Aligning Oncologist-Hospital Interests Through Co-Management Arrangements

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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 the hospital’s oncology service line.
Co-Management Arrangement
Structural Considerations

• The “management entity” may be a single existing physician practice, or a new entity (“NewCo”) may be created consisting of multiple physicians and/or physician practices

• The hospital may or may not have an ownership interest in NewCo
Service Line Co-Management
Direct Contract Model

Payors → Hospital → Operating Committee

- Service Line: HospitalLicensed services
- Designees
- Operating Committee: Designees
- Co-Management Agreement:
  - Multi-party contract
  - Allocates effort and reward between groups

- Oncology Group I
- Oncology Group II
- Other Group(s)
Service Line Co-Management
Joint Venture Model

Payors

Hospital

Service Line

Service Line Physicians/Groups

JV Management Company

- Capital Contributions
- Management Infrastructure

Profit Distribution

Co-Management Agreement

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Notes:
- Service Line Co-Management Agreement (3-6% of Service Line revenue, which can be of both cancer center and hospital)
  - PSA component – RVU rate equal to aggregate current revenue
  - Co-management component – fixed fair market value fee
  - Incentive component contingent on meeting specified quality and efficiency improvement standards – fixed FMV fee per standard
Service Line Co-Management Arrangements

There are typically two levels of payment to oncologists under the service line contract:

• Base fee – a fixed annual base fee that is consistent with the FMV of the time and efforts participating oncologists 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
Service Line Co-Management Arrangements

• Pays participating oncologists 3-6% of service line revenues
  – Fixed, fair market value fees; independent appraisal advisable
• Base payment relates to scope of service line
  – Outpatient oncology
  – Inpatient oncology
  – Dedicated oncology ancillaries: pharmacy, lab, imaging
  – Radiation oncology
  – Surgical oncology
• Base pay relates to service line duties
Service Line Co-Management Arrangements

Sample Co-Management Services (select)
- Development of service line
- Medical director services
- Budget process
- Strategic/business planning process
- Community relations and education
- Patient, physician and staff satisfaction surveys
- Development of clinical protocols and performance standards
Service Line Co-Management Arrangements

Sample Co-Management Services (cont.)

- Ongoing assessment of clinical environment and work flow processes
- Physician staffing
- Patient scheduling
- Staff scheduling and supervision
- Human resource management
- Case management activities (e.g., discharge planning, arranging follow-up services and supplies, call back processes)
Service Line Co-Management Arrangements

Sample Co-Management Services (cont.)

• Materials management
• Medical staff-related activities and committee participation
• Credentialing assistance
• Coordination with the reporting to hospital
Sample Medical Oncology Performance Standards

- Increase in percentage of patients with written treatment plans at start of infusion
- Increase in percentage of written treatment plans with indication of:
  - Staging
  - Intention of therapy
  - Approved treatment regimen for tumor site/staging
- Increase in percentage of written treatment summaries at completion of course of treatment
Sample Medical Oncology Performance Standards

- Improved on-time infusion/RT starts
- Improved turn-around time for infusion chair/RT
- Compliance with QOPI/PQRI standards
- Increase in patient satisfaction
- Increase in staff satisfaction
- Decrease in infusion-site infections
- Substitution of lower cost drugs/items for drugs/items of equivalent efficacy and quality
- Increase in patient accruals for hospital clinical trials
Principal Regulatory Considerations

• Civil Monetary Penalty Statute
  – No stinting: can’t pay for reduction in LOS or for generalized cost savings
  – Limited gainsharing permitted: substitution of lower cost items of equivalent quality

• Anti-Kickback Statute
  – No payment for referrals
  – No payment to change case mix, payor mix
  – Not safeharbored: aggregate compensation not set in advance
Principal Regulatory Considerations

• Physician Self-Referral Statute (Stark)
  – Direct contract model: Fair Market Value exception
  – JV Model: indirect compensation exception
    (or structure to avoid Stark)

• False claims Act

• Tax Exemption/Intermediate Sanctions
  – Reasonable compensation limitation
  – Rev. Proc. 97-13 durational limitations
Principal Regulatory Considerations

• Provider-Based Status Rules
  – Clinically, financially and administratively integrated with hospital/hospital reporting lines

• Securities laws
  – JV offering to non-accredited investors
Regulatory Considerations

• Legal constraints on Service Line Co-Management Agreements
  – No stinting
  – No steering
  – No cherry-picking
  – No gaming
  – No payment for changes in volume/referrals
  – No payment for quicker-sicker discharges
  – Must be FMV; independent appraisal required

• Proposed Stark Law Exception for Incentive Payment and Shared Savings Programs
Additional PSA Regulatory Considerations

• Medical provider-based status rules
  – Cannot lease mid-level providers to hospital for off-campus facilities (more than 250 yards from main campus)

• Stark Law
  – In-Office Ancillary Services Exception – 75% of patient care services billed through group
  • Hospital services provided under PSA counted toward 75% test even though billed by hospital (otherwise not more than 25% of services could be billed under PSA if group continues to provide and bill for any in-office ancillaries)
Other Considerations:
• Commits 3-6% of service line revenues
• Requires active participation and real time and effort by busy physicians
  – Documentation requirements
• Allocation of fees among participating oncologists
• Durability: need to periodically adjust performance standards and targets?
  – Will the parties reach agreement/dispute resolution?
Service Line Co-Management Arrangements

- Dilution by adding physicians
- Physicians may not share in reward from growth of service line
- Physician entity to organize participating physicians and allocate payments?
- Cost of independent appraisal (and clinical monitor)
- Legal costs
- Some irreducible legal risk
Co-Management Arrangements

FMV Considerations

- Compliance with FMV is critical for regulatory compliance, but also for the ultimate success of the project.
- FMV compensation payable under a co-management arrangement is particularly subjective.
- As with other management agreements, the physician managers are not compensated based upon hours worked; compensation is based upon a specific set of management duties and desired performance metrics.
Co-Management Arrangements

FMV Considerations

• The physicians are expected to provide those specific duties outlined in the co-management agreement.
  – Skeptics may say that there is a risk of overcompensating physicians’ contributions to co-management arrangements.

• One means of valuing a co-management fee is by comparison to other management arrangements (e.g., ASC management or practice management).
  – Such management entities are expected to devote required time and resources to their management obligation, and there is little opportunity for the manager to “hide”.

• Specifically identified medical directors can still exist (and be compensated), but the medical director roles must be integrated with the overall financial analysis of the program.
Co-Management Arrangements
Establishing FMV

• Available valuation methodologies are limited and somewhat subjective.
• In considering the primary valuation approaches (cost, income and market), an income approach can likely be eliminated.
• Using a cost approach, FMV of the management fee can be established by assessing the estimated number of work hours needed to provide the management services multiplied by a FMV hourly rate.
  – However, the exact number of required work hours cannot reasonably be determined in advance.
• Further, a key ideal of most co-management arrangements is to reward *results* rather than time-based efforts.
Co-Management Arrangements

FMV Considerations

• A market approach recognizes that each co-management arrangement is unique, and considers specific market and operational factors related to the subject arrangement.
  – Break the specific services down into specific tasks and objectives, and then compare to other arrangements.
  – On an item-by-item basis, assess the relative worth of each task/objective, and determine necessary adjustments to the comparable arrangements.

• The cost and market valuation methodologies described above must be reconciled to arrive at a final conclusion of value. Consistency in approach aids in supporting the FMV of subjective compensation arrangements.

• The FMV of the total management fee must be established, as well as the base and incentive components.
Co-Management Arrangements
Valuation Expectations

• Management fee equals 3-6% of service revenues?
  “So which one is it? 6% sounds better than 3%!“

• Key determinates of the FMV compensation:
  – Size (e.g., net revenue) of the service line being managed
  – Complexity of the service line being managed
  – Extent and scope of services being provided
  – Service line maturity and opportunities
  – Unique attributes/considerations
  – Valuator’s judgment and experience
Other FMV Considerations

- Integration with other agreements:
  - Clinical staffing agreements
  - Call/coverage agreements
  - Medical directorship agreements
  - Department/division chair agreements
  - Physician lease/lease-back agreements
- Allocation of value among participating physicians/medical groups
- Engagement of valuator by counsel to obtain benefit of attorney-client privilege?
Co-Management Arrangements

FMV Pitfalls/Issues

• No independent FMV analysis was obtained.
• The government fails to find the FMV analysis compelling.
• A retrospective review of facts and circumstances may cast the arrangement in a poor light (e.g., if there is no record of active physician involvement, notwithstanding the fact that hours are not tracked).
Practice Acquisitions

Two primary approaches:

• Practice purchase price equals tangible asset value, and future compensation to the physicians is unencumbered by the purchase transaction.

• Practice purchase price includes value for specifically identified intangible assets (e.g., workforce in place, trade name), but future compensation to the physicians must be consistent with past practices, or the purchase price must be reduced.
“Synthetic” Employment Agreements aka PSA Models

• Instead of employment, new arrangements are gaining traction whereby oncologists retain their own practice, and are compensated on a productivity basis (e.g., per wRVU) for their clinical services.

• A transaction may involve the purchase of the oncologists’ tangible assets and payment for workforce in place (or an employee leasing arrangement).

• The wRVU rate payable to the oncology group is a “gross” rate that includes remuneration for:
  – cash compensation;
  – taxes and benefits; and
  – “retained” practice expenses (e.g., malpractice insurance, CPE costs, etc.)

• The FMV analysis should consider pre- and post-transaction compensation to the physicians.
**FMV Considerations in Employment and PSA Arrangements**

- Compensation “stacking”
  - Medical director fees
  - Management fees
  - Administrative fees
  - Quality bonuses
  - Sign-on bonuses
  - Retention bonuses
  - Tail coverage, etc.

- Consider that the data reported by the compensation surveys generally include all sources of income.

- Sources of compensation survey data:
  - Medical Group Management Association (MGMA)
  - Sullivan Cotter & Associates
  - Hospital & Healthcare Compensation Service
  - American Medical Group Assn (AMGA)
  - Towers Watson Data Services (fka Watson Wyatt)
FMV Considerations in Employment/PSA Arrangements

• Confucius Statistician say...If you torture the data long enough, it will confess to the crime it did not commit.

• For oncology/hematology in particular, available market data are somewhat schizophrenic.
  – Are survey respondents reporting data in a consistent manner (e.g., total collections vs. professional collections)?

• MGMA data can be misused in a variety of ways, including:
  – Cherry picking from among different tables (e.g., regional data vs. state data)
  – 90th percentile compensation times 90th percentile wRVU productivity

• Failure to consider ownership/ancillary profits that may be inherent in 90th percentile compensation
For Hematology/Oncology:

- 90\textsuperscript{th} percentile cash compensation - $784,000
- 90\textsuperscript{th} percentile wRVUs – 7,905
- 90\textsuperscript{th} percentile compensation per wRVU - $127

Where is this going?

- 90\textsuperscript{th} percentile wRVUs x 90\textsuperscript{th} percentile compensation per wRVU = $1,004,000
- 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!
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