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# Valuation Of Co-Management Arrangements: Achieving Operational And Quality Improvements Through Hospital/Physician Partnerships

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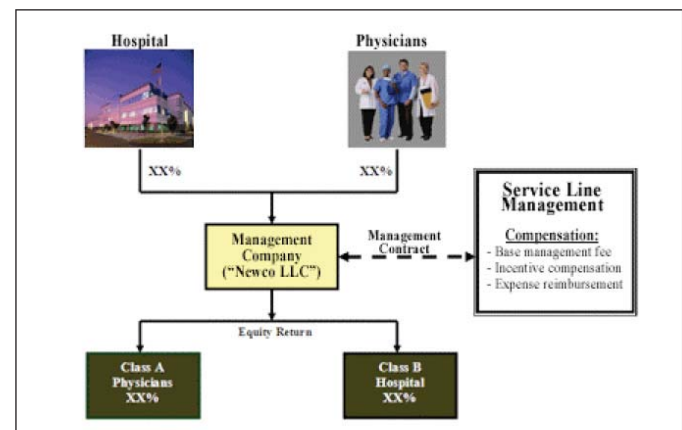
## Overview

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 with hospitals. 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 payor community. Technological advances allowing less invasive interventions and improved outcomes offer the promise of revolutionizing the way medicine is practiced. Furthermore, medical procedures that were once performed exclusively within the realm of inpatient facilities are now delivered in outpatient clinics and ambulatory centers, making the reality of competition a more immediate issue. Perhaps even more significantly, due to readily identifiable operational interdependencies within healthcare delivery systems, even a small change in one area of functioning will have an impact on multiple hospital operations and processes. As a result, the achievement of significant improvements in productivity, financial performance, patient satisfaction and clinical outcomes are major priorities for most hospitals as they strive to remain competitive, both from a price and quality perspective to the consumer, as well as from an attractiveness standpoint to their physician community.

## The Co-Management Model

As hospitals and integrated delivery networks focus on improving the accessibility, quality, and efficiency of medical care and delivery systems within a framework that promotes accountability and outcomes-based metrics, new partnerships are emerging and gaining traction within the healthcare community. One of these newly emerging partnership models is generally referred to as the co-management arrangement. Within this model, the hospital or healthcare delivery system enters into an agreement with a new company (e.g., "Newco") formed for the purpose of providing services to manage a specific hospital service line (e.g., cardiovascular services, orthopedic services, surgical services, etc.). This newly created management company is typically formed with equal (i.e., 50/50) ownership between the hospital and the participating physicians involved in providing medical care within the service line. Co-management entities may also involve non-physician investors as well as professional managers. The following Exhibit 1 provides a graphical depiction showing how these management companies are typically structured.

### Exhibit 1 - Management Company – Organizational Structure




Co-management arrangements are generally initiated for the following reasons:

1. To enhance service line delivery;
2. To help coalesce the physician members involved in providing the medical service;
3. To create new service line opportunities and improve overall operations; and
4. To more appropriately align the goals of physicians and the hospital through collective management, as well as the delivery of quality, efficient, and effective healthcare services.

The incentive-based healthcare delivery model is based on the belief that well-designed programs bring about behavior changes that result in consistently delivered high quality healthcare. Therefore, these types of co-management arrangements typically include both base management and incentive-based fee structure components.

With respect to the base management services, healthcare entities including hospitals, ambulatory surgery centers, and physician practices, routinely engage organizations to provide medical and/or administrative aspects of a wide variety of programs. Such organizations are typically regarded as having a high degree of administrative ability and technical expertise within a particular area, whereas it would be difficult for the healthcare entity to achieve the same degree of expertise and efficiency without a significant investment in infrastructure. Areas of outsourcing include the routine non-medical operational needs, ranging from contract negotiations to legal and financial services as well as specialized services such as risk management and human resources support. As notable examples, there are numerous companies that provide management services to ambulatory surgical centers (ASCs). These companies range from large publicly traded entities such as AmSurg, Symbion Healthcare, United Surgical Partners International, and NovaMed to privately held companies such as Ambulatory Surgical Centers of America, National Surgical Care, and Surgis, Inc. Most often, these companies provide a comprehensive basket of services based on a fixed percentage of net revenue of the service line being managed.

However, unlike traditional management company arrangements, a primary objective of co-management arrangements is to allow the management company to earn an incentive management fee in addition to the base management fee. Incentive-based management fees are typically derived from the hospital's performance improvement initiatives and act to facilitate the coordination of efforts among the physicians involved in delivering associated medical care. Performance improvement initiatives are generally quantified through key operational and financial benchmarks as well as through quality of service metrics. A fundamental aspect of this effort involves the ability of the physicians to realize performance-based compensation for the achievement of predefined goals and objectives rather than the traditional hourly compensation associated with medical directorships.

Incentive-based programs clearly parallel pay-for-performance programs,[1] which seek to improve healthcare quality and stem rising healthcare costs by rewarding efficiency and effectiveness through the monitoring and reporting of treatment patterns and health outcomes. These programs generally base a portion of physician payment on quantitative measures including patient care process measures, outcomes, and patient satisfaction. As part of our review of these arrangements we have examined the efficacy of pay-for-performance programs including the national Bridges to Excellence program.[2] Early results indicate that financial incentives can motivate change, that improved care processes result in increased patient visits, and that high quality care does not have to mean higher costs (e.g., participating physicians who had been recognized as providing high quality care, actually delivered care at 15%-20% lower cost than non-participating physicians).[3]

In additional support of the incentive-based model for the delivery of healthcare services, we note that the Joint Commission recently introduced a set of principles to guide the development and refinement of pay-for-performance programs. According to the Joint Commission, the alignment of financial incentives to promote high quality care must be patient-focused and aligned with clinical outcomes. In fact, the Joint Commission states the goal of pay-for-performance programs should be to align reimbursement with the practice of high quality, safe healthcare. Accordingly, the Joint Commission indicates that these programs should be based on metrics that are evidence-based, valid, risk-adjusted, and reliable.

## Establishing Fair Market Value

Determining the fair market value of the base and incentive management fees under a co-management arrangement is important not only for compliance with existing laws, but also is critical to the ultimate success of the project. However, there is little valuation theory for an appraiser to rely upon in assessing these unique arrangements. In considering the primary valuation approaches, namely the cost, income, and market approaches, an income approach can likely be eliminated for two reasons. First, the identification of an income stream resulting from the co-management arrangement is not the hospital's foremost objective. Secondly, any attempt to utilize an income approach would give the appearance of considering the volume or value of referrals.

Using a cost approach, the fair market value of the management fee can be established by assessing the required number of work hours needed to provide the management services multiplied by a fair market value 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. Further, a

key ideal of most co-management arrangements is to reward results rather than time-based efforts.

In order to step away from the constraints of a time-based analysis, the valuator should also consider a market approach to determine the fair market value range. Each co-management arrangement is unique, and reflects specific market and operational factors that are singular to the specific setting. This precludes direct market comparisons of the subject arrangement to other arrangements in the marketplace. However, if the basket of services within a co-management arrangement is broken down into specific tasks and objectives, the arrangement can then be compared to other arrangements (such as ASC management arrangements) that have been similarly broken down into their specific tasks and objectives. On an item-by-item basis, the valuator can assess the relative worth of each task/objective, and determine the presence or absence of each task/objective in comparison to the comparable arrangements. Then, with reasonable objectivity, the valuator can assess the overall relative value of the subject arrangement by comparison to other market arrangements.

The cost and market valuation methodologies described above must be reconciled to arrive at a final conclusion of value. Furthermore, consistent with other service/consulting organizations, the invested capital required by a co-management entity is generally minimal. Therefore, we believe that analysis related to return on equity or return on assets is not useful in assessing fair market value.

A reliable, comprehensive valuation approach should provide a fair market value range that encompasses the total management fee (i.e., both the base management fee and the incentive management fee), providing the hospital with the opportunity to establish the proportion of the management fee payable as a base fee versus the incentive fee. Although the hospital should have significant discretion in establishing the relative value of the base management fee versus the incentive management fee, there are certain market-based constraints that should be observed. For example, while it may be reasonable to set the base fee equal to 50% of the total management fee, it is probably not reasonable to set the base management fee to equal 80% 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).

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, in today's regulatory environment, objectively demonstrating compliance with fair market value is critical.

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[1] Pay-for-performance programs for the federal government and the private sector are in various stages of development and implementation. The Centers for Medicare & Medicaid Services (CMS), the Medicare Payment Advisory Commission (MedPAC), as well as health plans and large employers are sup porting pay-for-performance programs.

[2] The Bridges to Excellence program is a multilateral effort of employers, health plans, and patients that offers financial incentives to physicians who improve the quality of care they provide.

[3] Bridges to Excellence 2005. BTE: Program Evaluation [Online], (accessed Mar., 28, 2007).

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