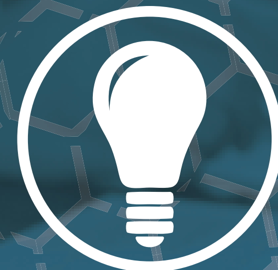
HSG THOUGHT LEADERSHIP



SETTING TRANSACTION EXPECTATIONS FOR HOSPITALS AND HEALTH SYSTEMS

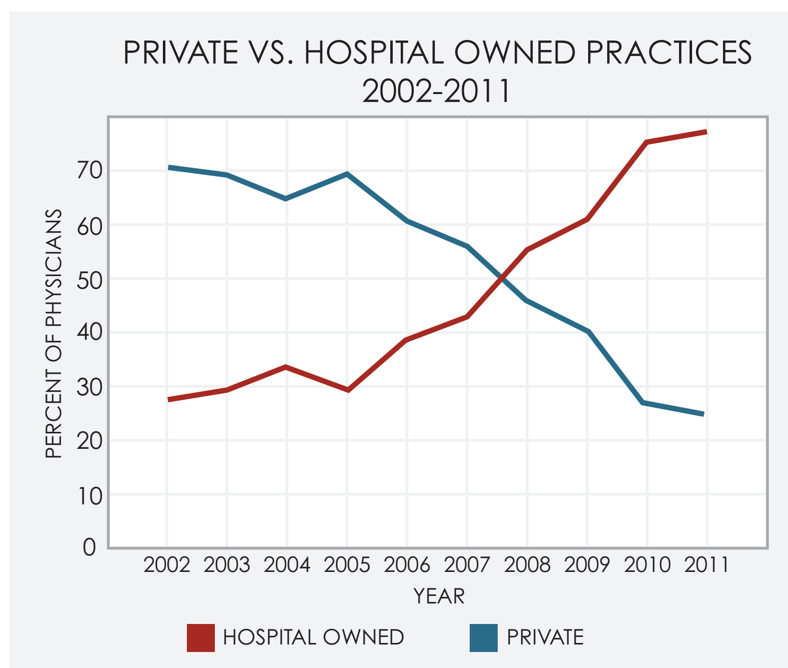
BY: NEAL BARKER AND BETH SIMPSON

INTRODUCTION

The United States has been experiencing and continues to experience a shift in physician practice ownership.

According to the American Medical Association (AMA), 2018 marked a point time at which for the first time, more doctors are employed than are owners in private practice. In a press release, the AMA described the event as "the continuation of a long-term trend that has slowly shifted the distribution of physicians away from ownership of private practices." AMA's release indicates that in 2018 employed physicians (physician and hospital-owned practices) were 47.4% of all physicians. Self-employed (owner) doctors only represented 45.9% of all practicing physicians. The remaining 6.7% were independent contractors. According to the AMA's 2018 Policy Research Perspectives in 2012, 60.1% of physicians worked in physician owned practices ("private practice"). By 2018, that number had decreased to 54.0%, with over half of that decrease according in the two years from 2012 to 2014. According to the AMA's 2018 survey, "34.7% of physicians worked either directly for a hospital or in a practice at least partly owned by a hospital in 2018 – up from 29% in 2012."

The Medical Group Management Association (MGMA) is a national medical practice membership organization with 50 state affiliates that represents more than 40,000 medical practice administrators and executives in practices of all sizes, types, structures and specialties. MGMA also publishes a variety of industry reports based on surveys of its membership and other eligible participants. Based on MGMA's survey data, the shift to hospital employment of physicians has been more pronounced. According MGMA, by 2011, more than 70% of practices were owned by hospitals and health systems (as shown in the graph, which is based on MGMA survey data).



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Regardless of the data source, one thing is sure: since the early 2000s, hospital and health systems have gone through an accelerated growth phase as transactions with physicians and physician-owned practices have reached an all-time high. This trend will undoubtedly continue as hospitals seek tighter alignment with physicians while population health initiatives, quality/outcome improvement programs, and value-based reimbursements mechanisms continue to evolve. Additionally, hospital-owned practices have no choice but to grow as older physicians who own their practice retire, and younger physicians, who have no interest in being practice owners, seek employment opportunities.

Alignment goes beyond employment and manifests in the form of Professional Services Agreements, Co-Management Agreements, Bundled Payment Programs, Joint Ventures, Medical Directorships, Call Coverage Agreements, and other arrangements. During this stretch of unprecedented changes, many best practices have emerged for making these transactions. Setting clear expectations for the process is essential.

Here are seven principles to follow when guiding your organization through transactions:

1 | KNOW WHAT YOU ARE GETTING INTO

Know what you are getting into from a performance perspective and how to operationalize it. Complete a detailed assessment of practice operations and performance before executing a contract and finalizing a transaction. Not every practice is a good fit, culturally or financially. We witness hospitals and health systems so eager to "make a deal" that they lose sight of the long-term goal of being financially and culturally sustainable for the community they serve. Know that it is appropriate to walk away from a potential deal if it is not a good long-term fit.

2 | ONE SIZE DOES NOT FIT ALL, SO BE CREATIVE

If you have seen one physician deal, you have seen one physician deal. They are never the same. Each deal is unique because each involves different people with different personalities, goals, and personal aspirations, and different organizations with different cultures, strategies, and organizational objectives. A cookie-cutter approach does not work in terms of compensation and financial structure or fair market value assessment and determination. Though you should have standards and parameters around your compensation structure, you definitely do not want 50 different compensation models either. There should be flexibility with the system to tailor the structure such that the right incentives are put in place. Parameters and standards are a must, but don't let them get in the way of doing what is needed.

From a structure perspective, many factors influence the compensation arrangement. If the physicians are steadfastly against employment and want to maintain a certain level of independence or to maintain identity or flexibility to provide services in other areas or markets, perhaps a Professional Services Agreement is the best alignment approach. If bringing multiple groups together to positively affect inpatient service line outcomes, efficiency, quality, and patient satisfaction is the purpose, then Co-Management may be the appropriate structure.

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For a soon to be employed physician practice that you wish to lead your primary care outreach efforts, a pure eat-what-you-kill Work Relative Value ("wRVU") focused model is not likely to achieve the results you desire. The physicians are not going to be motivated to leave locations of known volume for locations where volume is unknown, if the compensation is not appropriately structured. Likewise, a significant emphasis on quality-based financial incentives is not going to achieve desired results when driving patient volume is the true intent.

Most people do not think of creativity when they think of fair market value. Truth is, fair market value assessment and determination requires creativity. The first type of creativity involves combining or blending multiple sources. We have experienced many organizations that rely on a single source (i.e., MGMA or AMGA) for their internal fair market value evaluations. According to Phase III of the Stark Law, "Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating fair market value." Not only is evaluating multiple sources the most prudent approach from a business perspective, but it is also the most compliant.

While evaluating multiple surveys is clearly necessary, it might also be appropriate to evaluate various data sets within those surveys (i.e., by geographic region, rural versus urban, or hospital owned versus physician owned). Additionally, for arrangements such as Professional Services Agreements with independent groups, benchmarking and fair market value analysis may require incorporation of comparable data for benefits and malpractice costs. In other cases, perhaps other operational and overhead costs need to be considered, such as billing and collections resources, or technology costs for telemedicine services/coverage must be incorporated.

Finally, new, nontraditional, and/or multifaceted services such as telemedicine coverage and neurohospitalist or surgicalist services may require additional creativity and the utilization of a variety of sources and data sets. Data sets such as clinical hourly rates, medical director compensation data, call coverage rates (unrestricted or restricted), and per procedure rates may apply. An experienced valuator knows the nuances and limits of each type of data and knows how best to utilize the data sets and sources to document fair market value.

3 | BE FLEXIBLE AND WILLING TO COMPROMISE

As previously stated, you need to be willing and able to walk away from a deal if necessary. Certain points are deal breakers, upon which negotiation is not possible – sometimes not permissible. You must be clear to yourself, your team, and the physician(s) what points are nonnegotiable. That said, in most situations there are certain points that are not deal breakers, and you must be willing to compromise in certain areas. Very rarely does the end deal look exactly like the deal when discussions started, so do not be so rigid as to "throw the baby out with the bathwater." Also, be careful in crafting Letters of Intent ("LOIs") to not lock yourself into anything that you are going to have to walk back down the road.

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4 | GET TO KNOW AND UNDERSTAND INDIVIDUAL MOTIVATIONS AND GOALS

While basic, it is important to know the motivation(s) and goal(s) of each party. If goals do not align between the two parties, frustrations and unmet expectations will surface that can hinder the ongoing relationship. Being explicit upfront will help set the stage for open and honest communication throughout the relationship. Also, set reasonable and realistic timeline expectations, give the parties time to talk and get to know each other.

5 | DEVELOP A SHARED VISION FOR THE FUTURE OF THE RELATIONSHIP

It is crucial to the future success of the relationship to develop a shared vision for the relationship and make sure the physicians understand and buy into their role in the organization's vision of the future. Doing so reduces confusion and speculation while increasing communication and accountability. A shared vision is the cornerstone for a successful relationship and mutually successful entities (practice and hospital). These shared expectations create future behavioral norms.

6 | DON'T NEGLECT FAIR MARKET VALUE AND COMMERCIAL REASONABLENESS PARAMETERS

Never lose sight of fair market value or commercial reasonableness when structuring financial arrangements and components of deals with physicians. Just like knowing your deal breakers upfront, having preestablished fair market value parameters and standards are extremely valuable and can save time and headache. These include use of multiple surveys, as highlighted under number 2 above, and requirements and thresholds for internal versus external audits and reviews.

According to Integrated Healthcare Strategies (IHS) 2018 Physician Compensation and Production Survey Report, "23% of surveyed organizations require an external audit for compensation above the 75th percentile, while 32% are triggered for compensation above the 90th percentile. Twenty-one percent (21%) look to compensation to production ratios that are above 'market.' While 24% evaluate various other factors."

While determining fair market value for physician compensation can be as much art as it is science, having predetermined standards and consistencies are a must. At HSG, two of our staples are 1) guaranteed (or base) compensation, absent unique and warranted circumstances, not to exceed the 75th percentile (above the 75th, even above the 90th can be warranted in unique situations and compelling circumstances); and 2) absent compelling factors, compensation-to-production alignment such that compensation does not exceed production levels (based on use of multiple sources) by more than 10 percentile points.

Finally, be cautioned in using survey published physician compensation-to-production ratios as a basis for bonus conversion factors. These ratios are usually not published bonus factors. In other words, the surveying companies did not ask the organizations or individuals taking the survey to provide the bonus factor they use in their physician contracts. Rather, the surveyors have typically divided reported compensation by reported production (i.e., wRVUs) to calculate a ratio. For physicians or advanced practitioners with guaranteed

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or straight salaries, relatively high compensation divided by low production equals a high ratio (i.e., a 75th to 90th percentile ratio). Using 75th to 90th percentile ratios (and often median to 75th) can result in significantly misaligned compensation to production.

A better approach is to create your own ratio by dividing reported compensation by reported production (i.e., 25th compensation divided by 25th production, median compensation divided by median production, and so on). The result will yield ratios that will provide much more acceptable and sustainable alignment.

7 | FAIR MARKET VALUE DOES NOT EQUAL FINANCIAL SUSTAINABILITY

Again, no two physician deals are ever the same. Each deal is, in today's culture, the equivalent of "keeping up with the Joneses." It is important to remember that every organization's financial well-being is different. While it may be fair market value to provide compensation in the amount of $900,000 to an experienced and highly productive neurosurgeon, it may not be financially sustainable for an organization. Many factors play a role in determining the level of compensation that is affordable and sustainable on a long-term basis, including community need, demand, payer mix, and the hospital's capabilities. As the saying goes, "just because you can, does not mean you should."

CONCLUSION

Hospital-physician relationships have always been complicated. Today's health care environment of integration, value, quality, team-based care, shared risk, bundled payments, etc., does not permit these relationships to be any less complicated. No matter where you are in your employed physician network's life cycle or the complexity of your relationship with an independent practice, HSG has the experience and expertise to help you navigate potentially choppy waters and provide sound advice in your physician transactions.

For more information, or if you'd like to discuss your current physician transaction methodology, email Neal Barker or call (502) 814-1189.

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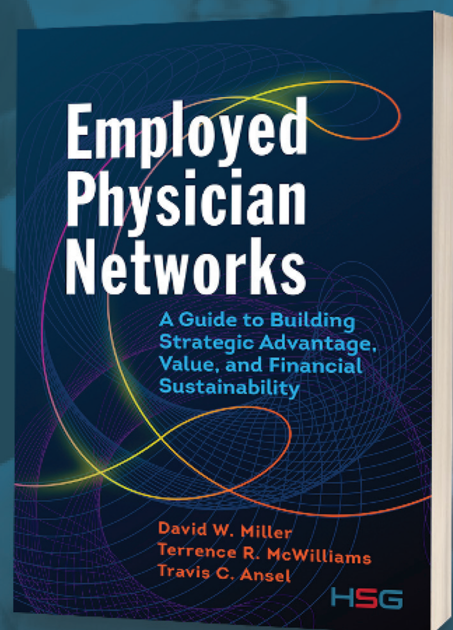

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