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Service Line Co-Management: The Ultimate Sustainable PSA? Creating Legal, Effective, and Lasting Alignment

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Service Line Co-Management:

The Ultimate Sustainable PSA?

Creating Legal, Effective and Lasting Alignment

Presented by:
John C. Erickson, Esq.
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June 16, 2021

Why Drives What

- What are the objectives of a Co-Management Agreement?
- Why is a Co-Management Agreement sometimes the optimal arrangement to seek to satisfy those objectives?

Hospital Service Lines

- A set of specialized services patients receive in a hospital IP and/or OP setting
- Facility services and professional services
- Physicians are an essential component of any service line

Primary Objective

- Optimize service line quality and efficiency
- Address full range of services, both professional and technical, from admission to discharge and beyond

Best Way to Optimize a Service Line?

- Engage qualified physicians to provide meaningful management services through a Co-Management Agreement

Two Supporting Premises

- Community physicians have a unique ability to bring **best practices** and an **ownership mentality** from their private practices to make hospital services lean and efficient (e.g., infusion scheduling)
- **Physician behaviors** materially affect service line operations (e.g., on-time starts) and physicians respond – and can cause their **peers** to respond – to **economic incentives** to improve those behaviors

Measuring Success

- **Hospital ROI**: The service line provides objectively higher quality and efficiency at a fair price
- **Alignment**: Community physicians consider the hospital the facility of choice for their patients because the physicians have a direct effect on the quality of care

Third Benefit

- “Physician-Eye View” of hospital’s facilities and equipment
- Competitive intelligence
- Recruitment efforts / collaboration
- Improving physician-to-physician interactions

Today's Objective

- Use our experience to describe compliant, effective, and lasting Co-Management Agreements that satisfy these objectives

Approach/Agenda

- Identify applicable legal principles/constraints
- Identify applicable appraisal principles
- Draw upon lessons learned
- Describe national best practices

Typical Co-Management Agreement Elements/Services

- General Service Line Management
- Program Improvement
- Program Development

General Service Line Management

- Named Medical Directorships
- QA/UR
- Monitor and Reduce Errors
- Update and Effect Compliance with Protocols, Policies, and Procedures
- Accreditation
- Monitor Patient Satisfaction

General Service Line Management

- Hospital-Employed non-physician staff
  - Requirements, hiring, scheduling, training, evaluation
- Advise regarding space, equipment, and supplies
- Budgets and expense management
- Physician education
- Liaise with other Departments
- Service Line Excellence/Care Transformation Committee

Examples

"Assist the Hospital to hire and evaluate non-physician clinical employees within the Oncology Service Line."

Examples

"Assist the Hospital in strategic, financial, and operational planning for future Oncology Service Line services."

"Participate in the development of the Oncology Service Line capital and operating budgets."

Examples

"Monitor patient, physician, and staff satisfaction and, as needed, develop, implement, and manage programs for improvement."

Program Improvement

- **Clinical Quality**
  - Improve specific measured clinical indicators
  - Improve patient, staff, and physician satisfaction
  - Conduct in-service conferences
- **Operational Efficiency**
  - Improve specific measured efficiency indicators
  - Improve standardization (e.g., Preference Cards)
  - Reduce per-case costs without decrease in quality

Program Development

- Outreach
- Community education
- Develop protocols for new services
- Develop staff training
- New accreditation
- Develop strategic plan
- Develop parameters and identify infrastructure for future performance improvement initiatives

High-Level Structure for Services

- Direct Co-Management Agreement with a practice, multiple practices, or a physician-owned entity
  - Physicians/practice provide all contracted services
- Co-Management Agreement with an LLC that is formed by hospital and physicians/practices
  - Hospital contributes resources, performs a portion of the work, and receives a portion of the management fee

High-Level Fee Arrangements

- **Base fee** – a fixed annual base fee for the time and effort participating physicians are projected to dedicate to service line development and management
- **Incentive fee** – a series of pre-determined payment amounts, each of which is contingent on achievement of specified, mutually agreed, objectively measurable, program development, quality improvement, and/of efficiency goals

What Does a Performance Incentive Look Like?

12. Hospice/Palliative Care Enrollment More than Three Days before Death			
Year 3 Baseline	Year 3 Performance Goals	Percentage of Incentive Fee Earned	Annual Incentive Fee Earned
64.0%	< 64.1%	0%	$0
	64.1% - 65.6%	25%	$20,000
	65.7% - 67.3%	50%	$40,000
	67.4% - 68.9%	75%	$60,000
	≥ 69.0%	100%	$80,000

What Does a Performance Incentive Look Like?

PURPOSE	Increase quality of care and end of life quality of live by timely hospice referral
DEFINITION	Percentage of adult patients who die as a consequence of their cancer who are referred to hospice or palliative care for more than three days before death
NUMERATOR	Number of Hospital patients who (i) are enrolled in hospice (or palliative care) and (ii) have a date of death during the Annual Period that is at least three days prior to that enrollment
DENOMINATOR	Number of Hospital patients who are (i) 18 years and older on date of diagnosis; (ii) diagnosed with an invasive malignancy; (iii) die within a 12 month period as a consequence of cancer; (iv) die during the Annual period; and (v) have at least two clinic visits in the nine months preceding death
MEASUREMENT	Performance to be measured for the entire Annual Period
STANDARD REFERENCE	• QOPI End of Life • OCM • ASCO • NQF #0216 (Palliative Care and End-of-Life Care - A Consensus Report. 2012)

What Does a Performance Incentive Look Like?

2. Measure and Reduce the Causes of Unplanned Post-Operative Care			
DEVELOPMENT	Protocol Approved During Period Below	Percentage of Incentive Fee Earned	Incentive Fee Earned
	Protocol Not Approved	0%	$0
	> 10 Months ≤ 12 Months	25%	$3,939
	> 8 Months ≤ 10 Months	50%	$7,878
	> 6 Months ≤ 8 Months	75%	$11,817
	≤ 6 Months	100%	$15,753
PERFORMANCE IMPROVEMENT	Performance Goals	Percentage of Incentive Fee Earned	Incentive Fee Earned for Each Month Measured (Max Fee of $31,992)
	[TBD]	0%	$0
	[TBD]	25%	$1,333
	[TBD]	50%	$2,666
	[TBD]	75%	$3,999
	[TBD]	100%	$5,332

What Does a Performance Incentive Look Like?

PURPOSE	As more orthopedic surgical procedures are performed on an outpatient basis at the hospital, the long-standing quality metric, readmission rate, needs to evolve to align for this change. The traditional readmission rate metric only accounts for unplanned admissions, following an initial anchor admission. The denominator will be expanded to be more inclusive of the majority of orthopedics procedures (i.e., inpatient and outpatient).
DEFINITIONS	"**Orthopedic Surgical Patient**" definition will be developed/proposed by [PE] and approved by [Committee] as part of the Development phase. "**Unplanned Post-Operative Procedure**" definition will be developed/proposed by [PE] and approved by [Committee] as part of the Development phase.
NUMERATOR	Number of Orthopedic Surgical Patients who receive at least one Unplanned Post-Operative Procedure.
DENOMINATOR	Number of Orthopedic Surgical Patients.
MEASUREMENT	Development: [PE] will develop the metric and processes to be approved by the [Committee]. Performance Improvement: Performance is the percentage determined by dividing the Numerator by the Denominator. Performance shall be measured at the end of the Annual Period for the period of full calendar months following approval of the protocol (not to exceed six months).

Key Legal Considerations

- Stark Law
- Anti-Kickback Statute
- Tax Exempt Entity Standards
- Civil Monetary Penalties

Stark Law

- Personal Service Arrangements Exception
- Fair Market Value Exception
  - Writing
  - Identifiable services
  - Compensation set in advance
  - Consistent with FMV
  - Not determined in manner that TIA V&V
  - Commercially reasonable even if no referrals

Anti-Kickback Statute

- Personal Services and Management Contracts safe harbor
  - "Aggregate compensation" is not set in advance
- JV probably will not satisfy small investment safe harbor 40/40 tests
  - More than 40% of interests held by persons in a position to refer
- Analyze under "one purpose" test; some irreducible legal risk

Gainsharing

- CMPs allow hospital to reward for reducing unnecessary services
- Gainsharing has risk of inducing more referrals to increase the overall value
  - Risk eliminated if a % of expected case cost used

Legal Consideration Summary

- FMV fee for defined scope of necessary services
- No fee to increase volume/revenue/profitability
- No financial incentive to withhold necessary services
- No financial incentive to increase referrals
- Affirmatively prohibit physicians from stinting, steering, cherry-picking, or lemon-dropping

Focus on Fees and FMV

General Principles and Material Variables

- Though some general guidance can be provided regarding service line management fees as a percentage of revenue, it is nearly impossible to 'guesstimate'
  - All parties may not be using the same terms of art
- Determinants of FMV include:
  - Scope of the hospital service line being managed
  - Complexity of the service line
  - Breadth and scope of day-to-day duties
  - Number and type of physical locations included

Material Variables (cont.)

- Size adjustments based on program size:
  - Large programs may be subject to an “economies of scale” discount
  - Small programs may be subject to a “minimum fee” premium
- What is the 'split' of the fee, and is it appropriate given the circumstances?
  - Commonly, the base fee equals 60% **or less** of the total fee

Material Variables (cont.)

- Does the performance element of the arrangement influence FMV. If so, how?
  - Is the establishment of the incentive compensation reasonably objective?
  - Neither party should be able to 'game' or 'sandbag' the incentive portion of the CMA
  - Targets should be robust and meaningful
  - "Maintenance" standards – are they appropriate and how should they be weighted?

Key Issues

- What does the data pull look like and how will it be accomplished?
  - Hospital is ALWAYS in the best position to understand coding, financial systems, characterization of services, credentialing factors, daily operations and workflow/'who is responsible for what'
  - Ancillary services should generally be excluded
- Characterization of services
  - Will inform valuator decisions about which benchmarks
  - Must be able to identify the services covered and replicate the data pull in the future

Key Issues

- Are there factors supportive to the use of projections or ‘amalgamated’ data (or both)?
  - Operational changes and disruptions
  - Planned or known reimbursement changes, case mix shifts, provider coverage, service offerings
  - Expansion of service offerings or onboarding of new providers/locations of service
- Forecasts can have pitfalls

Mechanics of the Valuation Process

- Valuation approaches performed by HAI include:
  - Cost Approach
  - Market Approach

The Cost Approach

- The Cost Approach can be used to estimate the potential value of medical director arrangements in lieu of a co-management structure
- Allows the valuator to establish a 'proxy' for the annual administrative hours which might be required
- Important that all sub-service lines are represented by physicians from each indicated specialty

The Market Approach

- There are **no direct market comparables** in this case
- Valuation firms differ with respect to the mechanics of a Market Approach for the valuation of CMAs
- The Market Approach should give credence to the fact that each CMA is unique, but that there are certain management / administrative requirements associated with every service line management arrangement
- Key drivers of this approach include:
  - Annual net revenue
  - Specific tasks and responsibilities of the managers
  - Adjustments for possible overlapping positions, 'outside' arrangements and incentive-related efforts

Valuation Synthesis

- The Cost and Market valuation methodologies should be reconciled to arrive at a conclusion of value
- May or may not be appropriate to give equal weighting to the two approaches
  - Valuator may conclude that one method or data set should be weighted more heavily than the other
- Make applicable adjustments based on specific facts

Basis for Adjustments

- Performance Incentives may have an impact on final value
- Split of fees
- High-collection case types may be taken into consideration
  - It is not reasonable to assume that greater revenues equate to greater management burdens
    - EXAMPLE: The high cost of oncology infusion drugs and joint implants often drive revenue upward in relation to case volume.

Once we know what's going on, how does it all work?

Base Fee Considerations

- Often, hospitals do not set rates payable to physician participants
  - More common with a JV LLC structure
- Sometimes, a large proportion or entirety of the Base Fee is payable on an hourly basis.
  - Rates may or may not be commented on by the valuator
  - Rates may or may not be specialty-specific

Allocating the Incentive Fee

- "Allocation" can refer to how the Incentive Fee is divided among:
  - Included facilities/locations of service
  - Participants
  - Individual metrics
  - Performance targets
  - Sub-specialty areas
- Should reflect operational priorities
- Should not emphasize maintenance of 'status quo' absent mitigating circumstances

Best Practices

Know the Work Product

- Critical to identify what you want and what you are getting from:
  - Counsel
  - Valuators
  - Participants
  - Internal Stakeholders
  - External Consultants
  - Data Providers/Outcomes Reporting Entities

Long Range View

- "Think about now" and "Keep an eye on the future"
  - Potential for overlap between CMA and *any other arrangement*
    - Does it matter if the ‘other’ arrangement is not associated with compensation? It might!
  - Medical directorships are often integrated into the CMA, but not always
  - What is the 3-year plan? 5-year plan?

Scope of Services Included

- Are future special initiatives or projects “covered by” the CMA?
  - Center of excellence work or other designation activities
  - Research or teaching-related endeavors
  - Opening new locations or surgery centers
  - Rollout of new service offerings which require staffing, equipment selection, expansion of existing facilities
- Will the CMA persist post-acquisition or after employment models go into place?

Legal and Appraisal Coordination

- CMAs generally contemplate admin services
  - Should consider any quality focus associated with EAs or other arrangements
- Assure that each participating physician has sufficient time to provide full range of services
- An opinion of commercial reasonableness from counsel or a valuator might only be for the subject arrangement
- Differentiating 'standard of care' or 'unpaid' expectations from viable incentives

Legal and Appraisal Coordination

- Counsel should be comfortable with the basis for any projections and familiar with the basis of the data which informs the FMV opinion
- All parties should address what could or should trigger a revisit of the FMV analysis or terms of the underlying agreement, including the scope of services
- Mid-term changes; are they appropriate? If so, how will these be addressed in the legal documentation and supportive FMV opinion, and do they need to be?

Lessons Learned / Best Practices

- Include all physicians who affect performance
- Treatment of continuing separate directorships
- Do not underestimate value of non-physician staff
- Direct contract avoids distribution issues
- Match term/renewal with appraisal period
- Identify mutual POCs
- Obtaining data is universal bottleneck

Lessons Learned / Best Practices

- Reasonable assessment of EMR modifications for data capture
- Internal white paper to establish “commercial reasonableness”
- Require directed referrals?
- Obtaining dedicated cooperation
- No legal/appraisal reason for timesheets

Lessons Learned / Best Practices

- Improvement, not maintenance
- Ongoing annual review of scope of duties
- Start initiative refresh early
- Use resources to identify meaningful initiatives
- Involve physicians in initiative selection
- Identify/exclude additional hospital resources
- Prompt development bonuses
- Develop and then measure in a single year

Lost (in the) Details

This may appear to be a 'fully baked' incentive, but it leaves out almost every necessary detail!

On Time Starts			
Baseline (Based on the period from January 1, 2020 – December 31, 2020)	82.6%	Percentage of Incentive Fee Earned	Annual Incentive Fee Earned
	< 82.6%	0%	$0
	82.6% - 84.6%	25%	$20,000
	84.7% - 88.6%	50%	$40,000
	88.7% - 92.6%	75%	$60,000
	> 92.6%	100%	$80,000

Thank You

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