, published compensation surveys:
     o MGMA Physician Compensation and Production Survey
     o AMGA Medical Group Compensation and Financial Survey
     o SCA Physician Compensation and Productivity Survey
   • Annual hours set at 2,000 based on Stark guidance

➢ Limitations of the Cost Approach
   • Compensation does not match the services provided
   • Stark indicates that clinical compensation may not be FMV for administrative services

Takeaway: Limited reliance is usually placed on the Cost Approach.

Note: MGMA = Medical Group Management Association, AMGA = American Medical Group Association, and SCA = Sullivan, Cotter and Associates, Inc.
Medical Director Services – Valuation

➢ Market Approach
  ❖ Considers compensation data for similar services
  ❖ Considers multiple, published medical director compensation surveys:
    • IHS Medical Director Survey
    • MGMA Medical Directorship and On-Call Compensation Survey
    • SCA Physician Compensation and Productivity Survey
  ❖ Annual hours set at 2,000 based on Stark guidance

➢ Limitations of the Market Approach
  ❖ Limited number of respondents
  ❖ Some conservative parties argue the data is “tainted” with referral relationships

➢ Other Considerations
  ❖ Productivity data is not applicable to medical director survey data
  ❖ Percentiles above the median are often selected based on qualitative factors

Takeaway: The Market Approach matches compensation and services and is generally relied upon to determine FMV medical director compensation.

Note: MGMA = Medical Group Management Association, IHS = Integrated Healthcare Strategies, and SCA = Sullivan, Cotter and Associates, Inc.
Co-Management (Quality) – Overview

- Pay for performance (P4P) in the news

- HQID (CMS/Premier Hospital Quality Incentive Demonstration)
  - Raised their overall quality by an average of 18.6 percent over six years
  - Incentive payments of almost $12 million in the final year 6 to 211 providers for top performance, as well as top improvement

- UnitedHealth Group – largest US health insurer by sales
  - Currently paying 21 different specialties based on quality
  - Expect to save twice as much than the quality payments due to healthier patients

- WellPoint – largest US health insurer by membership
  - Will increase primary care physician pay by 10%
  - Additional cost savings bonus of 20% to 30% of savings achieved
  - Total P4P increase could be as much as 50%
Co-Management (Quality) – Overview

- **Aetna** – 30% of its primary care physicians are already eligible for P4P
  - New payments expected to increase physician reimbursement by 15%
  - Program spreading quickly

- **Tennessee Surgical Quality Collaborative**
  - 10 hospitals experienced significant improved surgical outcomes
  - Millions in cost savings - $2.2 million per 10,000 surgery cases

- **Ohio’s Medicaid Program – P4P component will be included when it rebids contracts for 2013**

- **February 2012 Committee on Ways and Means**
  - UnitedHealth Group discusses results of its Premium Designation Program (PD)
  - Results show over 50% decrease in some complication rates and 14% in savings for PD physicians
Co-Management (Quality) – Overview

- Hospitals critical success factors – shifting towards quality of clinical performance

- Massive surge in reporting initiatives

- Congress authorized value-based purchasing (VBP) program to replace the RHQDAPU program
  - Performance Incentives would be based on improving historical performance or attaining superior outcomes compared with national benchmarks
  - Proposed ACOs include similar guidelines

- Numerous third party payors provide quality payments to hospitals and physicians

- C-Level executives’ compensation may be subject to a hospital’s quality outcomes
Co-Management (Quality) – Overview

- 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.
Co-Management (Quality) – Valuation

- Common compensation structures for co-management agreements:
  - Fixed Fee
    - Time dedicated to meetings designed to improve the overall quality of care for a specific service line.
    - FMV based on cost to engage a physician to provide similar services (clinical and administrative survey data)
    - May include medical directorships and non-physician services (billing, administration, etc.)
  - Variable Fee
    - Quality targets are outlined and incentive payments are provided for those responsible for implementing best practices to achieve the predefined targets.
    - Must understand historical, superior quality and improvement
    - Carefully calculate incentive compensation pool – Tiered structure
    - Consider payment rates of other P4P programs in the market

Fixed Fee + Variable Fee = Total Co-Management (Quality Incentive) Fee
Final Thoughts

Many PSAs include multiple physician services – this has become known as “stacking”.

- Ensure that each “stacked” service is consistent with FMV
- Ensure that the total package of services is reasonable
  - Are the services required by the hospital / facility?
  - Can the physician reasonably provide all services included in the PSA (i.e., will the physician be working 90 hours per week?)?

Increasing trend in use of internal compensation calculators

- Great tool for call coverage and administrative services
- Internal calculators are based on systematic and unbiased overall guidelines which eliminate the user’s ability to include its results
  - Each indication of value considers the specialty and reflects the service provided by the physician.
  - Utilizes multiple, objective national surveys reflecting compensation data by specialty.
  - Each indication delineates between employed and independent contractor agreements.
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