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5 Things You Should Know About Co-Management Arrangements

FEATURE STORY BY JEN JOHNSON

Co-management agreements offer hospitals a means to focus compensation of physicians more on the quality of care they deliver than on the volume of services.

At a Glance

Key factors that a hospital finance leader should focus on when considering a potential co-management agreement with physicians, in which the physicians are compensated at fair market value, include:

- > **Fee structure of the agreement**
- > **The quality metrics that will be used**
- > **Benchmarking to set appropriate targets for metrics**
- > **Historical performance against the metrics**
- > **Legal guidelines regarding such agreements**

Hospitals today are increasingly turning to co-management agreements as tools for physician alignment. These arrangements, a direct outgrowth of pay-for-performance programs, are typically structured in two parts: a fixed fee for services rendered by the physicians and a variable fee based on the quality of the outcomes. Services provided by the physicians most often include time spent working on protocols and best practices to improve quality and efficiency of the service line. Common quality metrics include improving patient satisfaction and lowering infection rates.

When implementing a physician integration strategy, healthcare leaders should be mindful of federal regulations mandating that payments to physicians be set at fair market value (FMV). Healthcare fraud and abuse laws have identified FMV as the standard of value for determining compensation between a physician and hospital in order to prevent overpayment to a physician based on the value or volume of referrals. As a result, if an agreement between a physician and healthcare organization is audited by federal or state healthcare authorities, the analytical process and documentation to justify the payment is FMV will be essential in defending the compensation level. Co-management agreements are no exception. Failure to set payments under these arrangements at FMV could result in criminal and/or civil penalties. Regulatory authorities may subject not only the payments, but also the structure and terms of the arrangement to close scrutiny.

Determining the appropriate structure and FMV for the fees associated with co-management agreements can be challenging for two reasons. First, co-management arrangements are relatively new and the structures continue to evolve. Second, there is very little regulatory guidance on how these agreements should be structured and valued. Discussions among healthcare leaders, attorneys, consultants, and valuation firms when developing these arrangements tend to focus on five topic areas:

- Fee structure
- Quality metrics
- Benchmarking
- Historical performance
- Legal guidelines

These also should be the primary areas of focus for hospital finance leaders considering such arrangements.

Understand the Fee Structure

Regulatory guidelines require that payments to physicians be set at FMV. To document that an arrangement is at FMV, it is necessary to understand the services that are to be provided, as defined in the agreement. Compensation for such an arrangement therefore should be set only after an agreement has been drafted, thereby ensuring that the FMV analysis provides the hospital with defensible documentation for the arrangement. Ideally, the FMV analysis will reflect the services and structure exactly as outlined in the agreement.

The Office of Inspector General (OIG) has shown that it is more apt to scrutinize “creative arrangements” than standard arrangements. For this reason, hospitals should consider adopting the most commonly used fee structure for these agreements, which comprises two parts:

- A fixed fee for services rendered by physicians
- A variable fee determined by the quality of outcomes based on physician initiatives

Fixed fee. The fixed fee is included in this structure to demonstrate that services are being provided to produce higher quality outcomes. The structure of a co-management agreement should demonstrate and facilitate a joint effort between the hospital and the physicians. It is vital to be able to show that services are being performed for the expressed purpose of improving quality when compensating physicians for these services.

Various services may be covered by the fixed fee. The most common is physician participation on quality committees (also called joint operating committees and leadership councils). Meetings of these committees are intended to develop and assist in implementing best practices and protocols to improve quality. Some hospitals will add call coverage payments to the fixed fee, and others may compensate physicians for call coverage based on a sliding scale, depending on the quality of outcomes.

The fixed fee may also include management services conducted by nonphysician personnel, which can occur, for example, when a robust physician group with experience in administrative management provides the services. This approach is more common in instances when a hospital purchases an ambulatory surgery center (ASC) from physician owners who have been managing the center historically. Regardless of the services included in the fixed fee, hospitals need to be able to demonstrate that some services were rendered specifically to improve the quality of care, so that they can then support an outcome-based variable fee.

Variable fee. The variable fee should be just that—variable. Outcomes should determine whether physicians earn the maximum variable fee, and it should be awarded only for superior performance. Perhaps even more important, in some instances, outcomes will dictate that no payment is warranted (for example, if quality actually declines). CMS has specifically stated that thresholds should exist where no payment accrues under a pay-for-performance program.

Hospitals should consider mirroring CMS's payment policies, when possible. Under CMS's Hospital Quality Incentive Demonstration (HQID) project, financial incentives were provided to hospitals performing in the top first or second decile of quality, based on national benchmarks. This top two decile standard implemented by CMS invites the question, "Is it possible to pay physicians a variable fee if they assist in significantly improving performance without hitting the top two deciles?" I would argue yes. Other pay-for-performance programs award for improvement, and according to CMS, they will do the same with its 2012 Value-Based Purchasing (VBP) program ("CMS Issues Proposed Value Based Purchasing Regs," *Modern Healthcare*, Jan. 7, 2011).

From a valuation perspective, if the aim is to use comparable arrangements and fees in the market as a basis for setting the co-management arrangement and fees, it is important to establish that the services are truly comparable. For example, if the arrangement is a clinical co-management agreement, then management fees from typical management agreements for facilities such as ASCs will not provide a sound basis for comparison. Typical management agreements are most often serviced by non-physician personnel with expertise in areas such as human resources, purchasing, IT oversight, revenue cycle management, and marketing. These services are different from, and therefore not comparable to, services listed in a co-management agreement that is focused on clinical considerations such as patient satisfaction and clinical protocols. Co-management arrangements, as such, typically require physician personnel and varying levels of time commitments, depending on the specific needs of the service line or facility.

One additional complication with respect to a co-management agreement's fee structure relates to the restrictions on tax-exempt bond financed space. Specifically, hospitals with tax-exempt bond financing may be required to structure management agreements to meet one of the safe harbors under IRS Revenue Procedure 97-13 to ensure that the agreement does not result in private use of bond-financed facilities.^a The commonly used 50 percent periodic fixed fee safe harbor under Revenue Procedure 97-13 requires, among other things, that the management agreements be structured so that the variable fee does not exceed the fixed fee. If Revenue Procedure 97-13 applies, the determination of the maximum variable fee will be limited based on the fixed fee.

In summary, hospital finance leaders should familiarize themselves thoroughly with the structure and associated services that constitute their organizations' co-management agreements to make sure that both parties understand the services that are to be delivered to improve quality. This step also will be instrumental in meeting the FMV standard, because it will ensure the fee valuation reflects the services.

Choose the Appropriate Metrics

Once the structure has been defined, significant due diligence should be devoted to choosing the appropriate quality metrics, because the resulting outcomes will be the driver for the variable fee. Guidelines suggested by CMS present a solid foundation for determining what the agency expects from a carefully constructed arrangement. The OIG also has issued advisory opinions in recent years indicating similar guidelines. The following will provide an overview of pertinent points provided by CMS and the OIG related to metrics contained in agreements.

The agreement should clearly and separately identify the quality metrics that will be monitored. For the best results, the hospital and physicians should work together to select the metrics, thereby demonstrating a coordinated (co-managed) effort between the two parties and helping to ensure that the measures are reasonably related to the hospital's practice and take into account the patient population. Metrics are typically focused on improving the patient experience and quality outcomes.

The metrics also should be considered in context. For example, are the results easily attainable? And are the more difficult metrics excluded? If a hospital is planning to pay for improved quality of care, the hospital should expect to see clear evidence that significant work was required in obtaining targeted outcomes. Hospitals also should implement safeguards to ensure the metrics do not undermine patient care or promote inappropriate care. For example, legal counsel typically will suggest excluding

metrics associated with average length of stay, because this type of metric could create an incentive for physicians to expedite the release of patients who may not be ready for discharge.

Metrics related to cost savings, or gain sharing, should be valued separately. Some legal counsel might even recommend addressing these metrics in a separate agreement. One reason is that the valuation methods associated with compensation for these metrics are different. There are also more rigorous guidelines associated with cost-sharing metrics from a regulatory perspective. As an example, OIG opinions related to gainsharing arrangements suggest that such an arrangement should contain specific, identifiable, and transparent cost saving actions, as well as the use of third parties to develop and monitor the arrangement (“Gainsharing Arrangements,” www.ama-assn.org [search on Gainsharing Arrangements]).

It is also important to note that cost savings incentives are typically short-term because, in most instances, once the savings have been achieved, the opportunity to share in savings will be past. Based on unique guidelines and additional compliance challenges, it is best to exclude cost savings metrics from a typical co-management agreement. However, if these metrics are included, they should be monitored and valued using a different approach from that used to monitor and value quality-of-outcome metrics.

Be Sure to Benchmark

To create incentive for delivery of high-quality care, one must first understand what is meant by high-quality care. It was this need for a definition that prompted the CMS to establish several programs for reporting clinical outcomes, including formation of the Hospital Compare website (www.hospitalcompare.hhs.gov). The reporting of these outcomes has been the natural precursor to pay-for-performance programs. Public data allow hospitals to determine what constitutes high-quality care, as benchmarking an individual hospital’s outcomes becomes possible. Both CMS and the OIG have suggested that when providing incentives for high-quality care, the quality measures should be individually tracked and objective methodology should be used that is verifiable and supported by credible medical evidence. Moreover, CMS has specifically stated that it intends to rely partially upon data from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) for its 2012 VBP program.

It is therefore prudent that quality targets be developed by, and measured against, national benchmarks. For this purpose, when developing co-management arrangements, hospitals should understand and obtain data from organizations reporting outcomes (recognizing that these data may not be complete because not all hospitals subscribe to reporting agencies).

Regardless of the benchmarking data available, some hospitals prefer to consider benchmarking based on internal guidelines. It is important to realize that these benchmarks are more difficult to support because regulators may regard defining superior care based on subjective (internally developed) benchmarks as being less credible. One might consider including these metrics but perhaps limiting compensation tied to them due to the lack of objective benchmarking data.

In summary, obtaining industry recognized benchmark data for the quality metrics is critical when determining the variable fee under a co-management agreement. At the very least, hospitals should understand the average or median and top or 90th percentile performance levels to get a handle on what constitutes average- and superior- quality outcomes.

Consider Historical Performance

As with any other healthcare arrangements between physicians and hospitals, considering all the underlying facts and circumstances is important before setting compensation for co-management services. Historical performance is a significant consideration and should be factored into several aspects of co-management arrangements. In fact, regulatory authorities have stipulated that incentive payments should take into account the hospital’s historical baseline data.

There are various reasons that it is necessary to understand historical performance. Because some pay-for-performance programs provide financial incentives for improvement in quality, documented historical data are required to provide a basis for measuring the improvement and demonstrating that it was actually achieved. Historical performance also needs to be considered to ensure that there is room for improvement to achieve targeted outcomes for the chosen metrics. Although it seems reasonable to compensate physicians for assisting in maintaining superior quality, it would not appear compliant to construct an arrangement whereby each of the metrics contained in the agreement already reflected superior quality.

Historical performance data are needed, as well, if any portion of the fee is determined based on reimbursement. In such an instance, one would need to utilize historical versus projected volume to calculate the fee. This approach would demonstrate that the arrangement does not consider the value or volume of anticipated referrals.

In some instances, a service line or facility may have no reliable historical performance for benchmarking purposes, possibly because the services are new, the facility is new, or data were not tracked prior to the agreement. In these situations, it may be reasonable to consider national average benchmarking data as a minimum threshold and top decile benchmarking data as a threshold for maximum payout.

Ultimately, hospitals should develop a schedule whereby historical and national data are outlined and levels of improvement and attainment of top quality are clearly identified. This step is important to demonstrate a hospital's compliance efforts in constructing the agreement's terms and fees.

Keep It Legal

It is critical that healthcare executives be able to both explain the reasons for developing a co-management arrangement and defend the compensation stated in the agreement. Adhering to regulatory guidance with co-management arrangements has proven challenging among hospitals. Risk levels and physician alignment strategies vary greatly among hospitals across the nation, making structure and fee decisions more complicated due to lack of industry standards. It is important to step back once the terms and compensation of an arrangement are outlined and ask whether the agreement makes sense from the standpoint of economics and/or the hospital's mission, without regard for referrals.

The following questions can help a hospital's finance leader assess whether a co-management agreement complies with regulatory guidelines:

- Is the arrangement considered commercially reasonable? There should be a legitimate business need for the services being provided.
- Are all compensation components within FMV? It is important to understand the services being provided when setting fees.
- Are there various payment tiers? The variable fee should reflect incentives that compensate minimal amounts for modest improvement and higher amounts for top-tier quality.
- Do the terms of the agreement identify who is responsible for developing and implementing the strategy to achieve the quality targets? The incentive compensation pool should be allocated accordingly.
- Are there safeguards to protect against erosion of patient care?

As a hospital starts down the co-management path, its leaders should put themselves in a regulator's shoes to determine whether the arrangement makes sense (without any expected referrals). Specifically, the compensation needs to reflect FMV and legal counsel will be required to address the arrangement's complexities and nuances.

Bottom Line for Compliance

Based on the growth of pay-for-performance programs and guidance from the OIG and CMS, basing payment on quality of care rather than volume appears to be the wave of the future. Any organization considering a co-management arrangement should understand how to construct the agreement and determine the FMV of fees. Both the terms of the agreement and the analytical process for determining the payments will be essential in defending it before regulatory authorities.

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This article is not to be construed as legal advice.

Footnote

a. On Jan. 10, 1997, the Department of the Treasury issued Revenue Procedure 97-13, setting forth conditions under which a management contract does not result in private business use of a bond-financed facility (or unrelated use, in the case of qualified 501(c)(3) bonds). These conditions establish safe harbors.

Sidebar

Key Points Addressed by CMS/OIG Guidelines

Quality measures and incentive payments are two key focal points in the guidelines issued by the Centers for Medicare & Medicaid Services and the Office of Inspector General regarding how physicians and hospitals should structure co-management agreements.

The guidelines specify that quality measures should:

- Be clearly and separately identified
- Use an objective methodology that is verifiable and supported by credible medical evidence
- Be reasonably related to the hospital's practice and consider the patient population

The guidelines state that the incentive payments should:

- Consider the hospital's historical baseline data and target levels developed by national benchmarks
- Include thresholds where no payment will accrue
- Be based on fair market value and not consider the value and volume of referrals

Publication Date: Friday, July 01, 2011