Using Co-Management Effectively to Improve Results

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Michael Piver

- Director of Strategic Integration of Surgical Services and Rehab Services with Tanner Medical Center, Inc.
- Previously in ASC administration, development and practice management
- Former President of AL Assoc. of ASC
- 13 years of healthcare experience

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Jen Johnson

- 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

ABA Defending Liberty Pursuing Justice

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Presentation Overview

Physician Alignment Trends & P4P
- Jen Johnson

Practical Advice on Co-Management from Experience
- Michael Piver

Fair Market Valuation Guidelines for Co-Management
- Jen Johnson

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Growth in Physician Alignment through P4P

- Hospitals need physician alignment due to focus on quality:
  - Healthcare reform, changing reimbursement
  - Physician and hospitals increasingly participating in risk-based contracting, ACOs, quality initiatives
  - Compensation and reimbursement is being tied to quality
- Physicians seeking:
  - Increased compensation with various contracted arrangements
  - Replacement for loss of ancillary earnings
  - Options to align without employment or joint venture

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Quality Payments Overview

- Massive surge in reporting initiatives which are pre-cursor to being able to support quality payments
- Congress authorized the development and implementation of a value-based purchasing (VBP) program to replace the RHQDAPU program which reports quality.
  - 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 quality payments to hospitals and physicians
- C-Level executives' compensation may be subject to a hospital's quality outcomes

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Results of Quality Incentives

- In late 2003, CMS and Premier Inc. launched the Hospital Quality Incentive Demonstration (HQID) for over 250 hospitals over past 6 years.
  - Includes financial incentives for the top 20% of hospitals.
  - 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 seven projects including hospitals and physicians. Notable findings:
  - Financial incentives motivate change
  - Alignment with physicians is a critical activity for quality outcomes
- 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

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P4P - In The News

- 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%
- Tennessee Surgical Quality Collaborative
  - 10 hospitals experienced significant improved surgical outcomes
- Ohio's Medicaid Program – P4P component will be included when it rebids contracts for 2013

***Co-Management can be a successful option for alignment**

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Tanner Medical Center, Inc.
Carrollton Orthopaedic Clinic, P.C.

Management Services Agreement

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Who is Tanner?

- A nonprofit, four-hospital health system, serving a 9 county area – over 300,000 people.
- **Tanner's medical staff** comprises more than 300 physicians representing 34 specialties.
- Over **2,600 employees** strong.
- **Tanner Medical Group** has more than 30 practices in about 40 locations in west Georgia and east Alabama.

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A Commitment to Quality

- **Ranked a 15 Top Health Systems in the Nation by Thomson Reuters**, the only health system in Georgia on the list in any category – small, medium or large.
- **Given the Outstanding Patient Experience Award** by HealthGrades. Scored in the top 10 percent of American hospitals for patient satisfaction.
- **Ranked No. 1 in Georgia for Overall Orthopedic Services** by HealthGrades

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Factors Leading up to Agreement

- Years of distrust and threats by both groups
  - COC threatened to open up an ASC
  - Tanner threatened to bring in other Ortho group(s) into market
- Mix of old & young Ortho surgeons
- VMG Health hired to perform 3rd party valuation for employing COC
- Alternative option offered in addition to employment…MSA or Co-management Agreement

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Structure of MSA Agreement between Tanner Medical Center, Inc & Carrollton Orthopaedic Clinic, P.C.

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Current Structure of MSA Agreement

- Fixed Fees
  - Meetings
  - Call Coverage
- Variable Fees
  - Performance/Quality Measures
- Within the MSA Agreement, specific reference made to EMR assistance, recruitment and Market Analysis of service line
- Through structure of MSA Agreement, a Joint Planning Board was created, consisting of hospital CEO, COO, CMO, Director, and two Orthopedic surgeons which govern the Service Line.

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Results of MSA Agreement since Aug. 2011

- Focused attention on Orthopedic Quality through
  - Reduced SSI rates for Total Hip, Knee & Spinal Fusion cases
  - Reduction in Hip Fracture Mortality
  - Reduction in re-admission rates
- Focus on hospital-specific Performance/Quality Measures
  - Development of voice dictation/templates
  - ED disposition to floor process improvement
- Several new committees formed which has/is solving major issues of communication
  - Ortho/ED
  - Ortho/TIMS
  - Ortho/Anes

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Results of MSA Agreement since Aug. 2011

- Improved access to care for patients from ED afterhours
- Cost containment discussions already underway with joint & spine opportunities identified.
- Market Analysis company engaged for 3 years to develop Tanner Orthopedic Service Line into a regional Center of Excellence through:
  - Use of software, providing functional outcomes data
  - Prioritization of SWOT recommendations from Market Analysis
  - Re-invention of Tanner & COC's commitment to Work Comp
  - Creation of a Joint & Spine Center of Excellence
  - Recruiting new Orthopedic surgeons
    - Market Analysis identified the following as immediate needs and COC currently interviewing the following candidates:
      - Additional Spine surgeon
      - Hand surgeon

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Step 1 to Compliance

- Commercially Reasonable
  - Facility needs – check for overlap of services (numerous medical directors needed)
  - Operational assessment (quality metrics relevant for patient population)
  - Understand total hours (reasonable)
- Agreement terms must be understood and are sometimes unclear at valuation stage, define:
  - What services will be provided and how parties will be compensated
  - Valuation should match the agreement – may require several valuations for one agreement

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Valuation Starting Point

- Understand there are no published standards for physician compensation valuations
  - Appraisal firm should understand
    - Healthcare regulations
    - Valuation principles
  - Regulatory Guidance
    - Fair Market Value
    - Data considerations

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Tuomey Case Take-Aways

- Hospital is at risk for relying on unsupportable valuations
- 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
- Logic Test – Tuomey examples:
  - 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

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Fair Market Value Definition

- 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.
  - Offer equal P4P opportunities to all providers
  - Do not tie P4P compensation to expected referrals
- Rely upon generally accepted valuation theory – consider multiple valuation methodologies and approaches: cost, market and income approach

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FMV - Data/Analysis Considerations

- It is now likely a combination of several valuations will be required for one agreement, choose the right data/analysis to reflect each of the services
- Multiple, objective surveys suggested – thorough approach
- Data should not reflect referral relationships
  - Medical Director data
  - On-Call data
  - Competing Hospitals – Extra Caution
- P4P comparables
  - Stick to regulatory guidance when it comes to paying for quality or gainsharing
  - Governmental programs and third party payors are good market comparables

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Regulatory Guidance - Quality

- 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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Co-Management: Fixed Fee Overview

- Physician service related payments are justified by need for clinical expertise
- 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
- The duties must not overlap with hospital staff

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Co-Management: Variable Fee Overview

- Quality outcomes drive payments - create payment tiers for incentives based on various outcomes
- Improvement and superior outcomes may warrant incentive payment
  - Obtain industry-recognized benchmark data for the quality metrics, (average or median and top or 90th percentile)
  - Understand historical performance and who is responsible for developing and implementing the strategy
- Cost savings metrics notes
  - Administrative oversight to protect quality is essential
  - Measurement must be tied to physician's input

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Compensation Valuation Approaches

- Fixed Fee - Quality Meetings and On-Call Coverage
  1. May utilize low end of market compensation for guaranteed payment OR
  2. May utilize FMV rate for payment
- Variable Fee - Based on quality outcomes
  1. May utilize hourly differential if superior quality is achieved
     - High end of FMV less:
     - Low end of market compensation (guaranteed payment)
  2. Value variable fee separately based on other P4P programs
     - Check total compensation per physician

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QUESTIONS

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