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All Co-Management Arrangements are Not Created Equal: Understanding True Value-Drivers

By
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The trend towards improved quality and transparency in healthcare is shifting hospitals' critical success factors from financial performance to efficiency and quality performance that are on par with national and industry standards. In order effectively to elevate performance and keep up with these standards, many hospitals and health systems are involving physicians by integrating them into governance and leadership positions.

It has become abundantly clear that healthcare payment is making the shift from volume to value. As a result, physicians' participation is vital for hospitals and health systems to achieve performance outcomes related to quality.

Introduction to Co-Management Arrangements

The quintessential co-management arrangement is a strategic agreement between a hospital and a group of physicians in order to align the physicians with the hospital for the physicians' provision of improved quality and efficiency performance in exchange for compensation payable by the hospital. These arrangements can range in scope from a specific service

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line to an entire hospital or even multiple hospitals within a health system. They are most commonly seen for service lines such as orthopedic surgery and cardiology, but can be customized for nearly any service line or hospital program, from obstetrics/gynecology to neurosurgery to wound care.

There are two primary arrangement types. The first is the direct contract co-management model, in which the physicians can be individually engaged or engaged as a group. The other co-management model is the limited liability company ("LLC") model. In the LLC model, instead of the hospital contracting directly with the physicians, the hospital contracts with a management company, the LLC, which has been formed for the purpose of co-managing the subject service line. This LLC can be owned wholly by the physicians or jointly by the physicians and the hospital.

Whether engaged directly or through a management company, the services provided by the physicians and the accompanying fee structure in co-management arrangements are relatively consistent throughout the market. Services can be categorized into two buckets:

- Hourly-based, and
- Performance-based

The hourly-based services are administrative in nature, such as as clinical management, program development, committee meeting attendance, etc. The performance-based services are clinical in nature and are provided via the achievement of certain pre-determined quality outcomes related to the performance of the subject service line. The fee structure corresponds with the services provided and is typically comprised of the following components:

- A fixed fee, and
- A variable fee

The fixed fee is usually an hourly rate payable to the physicians for their time spent performing the hourly-based duties described above. The variable fee is at-risk compensation payable to the physicians

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based on their achievement of certain service line performance thresholds, as described above. The at-risk compensation amount is variable in that, based on the service line performance, the physicians may receive any compensation amount from $0 up to a maximum incentive compensation amount typically determined by a third-party valuation firm. The following discusses the importance of setting compensation amounts that are consistent with Fair market Value (FMV).

The Need for Fair Market Value

According to the Internal Revenue Service ("IRS") Revenue Ruling 59-60, FMV is defined as:

FMV, in effect, is the price at which the property would change hands between a willing buyer and a willing seller when the former is not under any compulsion to buy and the latter is not under any compulsion to sell, both parties having reasonable knowledge of relevant facts.

As it relates to the healthcare industry, and physician compensation arrangements in particular, federally mandated fraud and abuse legislation consider FMV the standard of value for physician arrangements. Therefore, the documentation and analytical process associated with an FMV opinion are crucial to have on record if an arrangement or facility is audited by government authorities. Specifically, since Medicare, Medicaid, or any other government program funding could trigger a review of transactions between referring parties (such as hospitals and physicians), legislation such as the anti-kickback statute, which prohibits compensation in exchange for patient referrals, and the Stark self-referral law, which limits certain physician referrals, guide healthcare's legal and regulatory environment. The anti-kickback statute is a criminal offense, with some intent or some level of knowledge of wrongdoing, while the Stark self-referral law is a civil offense punishable by monetary fines. As a high-level overview, this legislation seeks to prevent payments to physicians based on the volume or value of referrals.

Regulatory Guidelines & Compliance Tips

Due to the tightly controlled environment that

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surrounds the healthcare industry, compliance and regulatory guidelines should never be an afterthought, especially when it comes to co-management arrangements. In order to develop a compliant co-management program, hospital management should consider working closely with counsel and third-party consultants and be able to explain reasons for pursuing a co-management agreement. Specifically, the following summarizes the main regulatory guidelines to adhere to when paying for quality.

General Program Guidelines

- The hospital should monitor the program and implement safeguards to ensure patients' access to care is not limited due to participation in the program
- All eligible physicians should be asked to participate in the program
- The hourly-based and performance-based services and the payments associated with these services do not overlap and are not duplicative with any other arrangement
- The hourly-based and performance-based services are required for the efficient operation of the facility or service line and/or based on community need
- The arrangement is the best fiscal option, absent referrals
- The arrangement makes sense commercially.

Metrics Guidelines

- The metrics should be clearly and separately identified
- The metrics should be proven to impact patient care based on credible medical evidence
- The metrics were determined with particular consideration of the subject service line or facility's patient population.

Compensation Guidelines

- Compensation should be determined by a third-party valuation firm and be within FMV;
- The incentive compensation for quality should be

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paid based on performance thresholds, which consider historical performance and national/industry benchmarks;

- The incentive compensation quality ranges from no payment to a maximum amount based on level of performance;
- The maximum FMV incentive compensation for quality should be paid only if superior performance (typically consistent with the national/industry top decile) is achieved under all metrics.

What to Know About Quality Metrics

From a valuation firm's perspective, the quality metrics are the true value drivers in determining the maximum FMV variable fee payable to the physicians and the distinguishing factor in creating a meaningful quality improvement program. Therefore, the selection of the metrics to be measured, the determination of the associated benchmarks and stretch goals, and analysis of historical performance all play a large role in the determination of the FMV incentive compensation for quality.

Based on analysis of quality payments to physicians in the market, as well as analysis of hospital pay-for-performance programs funded by both governmental and commercial payors, the following summarizes the major types of value drivers typically observed in the market when incentive dollars are rewarded for quality:

- Metric Type (outcomes versus process)
- Metric Benchmarking Source
- Number of Metrics
- Performance Threshold for Payout
- Historical Performance
- Likelihood of Achieving Maximum Payout
- Physician Responsibility to Impact metrics

Additionally, various other more qualitative value drivers related to quality payments in the market have been observed, such as patient acuity, experience/expertise of the physicians, qualities of the physician organization, etc.

With adherence to the aforementioned guidelines and in-depth consideration of the true value drivers, the quality metrics of the program, a meaningful and compliant quality improvement program can be within reach. ❑

About the Author

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