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- Partner at VMG Health.
- VMG Health solely provides transaction advisory and valuation services in the healthcare industry.
  - Since 1995, offices in Dallas and Nashville.
  - 70 professionals, over 1,200 valuation per year.
  - Third party role and client base
- Leads Professional Service Agreements Division.
- Previously in KPMG's litigation department & finance professor, University of North Texas.
- Published and presented multiple times related to physician compensation and fair market value.

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Presentation Overview

- Physician Alignment Trends & P4P
- Fair Market Value Guidelines
- P4P Market Observations

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Physician Alignment Trends & P4P

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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

6

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Physician Service Agreements

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

- ❑ Administrative Services*
- ❑ Call Coverage*
- ❑ Co-management (fixed + variable)*
- ❑ Management*
- ❑ ACOs*
- ❑ Bundled Payment models*
- ❑ Clinical Services*
- ❑ Professional/technical splits
- ❑ Development
- ❑ Billing and Collection
- ❑ Leasing Arrangements
- ❑ All of the above combined

*May have a P4P component

7

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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
  - ⌀ Millions in cost savings - $2.2 million per 10,000 surgery cases

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P4P - In The News

- ❑ Ohio's Medicaid Program – P4P component will be included on contracts for 2013
- ❑ Medicare Shared Savings Program – Jan 2013 - 106 newest ACOs to join its Medicare Shared Savings Program (MSSP), bringing the total number of Medicare ACOs to 259.
- ❑ Bundled Payment arrangements - – Jan 2013 - CMS officially launched one of its biggest financial innovation programs under healthcare reform, more than 500 hospitals, health systems and other providers have enrolled: *Bundled Payments for Care Improvement*
- ❑ ACO Business News publication

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Quality Payments Overview

- Hospitals critical success factors – shifting towards quality of clinical performance
- Massive surge in reporting initiatives which are pre-cursor to being able to support quality payments (PQRI and now ASCs)
- 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.
  - ACO type arrangements 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

- CMS awarded incentive payments of $12 million in year six to 211 hospitals for top performance, as well as top improvement in the project's six clinical areas.
  - Overall, 1,343 awards were given in the sixth year of the project.
  - Through the project's six years, CMS awarded more than $60 million to participating hospitals.
- The average composite quality score (CQS), an aggregate of all process and outcomes measures within each clinical area, improved project-wide by 18.6 percentage points over the project's six years (October 2003 through September 2009)

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Results of Quality Incentives

- 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. Notable findings:
  - 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
- 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
- Less favorable findings and why

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Shared Savings Payments Overview

- Physicians assist in lowering cost of care and/or improve efficiencies
- Quality Driven Expense Reductions
  - Share costs saved from improved quality, for example lower readmission rates
  - Metrics are measureable, but savings difficult to quantify – lower readmissions
  - Often seen in quality payments based on outcomes to physicians
- Direct Cost Savings
  - Simple to quantify
  - Short-term
  - Share cost savings, for example:
    - Lower supply costs
    - Lower staffing costs
- Shared Savings for population or bundled payment

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Summary of P4P payments

- Standard process leading up to P4P payments
  1. Recognized organization identifies quality metrics or average costs
  2. Reporting measures is required, or costs are tracked
  3. Benchmarking data is gathered
  4. Payments for outcomes or savings is observed in market
- Early year P4P observations
  1. Payments for reporting
  2. Hourly payments for establishing protocols with uptick for completion of goals
  3. April 2013 Report from ACO Business News
     - 18 of the 32 Pioneer ACO's threaten to quit program
     - Due to fact CMS plans to switch from pay for reporting to pay for performance

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Fair Market Valuation Guidelines

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Valuation Starting Point

1. Agreement terms must be understood and are sometimes unclear at valuation stage, define:
   - What services will be provided?
   - How parties will be compensated?
2. Commercially Reasonable
   - Facility needs – check for overlap of services (numerous medical directors needed)
   - Operational assessment (quality metrics relevant for patient population)
3. There are no published standards for physician compensation valuations, P4P very new
   - 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
- P4P comparables
  - Stick to regulatory guidance when it comes to paying for quality or shared savings
  - 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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Regulatory Guidance – Gainsharing

Shared savings guidance

- Each member of the physician group should have medical staff privileges
- The arrangement should be administered by a program administrator, whose compensation was not tied in any way to the incentive compensation.
  - A program administrator should identify cost-savings metrics after reviewing historical practices and understanding its medical appropriateness.
  - The savings targets should be"re-based" at the end of each year in multi-year arrangements.
  - The hospital should calculate the cost savings separately for each group and for each cost savings recommendation.
- Engage an independent reviewer or auditor to review the program prior to commencement and at least once per year.
- The arrangement should include objective measures to monitor quality (i.e., CMS Specification Manual for National Hospital Quality Measures).
- Incentive payments should be set at FMV

- More complex factors should be considered for allocating savings associated with patient population and bundled payments - responsibility

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P4P Valuation Highlights

- Identify who is impacting what – need data
  - Quality measures and cost savings must be linked directly to a specific metric, expense or activity
  - Shared savings - bundled payment and patient population savings logical method for split
- Lack of strong guidance on determining FMV for these payments, governmental guidance good place to start:
  - Quality payments example – 2% HQID
  - Shared Savings exampled – 50% OIG opinions
  - Demonstration projects

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Arrangement Types with P4P

- Traditional deals with P4P component
  - Clinical
  - Medical directorships
  - Call coverage
- Co-management
- ACO type models
- Bundled Payments

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Quality Metrics

- Common metrics
  - Patient satisfaction
  - Infection Rates
  - Readmission
- Challenges with certain service lines, less data: oncology, imaging
  - Look to current reporting measures
  - Track what credible organizations are measuring
  - Identify metrics third party payors are measuring
  - CMS metrics

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Shared Savings Opportunities

- Common metrics
  - Supply costs
  - Staffing costs
  - Generic vs. brand drugs
- Challenges with certain shared savings arrangements
  - Measuring who has the impact and how to allocate dollars
  - Sticking to several regulatory guidance
    - Cannot limit vendors
    - No cherry picking
    - No lemon dropping

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Co-Management - The Basics

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

- 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
- Probably not a typical management fee

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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
  - Administrative oversight to protect quality is essential
  - Measurement must be tied to physician's input

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Clinical Integration payments/ACO models

- The following payment allocations may be included within a clinical integration model
  - Bundled payment splits – understand who is providing what service
  - Quality and Shared Savings splits among ACO entity and hospital and physicians
  - Quality and Shared savings distribution among physicians
  - PMPM from ACO to physicians
- FMV process - balanced approach for overall model should be assessed [ACO model]
  - Third party funded or from hospital
  - Infrastructure costs
  - Buy-in or participation Fee
  - Time spent/effort – hourly rate paid
  - Split of savings – existence of minimum savings threshold
  - Split of quality - benchmarks utilized
  - PMPM fee – acuity and NCQA
- Compliant P4P payment formula = Good Data + Logic + FMV guidance

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Questions?

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