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What It's Worth

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What It's Worth

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CHAPTER 21
VALUING CLINICAL
CO-MANAGEMENT ARRANGEMENTS

Valuating Clinical Co-Management Arrangements

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Origin of the Co-Management Arrangement

As the healthcare landscape continues to mature, most healthcare organizations find themselves caught in an era of increasing competition, changing reimbursement structures and shifting operational paradigms. Nowhere is this more notable than amongst hospitals, whether an independent not-for-profit or one that is part of a large public for-profit system. Benchmarks and key clinical performance indicators have taken on increased importance as evidence-based medicine and pay-for-performance initiatives continue to evolve within the payer community. Technological advances allowing less invasive interventions and improved outcomes offer the promise of revolutionizing the way medicine is practiced. These market forces demand a shift in the health care industry toward collaborative care and aligned incentives, yet collaborative relationships among health care providers trigger compliance and business strategies that have not yet been fully played out in the marketplace and the health care regulatory environment. These market forces and compliance risks lead physicians and hospitals to create relationships that concentrate on patient outcomes, safety and satisfaction, while yielding incentives that reward positive behavioral changes by both parties.

Increasing competition

“Hospitals and physicians care for the same patients. Both feel squeezed by stagnating payment, rising expenses, proliferating regulations and rising consumer expectations.”¹ Hospitals also face pressures from consumers for the latest technology, shortages of hospital personnel, increased regulation, rising cost of liability premiums, and the obligation to provide care to the uninsured.² Yet, the American Hospital Association recognizes that “the integration of clinical care across providers, across settings, and over time” is needed to reduce fragmentation in health care delivery and improve the quality and efficiency of care.³

Changing landscape of where services are performed

Advances in technology have transformed the delivery of health care in more ways than could have been imagined just a few decades ago. Many procedures that were exclusively performed in an inpatient setting are now furnished in hospital outpatient settings, specialty hospitals and ambulatory surgery centers, significantly altering the landscape in the industry and raising the element of competition between physicians and hospitals. These surgical and diagnostic facilities represent viable alternatives to acute care hospitals, as patient and physician convenience, cost and comfort lure insured patients away, leaving hospitals with an ever increasing mix of indigent and low-pay patients. In some cases, hospitals have entered into clinical co-management arrangements (CCMAs) with physicians who operate competing facilities. The competitive environment leads hospitals to place even more emphasis on achieving better outcomes, higher patient satisfaction scores and more cost-effective care.

Difficulty in securing robust medical directorships

Health care regulatory enforcement activity by the Federal government continues to spotlight medical directorships as highly susceptible to abuse, with examples of arrangements alleged to be disguised payments for referrals of Federal health care program beneficiaries. Many of these suspect arrangements lack substantiation of duties and fail to implement appropriate systems for tracking and documenting hours worked in providing these services. Further, medical directorship arrangements can sometimes conflict with clinical duties and schedules, resulting in inattention to all but the most basic of administrative duties.

Need for increased efficiencies and quality in patient care

Responding to America’s inefficient health care system, momentum is building for a shift to a pay-for-performance (P4P) system that correlates financial rewards with improved outcomes in patient care.⁴ P4P systems reward providers with compensation for performance measured against a pre-defined set of targets or objectives that define what will be evaluated. In implementing such a system, it is important to identify performance standards for establishing

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the target criteria, as well as the rewards that are at risk, including the amount and the method for allocating the payments among those who meet or exceed the established thresholds.⁵

The Leapfrog Group⁶ summarizes P4P programs containing incentives based on risk and rewards to providers. Various financial models exist in the marketplace, but while many models address quality-based measures, performance metrics could target any number of variables, including profitability, patient volume, or quality of care.

The nature and amount of bonuses and incentives play a significant role in determining how much providers will alter their current behaviors. For the P4P program to work, providers must be convinced of the benefits to investing in the necessary technology and in complying with the requirements of the program.

Although the P4P movement is gaining in popularity, several challenges still exist. First and foremost, providers, purchasers, and health plans have conflicting views on the funding of such programs. In addition, providers expect the program to be funded with new money, while purchasers and health plans believe the incentives should be generated through savings or by replacing fee schedule increases with performance payments.

Consumer-directed health care empowers consumers by giving them a direct financial stake in the quality and cost of their own care and by providing information on the quality and price of health care so as to make informed decisions. Pressure by purchasers for transparent reporting is bringing about quality and efficiency improvements through hospital and physician collaborative and P4P arrangements. In addition, with Medicare and other payers, it is clear that data reporting on quality is a precursor to performance-based reimbursement.

There are other issues of fairness of such incentives due to the inherent differences among specialties, geographic limitations, and financial barriers faced by providers. Despite these issues, P4P arrangements are becoming increasingly popular throughout the United States.

Government and payer recognition of core measures of quality

Common measures of quality performance allow physicians to receive feedback and tie performance to financial and other incentives through P4P and public quality reporting. Performance measurements for physicians are not as fully mature as those for institutional providers; however, these programs have gained traction in the past few years, particularly with the introduction of quality-reporting initiatives by professional organizations, accrediting agencies, and Medicare. These programs contribute to physicians' acknowledgement that other stakeholders have the right to monitor their behavior and hold them accountable.⁷

Opportunities for increased hospital-physician alignment

Longstanding hospital-physician integration strategies that remain in the current market include employment of physicians by hospitals, creation of physician-owned or joint venture hospitals, development of clinically integrated hospital/physician entities, formation of community health information networks, and various hybrids and permutations of provider integration strategies. Physician engagement is essential for many cultural and behavioral changes to be successful at the hospital level. Compensation under these plans is increasingly tied to success with varying measurements that align financial incentives among the provider groups.

CCMAs represent a way to integrate hospital and physician management of clinical services and generally exist between physicians and hospitals. Physicians in a CCMA provide management services to a hospital that go beyond traditional medical director roles, and the CCMA involves physicians as participants in the day-to-day management of the hospital's clinical service line operations. The primary advantage of the CCMA is the significant operational input of the physicians and the alignment of physician and hospital interests to achieve improvements in the overall efficiency and quality of patient care.

Structure of Co-Management Arrangements

Rationale for formation

Competition. As described above, competitive market forces are primary drivers in the creation of the CCMA. Below is a hypothetical example of a community hospital's struggle to remain competitive by aligning with physicians:

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Healthy Regional Hospital (one of two hospitals in its community) and one of the local cardiology groups reached an impasse when the cardiology group announced its intent to open a cardiac catheterization lab (cath lab) in its own clinic facility. When the cath lab became operational, Healthy Regional saw a substantial decline in commercial patients in its own cath lab, and revenues immediately began a sharp downward trend. As tensions grew, the cardiology group began demanding payment for emergency department call coverage and one of the cardiologists—the medical director for cardiology at Healthy Regional—elected not to renew his administrative contract.

Healthy Regional's new CEO entered into discussions with the cardiology group to form a CCMA. This endeavor would be in the form of a joint venture, which would acquire and operate the cardiologists' cath lab and enter into a management agreement with the Healthy Regional to manage the Healthy Regional's entire cardiology service line in the creation of a cardiovascular center of excellence. The end result was an immediate change in the competitive landscape in the community for cardiac care and an integration of the hospital and cardiology group in the operation of the joint venture CCMA.

Alignment with payer interests and participation in payer incentive programs. Many payers, including the Federal government, recognize the benefits to patients through enhanced quality care. The Centers for Medicare and Medicaid Services (CMS) sponsors various demonstration projects to encourage and reward improvements in quality health care. One such project is the Premier Hospital Quality Initiative demonstration project, which incorporates a P4P element that pays hospitals performance-based bonuses for quality measures associated with clinical conditions such as heart attack (acute myocardial infarction, or AMI), heart failure, pneumonia, coronary artery bypass graft (CABG) and hip and knee replacements.⁸ The Joint Commission and CMS co-developed the Specifications Manual for National Hospital Quality Measures, which contains core measures of quality for AMI, heart failure, pneumonia, surgical care improvement, pregnancy and related conditions, and children's asthma care. Other payers, such as Blue Cross Blue Shield, have developed their own quality incentive projects, many of which reward providers with bonuses tied to achievement of quality targets. The Healthcare Effectiveness Data and Information Set (HEDIS)⁹ is used by many such health plans to measure performance.

The following continues the hypothetical example of Healthy Regional Hospital and its cardiology CCMA:

Healthy Regional and its cardiology group partner developed a set of quality measurements that paralleled those of a significant local payer. The payer's program resulted in bonuses to the hospital for attainment of the payer's targets in quality care. The CCMA agreement for Healthy Regional's cardiac service line included financial incentives for reaching these quality measures, which effectively aligned the interests of the joint venture and the hospital with those of the payer.

Consolidate medical directorship duties. With physicians as partners in clinical quality, the CCMA affords hospitals with opportunities to develop more robust duties and responsibilities for physician administrative positions over the managed service line. CCMA agreements provide for significant enhancements in administrative requirements for clinicians, to which a portion of the compensation is related, and often allows for a consolidation of multiple, and sometimes duplicative, directorships. The hypothetical example of Healthy Regional's CCMA continues below:

In developing the CCMA, Healthy Regional's legal counsel recommended termination of the hospital's separate cardiology and cath lab medical directorship agreements, in favor of inclusion of the duties of both in the administrative responsibilities of the CCMA. The previous medical directorship agreements contained no requirements for contemporaneous documentation of physician administrative time and were paid in fixed monthly amounts, representing a significant compliance risk. Legal counsel also recommended additional requirements related to physician participation in quality assurance meetings, attendance at quality assurance training conferences, and additional duties as medical staff liaison to address quality concerns with staff physicians. As will be discussed in detail further in this chapter, such medical director duties were "folded into" the CCMA and were paid out of the negotiated management fee.

Consolidate other physician duties. With broader ties to physicians in hospital service line management, hospitals can use CCMA's to address other service deficiencies and staffing needs. The Healthy Regional Hospital example continues as follows:

Prior to the CCMA joint venture, a rift developed between the hospital and cardiology group, and the hospital found itself in a position of seeking sporadic and expensive emergency department on-call coverage in the specialty of cardiology. Through negotiations with the cardiology group to enter into the CCMA with the hospital, Healthy Regional was able to gain physician commitment to cover emergency call on a 24/7/365 basis. This embedded call arrangement saved Healthy Regional nearly \$200,000 in call coverage compensation paid to other local physicians and physician staffing companies and resulted in dependable cardiology coverage and improved patient quality outcomes.

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Applicable specialties

CCMAs apply to many physician specialties, particularly when there is a relationship between the physician's administrative and clinical skills and the success of the hospital in meeting quality measures within the related service line. Some of the more common specialties, in no particular order, include the following:

- Cardiology / Cardiovascular Surgery
- Orthopedic Surgery
- General Surgery
- Oncology
- Sleep Lab

Ownership

Commonly, CCMAs are formed and operated as joint ventures between hospitals and physicians. While typically done on a 50/50 basis, it is not uncommon to see many different variations. For example, while a hospital may want to have good alignment with its physicians, it may still want to retain ultimate control, and therefore, may prefer a 60/40 split instead (*i.e.*, in favor of the hospital). The impact of this issue will be discussed in more detail later in this chapter. Because some CCMAs have ownership in health care facilities (*e.g.*, cardiac catheterization lab or outpatient imaging center), these are also structured as joint ventures, although usually with a significant requirement for capital infusion to accommodate the acquisition and/or operation of the outpatient facility, and subject to applicable fair market value analysis.

Organizational structure

The CCMA entity is typically established as a limited liability company. This entity enters into a management services arrangement with the hospital for purposes of managing the hospital's designated service line. This is often accomplished in a manner that meets the requirements of the Stark exception for personal service arrangements and the anti-kickback statute's safe harbor for personal services and management contracts.

Fee structure—base-plus-incentive

CCMAs ordinarily maintain management service agreements with the hospital for the service line management, with a multi-stage compensation structure. The first stage is a base compensation associated with the day-to-day medical direction, management and administrative duties and responsibilities under the contract, and such services are paid for out of the base management fee, as further discussed in our chapter. This level of compensation is most often paid in the form of an hourly rate applied to the documented hours spent by the physicians furnishing the administrative services. This amount generally does not vary depending on the performance of the manager or the success in meeting the quality objectives of the arrangement.

The second component of compensation is the P4P incentive compensation, which is based on the attainment of clinical quality objectives and such other factors as patient satisfaction and budgetary compliance. There is a wide variety in the way P4P incentives are calculated and paid, the more common of which are described in the following section.

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Incentive metrics and Pay-for-Performance

Core measures developed by CMS, The Joint Commission, and third-party payers are often referred to as organizations develop quality standards for incentive pay under CCMA. Table 1 below summarizes core measures from CMS and the Joint Commission for heart failure:

Table 1: Heart Failure Core Measures	
Medicare Short Name	Description
Discharge Instructions	Heart failure patients discharged home with written instructions or education material given to the patient or caregiver at discharge or during the hospital stay addressing all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen.
Evaluation of LVS Function	Heart failure patients with documentation in the hospital record that left ventricular systolic (LVS) function was evaluated before arrival, during hospitalization, or is planned for after discharge.
ACEI or ARB for LVSD	Heart failure patients with left ventricular systolic dysfunction (LVSD) and without both angiotensin converting enzyme inhibitor (ACEI) and angiotensin receptor blocker (ARB) contraindications who are prescribed an ACEI or ARB at hospital discharge. For purposes of this measure, LVSD is defined as chart documentation of a left ventricular ejection fraction (LVEF) less than 40% or a narrative of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction.
Adult Smoking Cessation Advice/Counseling	Heart failure patients with a history of smoking cigarettes, who are giving smoking cessation advice or counseling during the hospital stay. For purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.

Quality measures like those above for heart failure are used as measurements in CCMA to assess the level of quality attained through the management of the hospital service line. For example, a cardiac CCMA would likely measure quality for AMI, heart failure, and cardiac artery bypass graft (CABG), comparing the actual quality scores with expected or target scores. In the case of the Discharge Instructions core measure, the quality score is a fraction: the numerator of which is the number of patients discharged home that were given discharge instructions or educational materials that included all of the required instructions (i.e., activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen), and the denominator of which is the total number of heart failure patients discharged home.

One of the key distinctions between a CCMA and a traditional management agreement is the P4P component, which provides for incentive compensation to the manager above and beyond the base compensation. The incentive compensation component is often based on attainment of quality scores like the one described above for heart failure. In the example of discharge instructions to heart failure patients, a score of 78 % may be the target score for discharge instructions. Reaching or exceeding this level would result in incentive bonus credit or payment to the CCMA manager. CCMA vary in the application of bonus methodology, as some examples include specific amounts of bonus payment upon attainment of target scores or credit in the form of points to the manager, which are accumulated for purposes of determining payment under the CCMA incentive bonus formula.

Determination of FMV

In the context of a co-management arrangement, determining the fair market value (FMV) of management fees is critical not only for compliance with existing laws, but also to the ultimate success of the project. Therefore, before any hospital undertakes the implementation of a co-management arrangement, it is critical to determine the FMV of the management fee, including both the base and incentive components (these two components were discussed

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earlier in the chapter), in order to maintain compliance with existing laws and regulations.¹⁰ However, there is little valuation theory for an appraiser to rely upon in assessing performance-based incentive or pay-for-performance programs, as these arrangements are still relatively new and, therefore, vary widely in their structure.

In theory, the FMV of the management fee could be established by assessing the required number of work hours needed to provide the management services, multiplied by a FMV hourly rate. However, as with most management services and/or service arrangements, the exact number of required work hours cannot reasonably be determined in advance. Most management arrangements observed in the marketplace are not based upon actual underlying time to establish the management fee.

Valuation theory applicable to CCMA's

The following three fundamental principles co-exist in the theory of business valuation: (i) the Principle of Substitution, (ii) the Principle of Alternatives, and (iii) the Principle of Future Benefits; each of these can be transferred into the context of valuing service agreements. For example, the Principle of Substitution states that an investor will pay no more for a service than for a substitute of equivalent economic utility. Under the Principle of Alternatives, each party to a contemplated contractual arrangement has alternatives to consummating the deal. The Principle of Future Benefits emphasizes that the value of an investment is based on the future benefits the investment will provide. These principles lay the foundation for the application of valuation methodology to developing a conclusion of fair market value in compensation arrangements as well, including CCMA compensation arrangements.

Valuation methodology

Several methods exist for determining value in a compensation arrangement. The justification for the use of a particular method or methods will often be dictated by the facts and circumstances of the contractual arrangement. These methods of valuation can be generally categorized into three broad approaches: Cost-based, Income-based and Market-based. Within the each valuation approach, one or more methods exist for determining value, with the relevance and applicability of each depending on the circumstances and the analyst's judgment.

In considering the value of payments under a CCMA, it is critically important to consider the value of the individual components of compensation (base compensation and incentive compensation), as well as aggregate compensation under the arrangement. A key consideration that must not be overlooked is that the methodology (and application thereof) that considers the fair market value of the individual components of compensation may differ from methodology that considers the value of aggregate compensation. The valuation analyst should consider the merits and applicability of all three valuation approaches in developing an appropriate FMV range.

Income-based approach

Valuation of a CCMA under the income-based approach considers the economic benefits enjoyed by the hospital from the management services furnished by the manager. The following examples demonstrate that quality care does indeed result in economic benefit, thus demonstrating that quality measures bring economic value to an organization:

- Use of beta blockers reduces 30-day readmission rates by 22 %.¹¹
- Use of aspirin can result in savings of \$209 per patient.¹²
- Use of smoking cessation advice results in a \$15 savings per patient.¹³
- Use of a one-time 60 minute educational session prior to hospital discharge results in a 35 % reduction in hospital costs.¹⁴

The measurement of these and other benefits can represent a proxy for the fair market value of P4P arrangements, such as CCMA's. In two examples to follow, the FMV of physician management services are attributed in part to the reduction in costs associated with reduced hospital readmissions and reduced lengths of stay (LOS).

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Reduced hospital readmissions

Valuation of a CCMA under the income-based approach may consider the value of management services as attributable in part to the reduction in costs associated with reduced readmissions. It is widely accepted that hospital readmissions increase the cost of care for patients by thousands of dollars. Therefore, an increase in quality that reduces readmission rates not only results in better patient care but is also accompanied by the potential of significant economic benefit to facilities.

The application of this method involves research and financial analysis regarding the link between pay-for-performance quality measures and the financial benefits of preventable patient readmissions. For example, a hospital managed under a CCMA for its cardiology service line found that its use of discharge instructions, prescription of ACE inhibitors and smoking cessation programs are associated with a reduction in readmissions for heart failure patients. These findings are consistent with research studies performed on heart failure quality core measures.

Measurement of the reduction of readmission rates resulting from the improvement of heart failure core measures begins with a study of research on the subject of reduced readmissions for this disease when the quality of care improves. Working directly with the hospital to determine the projected decrease in readmissions associated with these core measures results in expectations of hospital readmission rates for the managed facility under the CCMA.

Financial analysis of the implications associated with reduced readmissions involves work with the financial staff of the managed facility in projecting the changes in revenues, expenses and profitability resulting from the projected reduction in readmissions. The application of readmission methodology under the income-based approach to valuing CCMA involves projections of the financial impact of changes resulting from improvements in quality, and this methodology requires experience in hospital reimbursement and costs. In some cases, market research and the valuation analyst's study of the applicable financial effects can be inconclusive or show that measurable cost savings are either negligible or nonexistent.

In the example of the hospital managed under the cardiac CCMA, findings linking reduced readmissions with core measures of quality resulted in a predictive analysis of reduced readmissions, and related cost savings could be projected from the anticipated decline in readmission rates.

It is important to consider under such an analysis that a portion of the benefits attributable to the management services under the CCMA can be a result of factors outside the manager's control. These must be factored into the analysis by the valuation analyst, lest an erroneous conclusion be reached. For example, in a hospital-physician CCMA in which no joint venture is established between the hospital and physicians and the physicians are designated as managers of the hospital service line, it is critical to determine the portions of management duties that are associated with the work of the physicians and the hospital. On the other hand, in cases in which a joint venture CCMA is in place, other environmental factors that contribute to patient readmission rates should be considered. Examples of these include changes in technology, pharmaceuticals, and clinical pathways associated with the managed disease.

It is also vitally important that the valuation analyst consider whether the methodology employed resulted in the value of the base compensation, the incentive compensation or the aggregate of both when considering the FMV of a CCMA. In the example of the hospital managed under a cardiac CCMA, the savings resulting from reduced readmission rates resulted in a proxy for FMV associated with the total administrative and management services under the CCMA; thus, the value conclusion reached was applicable to the aggregate compensation under the CCMA, because reaching the target core measures scores and the achievement of savings in this example was attributed to the entire scope of management under the CCMA. This becomes critical in the valuation of a CCMA because of the various components of compensation. For example, had the valuation analyst determined under the income approach that the resulting value was only applicable to the incentive compensation rate and not to the base component of compensation, the conclusion of value for the entire CCMA could have been significantly overstated.

This principle of properly matching the valuation methodology to the appropriate conclusion of value can be demonstrated in the use of market-based "inputs" into the income-, cost- or market-based approaches. For example, a conclusion of value based on a "build-up" of the value of physician administrative time (at market hourly rates) and a separate value for the P4P aspect of the agreement must be tested to ensure that the aggregate value conclusion is not overstated. In a simplistic sense, consider the fact that the administration of aspirin upon arrival in a myocardial

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infarction case yields value under the P4P aspect of the compensation arrangement. This compensation, in addition to compensation for the medical directorship element of the arrangement, is consistent with the proposition that meeting the core measure brings additional value to the patient, hospital, and insurer. However, methods that arrive at a conclusion of FMV for the aggregate service (including the medical directorship element), such as an income-based approach model that considers aggregate value to the hospital for the totality of services under the CCMA, should not then be added to the value of medical directorship compensation as separately computed.

Value of reduced hospital lengths of stay

Valuation of a CCMA under the income-based approach may also consider the value of management services as attributable in part to the reduction in costs associated with reduced hospital lengths of stay (LOS). Increases in quality that support reduced LOS data result in improved patient mortality, better care, and significant economic benefit to facilities.

Similar to the study of readmissions, the application of this method involves research and financial analysis regarding the link between pay-for-performance quality measures and the financial benefits of reductions in patient LOS. For example, studies have shown that a one-day improvement in LOS can significantly reduce the costs of caring for patients with pneumonia. Measurement of these reductions in LOS resulting from the improvement of core measures can be obtained with data from the managed facility and from market data on other facilities in the market, using such data as measurements from CMS on hospital quality incentives and data from the American Hospital Directory.

Financial analysis of the implications associated with reduced LOS involves analysis by the managed facility to projecting the changes in revenues and profitability associated with the projected decrease in LOS associated with the managed disease. Findings linking reduced LOS with improvements in core measures of quality can result in a study of reduced readmissions and related cost savings. As with readmission rates, market research and the valuation analyst's study of the applicable financial effects can be inconclusive or show that measurable cost savings are either negligible or non-existent.

Cost-based approach

Discussion of applicable service lines. While the income approach certainly has applicability in many instances, the two more prevalent valuation approaches utilized in the marketplace appear to be the cost and market approaches. In considering the cost approach (or "replacement cost" methodology), a possible alternative to the implementation of an agreement is a hospital's opportunity to engage various medical directors (either as employees or as independent contractors) to manage its identified service line offerings. As an example, were a valuation analyst engaged to determine the FMV of a cardiovascular co-management arrangement, such service line offerings for consideration would likely include, but not be limited to: medical cardiology, interventional cardiology, cardio/thoracic surgery, cardiac rehabilitation, cardiac intensive care and outpatient programs and services. Giving consideration to the number of medical directors that might reasonably be required to provide physician management to hospital's service lines, the valuation analyst could then consider the following key factors:

- What are the projected gross charges of the service line? Since most co-management arrangements are implemented for the management of existing service line offerings, looking at the most recent 12-month period of historical charges would be advisable. Alternatively, if the service line in question is a new division of a hospital, for example, a cardiovascular center of excellence, it would be acceptable to rely on the hospital's annual projected gross charges for purposes of an analysis.
- How diverse are the service offerings? The diversity of service offerings in combination with the complexity of clinical operations and the volume of procedures, including both inpatient and outpatient services, require significant coordination among numerous physicians, associated hospital services, and a myriad of operational details. For example, for hospital-specific reasons, a proposed orthopedic co-management arrangement might exclude outpatient rehabilitation services. In this instance, all other things being equal, the resulting range from methodology employed under the cost approach would likely be significantly less than an arrangement that was all encompassing.

Determination of comparable positions. Once the scope of the service line is discussed and agreed upon, the determination of the particular physicians and the corresponding amount of time required to provide medical

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director services is dependent upon a variety of factors, including (i) the size of the hospital, (ii) the complexity of services being provided and (iii) the number of procedures performed. In consideration of these factors, the initial step would be to develop an expectation for the number of medical director positions that could have *reasonably* been supported in the absence of the co-management arrangement. The valuation analyst can either develop this guidance based on his or her own experience and informed judgment with similar arrangements, or can engage the services of an independent staffing expert (typically an independent physician with previous department head experience). By evaluating the applicable service lines, the valuation analyst should be in a good position to identify the relevant medical director positions, ensuring that there is no overlap and/or redundancy in the identification of such positions.

For example, if the valuation analyst were analyzing a co-management arrangement for a comprehensive cardiovascular center of excellence, by evaluating each potential service line component, it would not be unreasonable to conclude that the following Table 2 contains the six, part-time medical director positions that might have been engaged. Such positions would have been engaged on an independent contractor basis, in the absence of a co-management arrangement, to manage daily operations and provide needed oversight to hospital's service line.

Table 2 – Identified Service Line Medical Directorships
Medical Cardiology
Interventional/Invasive Cardiology
Cardiovascular and Cardiothoracic Surgery
Cardiac Rehabilitation & Recovery
Cardiac Intensive Care (CCU)
Outpatient Programs and Services

Determination of appropriate compensation rate. In order to determine the appropriate compensation for each identified medical director position, it is important to note that compensation earned by a physician in his specialty practice of medicine *may not* be directly comparable to the compensation for medical directorship duties. However, the valuation analyst should recognize that with regard to a medical director position, a hospital would need to identify not only an appropriately experienced clinician, but an individual with the skills and experience necessary to perform required administrative duties. At this point in the analysis, the valuation analyst should also give recognition to the size of the hospital. For example, a 500-bed, trauma facility, given its size and focus, would likely need the support for a more diverse community of both inpatients and outpatients as opposed to a 150-bed regional hospital. The implication here is that there is likely support for higher compensation and/or allowable monthly hours for the 500-bed trauma facility arrangement.

Given the above, the valuation analyst should review available compensation levels expected to be earned by a physician in his or her specialty practice of medicine as a reasonable starting point.¹⁵ However, in most instances, such compensation values are likely *not* comparable to the FMV of compensation for medical directorship duties as described above. As stated above, in valuing administrative positions, a FMV analysis is not intended to establish an “opportunity cost” related to professional services. Therefore, to develop the most appropriate compensation range, the valuation analyst should review and consider available published sources of administrative compensation data. In developing compensation ranges, as *general* guidance, the valuation analyst should consider benchmark compensation values between the 50th (*i.e.*, the median) and 90th percentile values. However, as will be discussed below in detail, depending on the specific facts and circumstances of the arrangement, it may be reasonable to limit the upper end of the compensation range to the 75th percentile (*e.g.*, in those instances where there are multiple medical director positions, relatively low program revenue, etc.).

Determination of appropriate hours. Once a compensation range is identified, the next step in the cost approach is to identify the applicable hours attributable to each identified position. For ease of calculation, the typical convention would be to identify an annual number of hours, as this number would then be multiplied by the hourly

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compensation range identified above to determine the annual compensation attributable to the position. To identify the appropriate range of expected monthly hours, the valuation analyst should consider the following questions:

- How large is the hospital's service line to be managed (as measured by net revenue)?
- How large is the hospital, as measured by licensed bed count?
- Does the co-management arrangement contemplate the management of a single campus, or multiple campuses?¹⁶

As with the development of the compensation range, the valuation analyst should review and consider available published sources of administrative data regarding ranges of hours for respective administrative positions. The valuation analyst should view general guidance for annual hours as reasonably going up to the 75th percentile for most arrangements. However, as with the derivation of the hourly compensation, specific facts and circumstances might warrant exceeding this upper range. For example, using a hypothetical cardiovascular center of excellence, co-management arrangements relate to unique cardiovascular surgery services, in that these services are also provided to a hospital's patients that are transferred in from smaller regional hospitals where such services are not provided. In recognition of the added complexity of this relationship between hospitals, it would have been reasonable to utilize benchmark data for the 90th percentile to determine the number of hours required by the applicable cardiovascular surgery medical director positions. Such reasoning follows from our review of other comparable arrangements where either (i) the services are now more complex due to the varied parties involved, thus requiring a more experienced physician, or (ii) a physician would negotiate a higher reimbursement due to the additional burden of the second campus, etc.

Once these two market data points are identified, this data would then be used in conjunction with the appropriate staffing breakdown as detailed from Table 2 to determine the total FMV range as determined under a cost approach. Table 3 provides a simple summary of a hypothetical analysis used to determine the FMV range, under a cost approach, associated with the management of hospital's cardiovascular center of excellence:

Table 3: Summary of Cost Approach					
Service Offering	Hours Worked Per Year	50 th Percentile		90 th Percentile	
		Hourly Rate	Annual Compensation ¹⁷	Hourly Rate	Annual Compensation
Medical Cardiology	215	\$134	\$28,810	\$174	\$37,410
Interventional/Invasive Cardiology	150	\$141	\$21,150	\$184	\$27,600
Cardiovascular and Cardiothoracic Surgery	856	\$186	\$159,216	\$256	\$219,136
Cardiac Rehabilitation & Recovery	174	\$150	\$26,100	\$173	\$30,102
Cardiac Intensive Care (CCU)	220	\$164	\$36,080	\$200	\$44,000
Outpatient Programs and Services	220	\$164	\$36,080	\$200	\$44,000
TOTAL	1,835		≈ \$308,000		≈ \$402,000

Market based approach

The market approach to valuation provides an effective methodology to determine a FMV range while eliminating the constraints of a time-based analysis as required under a cost approach. However, the uniqueness of each co-management arrangement precludes *direct* market comparisons of the subject arrangement to other arrangements in the marketplace. Therefore, a critical part of the valuation process involves breaking down the co-management arrangement into its individual components. Once individual tasks, objectives, and performance metrics are identified, the arrangement can be compared to other arrangements with similar elements.¹⁸ By comparing specific elements

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on an item-by-item basis, the valuation analyst is able to assess the relative worth of each metric¹⁹, and determine the presence or absence of each metric in comparison to the comparable arrangements. Then, with reasonable objectivity, the valuation analyst is able to assess the overall relative value of the identified arrangement by comparing it to other available market arrangements.

Identification of services performed. In order to compare the management services to be provided by a manager against market comparables where the management fees are known (*i.e.*, a review of ASC management agreements), the valuation analyst should consider the creation of a “scoring grid,” whereby a weighting factor and point value are assigned to each specific identified task contemplated under the arrangement. The services to be included in the arrangement can usually be found in the draft agreement provided by counsel (usually as an exhibit to the body of the agreement), but often times such services are also either contained within the body of the agreement or not addressed in detail at all. In these latter two examples, the valuation analyst should have a detailed discussion with counsel with regard to the detail and “breadth” of the contemplated management services, as the accurate identification of the specific services to be performed is the main driver within the market approach. For example, will the management company simply “assist” with the credentialing function by coordinating the necessary paperwork, or will the management company be responsible for handling the credentialing function? Once these services are identified, the valuation analyst will have a grid comprised of up to 35 specific services. This comprehensive listing of services typically provided by management companies will be a “baseline” listing from which the valuation analyst can then begin to make a series of “normalizing” adjustments to the available management fee percentages in developing a range applicable to the agreement.

Identification of baseline market comparables. One common type of management arrangement whereby significant market data is available involves the management of ambulatory surgery centers (ASC) by professional management companies. Generally, ASC management companies provide comprehensive management services, with recognition that the services do not include services that typically require the involvement of physicians.

Since there is a plethora of available data in the marketplace, the valuation analyst can conduct a survey of identified national or regional ASC management companies, identifying the management fee ranges, stated as a percentage of collections (or net revenue). In the authors’ experience, management fees range from approximately 3 % to 6 % of collections; however, the vast majority of such arrangements involve the existence of a full-time on-site manager who is compensated by the ASC, thereby effectively raising the total management fees to levels higher than 6 %. [Editor’s Note: These arrangements are described in more detail in this Guide’s chapter on Ambulatory Surgery Centers.] If there is not enough marketplace data available on such arrangements, the valuation analyst can also attempt to identify other management arrangements involving such programs as substance abuse, respiratory therapy, and physical therapy.²⁰ In considering the applicability of these arrangements to the agreement, however, the valuation analyst should be careful to ensure that such arrangements do not include clinical staffing services, as such arrangements would report a higher than expected management fee and result in a skewed analysis. As a result, a review of such arrangements may be helpful from a comparison perspective, but may not be as reliable as information gleaned from more “typical” management company arrangements.

Adjustments given scope of services. Armed with the data developed in steps 1 and 2 above, the valuation analyst is now in a position to utilize the developed grid to evaluate and score each task under the agreement. Some aspects to consider in the creation of a grid would be the following:

- **Task Importance**—Develop a point system that values the complexity and anticipated time commitment required by each identified task, possibly ranging from 1 to 5. For example, “arranging for the purchase of liability insurance, paid for by the hospital,” is a much complicated and time intensive task as compared to the task of “develop community relationships that result in a satisfied referral base.” As such, the scoring grid should be able to effectively distinguish between the two, and in this example, the latter task may be scored a 5, whereas the former task may be scored as a 3.
- **Task Involvement**—In management agreements, it is common to see tasks identified in an agreement that are meant to be more “supportive” in nature as compared to the management company having sole responsibility for the task. As referenced in the hypothetical example above, will the management company simply “assist” with the credentialing function by coordinating the necessary paperwork, or will the management company

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be responsible for handling the credentialing function? The grid should be able to delineate between the two, as the former task is certainly more limited in nature.

- **Weighting Factor**—A weighting factor is recommended to be developed and applied to each task based on the above identified categories. For example, a limited task may receive a weighting of 1.0, whereas a full task may receive a weighting of 3.0. Similarly, those tasks not included in the proposed agreement may receive a weighting of 0.0.

As a result of the above calculations, the analysis will yield a total point value, calculated as the sum of the various point values assigned in the above *task importance* section. In addition, the grid will produce a weighted point value, which would be the product of each specific point value, multiplied by the identified weighting factor. For example, if there were 30 tasks, resulting in a total score of 110 possible points, the weighted score might have totaled 80 points, resulting in a final score of 73 % (*i.e.*, 80 / 110). In order to determine a comparable value for the management services, the results of the above-described scoring grid (*i.e.*, 73 %), would be applied to the identified market range for management fees. In this example, the result would be a *preliminary* fee range for the management services, under a market approach, of from 2.2 %²¹ to 4.4 %²² of net revenue.

Adjustments given revenue size. Depending on the specific facts and circumstances of the arrangement, the valuation analyst should also give consideration to the application of a *discount* of the preliminary range. While this may not appear to be intuitive, it is logical for a number of reasons. First, although the management services contemplated by the co-management agreement are likely comprehensive in nature, the hospital likely has the ability to rely upon many aspects of its infrastructure.²³ This is a significant point to consider, in that this reduces the hospital's required degree of dependence upon the management company. Second, in most instances, the revenue size of a service line subject to a co-management agreement is significantly higher than the typical ASC that is subject to an outside management arrangement, thereby warranting a lower fee as a percentage of net revenue.²⁴ Third, research indicates that as revenue sizes grow, there is an increased likelihood that a management organization would discount its normal management fees in recognition of the fact that it is able to achieve certain economies in the arrangement. Furthermore, once net revenue exceeds a certain threshold, the correlation between net revenue and the cost to manage the services is significantly reduced. Therefore, in recognition of this disconnect, and in order to apply a certain degree of conservatism to the analysis, the valuation analyst should consider the application of a discount to the initially calculated fee range, with a reasonable range of discounts being from 10 % to 30 %.

Reconciliation of the approaches. In considering the outcomes of the valuation approaches, the market approach is generally preferable in valuing management services. However, the market approach can be subject to certain limitations since, as discussed above, there are no directly comparable market values. The income approach contains some element of speculation in the projection of LOS and readmission impact and may sometimes yield inconclusive results. Therefore, the valuation analyst must weigh these factors in determining the degree of reliance placed upon these methods. With respect to the cost approach, the buildup of the medical director time requirements does not necessarily value the services that will be contributed by a hospital partner in the management company (since the valuation of such services would result in significant subjectivity). As such, a common approach would be to give each methodology equal weighting, and take a simple average of the calculated values. In other instances, however, there may be a need to provide a double weighting of one approach or the other in recognition of additional arrangement dynamics. For example, if the valuation analyst were analyzing a relatively "light" management arrangement (*i.e.*, a small service line like ENT at a regional hospital), given the relatively scaled down services contemplated under that type of arrangement, an equal weighting may not necessarily accurately capture the essence of the arrangement.²⁵ In this instance, the valuation analyst might elect to normalize the valuation by giving a *double weighting* to the results of the cost approach.

Valuing the total fee

Within the framework of co-management arrangements, a reliable and comprehensive valuation approach should provide a FMV range that encompasses the total management fee (*i.e.*, both the base management fee *and* the incentive management fee). In addition, each co-management arrangement is unique and reflects specific market and operational factors which are singular to the specific setting. Therefore, by providing a broad range for the total management fee, the valuation analyst also provides the hospital with the opportunity to establish the proportion of the management fee payable as a base management fee versus the incentive management fee (which will be

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based upon achievement of the predetermined measures). That said, although the hospital should have significant discretion in establishing the relative value of the base management fee as compared to the incentive management fee, there are certain regulatory and market-based constraints that should be observed. In particular, regulatory considerations may affect the maximum percentage of the total fee that can be incentive based.²⁶

However, within those constraints, it is not likely beneficial to set the incentive management fee at too low a percentage of the total management fee (since such an over-emphasis on the base fee would seem to diminish the ideals of achieving the pre-established performance objectives). As general guidance, the base management fee should generally be no higher than 60 % and no lower than 25 % of the total management fee. These constraints are based on observations of similar arrangements in the marketplace and, in the authors' opinion, preserve the general intent of the hospital with respect to the desired outcome of the co-managed services.

Issues impacting the FMV analysis

Once the FMV range of the management agreement is identified, it is important that the valuation analyst recognize that each management arrangement is completely unique, and as with most arrangements, these "unique" attributes can have a significant impact on the resulting FMV of the arrangement. This section of the chapter will focus on some of the common areas for discussion amongst the parties, each of which should be thoroughly explored by the valuation analyst.

The use of medical director positions. A very commonly used practice within co-management arrangements is to utilize medical directorships for select physician participants. While the intent of the arrangements are to typically have the management company perform all of the management services, it is not uncommon to find that certain of the management services are intended to be provided through a medical director arrangement provided by a qualified physician associated with the management company. While this is an acceptable practice, the valuation analyst should ensure the following:

- Such medical director arrangements are to be paid as an expense from the identified management fee. Since the FMV "build-up" of the management fee as discussed above in the Cost Approach section already contemplates the use of such positions, paying for these positions outside of the management fee would be considered redundant. However, there are instances in which such positions would be allowed in a manner consistent with FMV, such as in a situation in which the medical directorship was for a specific subset service line, which was now going to be "carved out" from the management company (e.g., in a cardiac co-management arrangement, the parties might agree to carve cardiac rehabilitation out of the arrangement). In this instance, the valuation analyst should ensure that the net revenue provided for the analysis specifically "excludes" any revenue attributable to the cardiac rehabilitation so as to not allow for redundancy of payment.
- If all parties agree on the treatment of revenues and positions, it is important that the valuation analyst ensure that such medical director arrangements will be for a number of monthly hours and rate that is *consistent with FMV*. As a good rule of thumb, the valuation analyst should ensure that the proposed hours and rate are equal to or below the upper end of the values provided in Table 3 above.
- Since the intent of a co-management arrangement is that there are no "passive investors," the valuation analyst should also give consideration to the magnitude of the total monies being allocated toward medical directorships. As discussed above, the base management fee is meant to compensate the management company for handling the day-to-day management services, which are expected to be handled in a proportional manner to each party's ownership. Therefore, assuming a 50/50 ownership (as is typical), it would not be reasonable to have a disproportionate share of the base management fee paid out as medical directorships. While there is latitude in the ultimate percentage "ceiling" that can be approved, another good rule of thumb is that *no more than 50 %* of the base fee should be allocated to medical director positions. By doing so, the valuation analyst can avoid any possible interpretation that this management company is simply a vehicle under which a hospital intends to distribute monies to the physicians while allowing the physicians to perform less than the required share of the overall duties. This is especially critical when the medical directorships are going to be with physician owners.

Provision/purchase of administrative services. It is not uncommon in many arrangements for the management company, whether jointly owned or not, to have a need for certain administrative services. In the case of a

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physician-owned management company, given the “loose” structure of the arrangement, and since there is no need for dedicated building space and/or staff, the physician owners simply do have the requisite infrastructure necessary to manage their operation. Such needed administrative support services may include, but not be limited to, the following: accounting, financial statement preparation; tax return preparation; payroll processing; legal support and clerical support, and in most instances, the hospital is more than willing to provide such services to the management company. By doing so, however, the hospital has just unintentionally (or intentionally as the case may be) created a fair market value implication by providing additional services that have a defined market worth.²⁷

Ensuring equitable division of responsibilities. As has been stated numerous times throughout this chapter, the co-management structure is intended to be a vehicle that ensure that hospital and physician members both actively participate in the provision of the management services (i.e., there are no passive investors in a management company). Furthermore, a key representation in most management company analyses is that the resulting division of responsibilities within the management company (i.e., the management contribution of each party related to providing the management services), will be in approximate proportion to the ownership percentages determined. However, under most arrangements, assuming a 50/50 ownership structure, it would be virtually impossible to ensure that all of the required duties are handled on an “exact” 50/50 basis. That said, if the parties each own 50 % of the management company, and will thus receive 50 % of the management fee, the valuation analyst should ensure that (i) each party takes an active role in the management duties, and (ii) each party will manage efforts in approximate proportion to their ownership.

Summary

In summary, the emergence of incentive-based models for the delivery of healthcare services has contributed to the development of a broad range of new opportunities for hospital / physician partnerships. One of the most common forms of these partnerships involves the establishment of a hospital/physician-owned co-management company for the purpose of managing a specific hospital service line. This type of arrangement offers significant value propositions to *patients*, who have improved access to needed services; to *hospitals*, which realize improved patient satisfaction, operational efficiencies, financial controls and enhanced clinical quality; and to *physicians*, who are incented to effectively and efficiently manage the service line and facilitate the achievement of identified performance-based metrics.

However, the uniqueness of each co-management arrangement precludes *direct* market comparisons of the subject arrangement to other arrangements in the marketplace. Therefore, a critical part of the valuation process involves breaking down the co-management arrangement into its individual components. Once individual tasks, objectives and performance metrics are identified, the arrangement can be compared to other arrangements with similar elements, and/or analyzed by completing a “build-up” of comparable positions that would be required in the absence of such an arrangement. Regardless of the approach undertaken, determining the fair market value of these types of management agreements is of paramount importance, and by incorporating the above elements into a valuation repertoire, one can be assured that a thorough analysis will result.

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10. In addition, it should be noted that according to Rev. Proc. 97-13, certain not-for-profit entities with public bond financed property may also face additional Internal Revenue Service scrutiny regarding the split of the Management Fee. The authors would recommend that any hospital considering a co-management arrangement involve outside counsel in the process.
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15. A good resource for cash compensation values can be obtained from the *MGMA Physician Compensation and Production Survey*, as this publication is a commonly used benchmark percentile in the determination of appropriate FMV compensation values.
16. In the authors’ experience, it is not uncommon to see co-management arrangements covering multiple campuses for a hospital, particularly if certain services (*i.e.*, rehabilitation) are handled in a distinct location. This dynamic increases the complexity of the management arrangement, and would likely warrant an adjustment to the hourly and rate ranges.
17. Calculated by multiplying the number of hours worked per year by the hourly rate at the applicable percentile for each specialty (*i.e.*, 50th or 90th).
18. In the case of co-management arrangements, in the authors’ experience, similar tasks and objectives might be found in ASC arrangements, which are readily available in the marketplace.
19. For example, metrics can be focused around tasks, objectives or performance outcomes.
20. Such arrangements may not be based upon designated percentages of net revenue. As such, to ensure an accurate comparison, it will be essential for the valuation analyst to convert each arrangement to a percentage of net revenue equivalent basis in order to facilitate comparisons.
21. .03 x 73%
22. .06 x 73%
23. Even if the agreement is not a traditional “co-management” agreement (*i.e.*, it is not uncommon to have such management companies solely owned by the physicians), the authors believe that the participating hospital will still be in a position to leverage aspects of its infrastructure.
24. In the authors’ general experience, the “typical” revenue size of a co-managed service line might be in the \$30-\$70MM range, whereas the typical ASC has revenues in the range of \$10MM or less.

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25. In other words, the results of the Market Approach would likely understate the “value” of the services being provided by sole virtue of its reliance on the net revenue of the service line.
26. According to Rev. Proc. 97-13, certain not-for-profit entities with public bond financed property must ensure that the incentive portion of the management fee is not set too high as compared to the base fee, depending on the length of the contract term and other terms of the arrangement. Therefore, parties considering such arrangements are advised to seek the advice of experienced legal counsel prior to entering into any such arrangements.
27. In many instances, the valuation analyst is not asked to analyze and determine the FMV of such services. It is therefore acceptable to rely on the party’s representation, and to list such as a governing assumption in the valuation report, that any such services will be subject to an appropriate FMV analysis.