HEALTH CAPITAL Topics

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In this issue

Pay for Performance (P4P): Who Gets to Decide?

The accelerating movement from the traditional U.S. health benefits coverage system of "*defined benefits*" (where employers provide a package of defined benefits to their employees) to a system of "*defined contributions*," (where employers contribute a set amount and then require employees to decide how much of their health benefit dollars to spend by selecting from a range of benefit plans), is being driven by employers seeking to limit cost increases significantly above other inflation indices. This "*sea-change*" in the US Healthcare delivery system represents a fundamental shifting of the financial risk of health coverage from the employer to employees, which presents both challenges and opportunities for healthcare providers, based on the fundamental underlying factors of quality, convenience of services provided, and access for patients and their families, who will now be more directly involved in the "*purchase and payment*" decision continuum.

These changes come in the wake of an ongoing national controversy over several recent studies finding that medical errors are a leading cause of death in the U.S., and the resulting demands waged by both private and public payors regarding accountability of providers. The Institute of Medicine's ("IOM") 1999 study reported that as many as 44,000-98,000 deaths may be directly linked to medical errors.[3]

Indeed, deaths related to preventable adverse events exceed deaths attributable to motor vehicle accidents, breast cancer or AIDS.[4] Over the last several years, the IOM report and others have increased public awareness of medical errors.[5] A recent study by the U.S. Agency for Healthcare Research on eighteen types of hospital complications "*sometimes caused by medical errors*" found that "*postoperative infections, surgical wounds accidentally opening and other often-preventable complications lead to more than 32,000 U.S. hospital deaths and more than $9 billion in extra costs annually.*"[6]

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This transparency and full disclosure to the public regarding provider fees, quality and other information related safety and medical errors, will significantly impact the future of the healthcare delivery market. In this market milieu, niche providers, who have a

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[3] "To Err is Human: Building a Safer Health System" Edited by Linda T. Kohn, Janet M. Corrigan and Molla S. Donaldson, Committee on Quality Health Care in America, Institute of Medicine, 1999, p. 1.

[4] "To Err is Human: Building a Safer Health System" Edited by Linda T. Kohn, Janet M. Corrigan and Molla S. Donaldson, Committee on Quality Health Care in America, Institute of Medicine, 1999, p.

[5] "New Push After Transplant Tragedy – Hospitals Search for Ways to Prevent Errors, Help Doctors Learn From Others" DoctorQuality, Oct. 1, 2003).

[6] "Med complications may cost $9B per year." Yahoo! News, Oct. 7, 2003.

Pay for Performance

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reputation for quality, convenience, and quick turn responsiveness to patient needs, pose an even more formidable competitive challenge to more established provider systems in the healthcare marketplace. However, several fundamental questions arise concerning the potential risks associated with this apparent paradigm shift to patient "*pay for performance*" (P4P), e.g.; (a) who decides what "*performance*" is and who will measure what "*performance metrics*" are achieved; and, (b) more importantly, without an accurate, comprehensive, and uniform quality reporting system currently in place, there exists the opportunity for market oligopoly healthcare and insurance providers to manipulate the currently voluntarily reported physician quality data in furtherance of their own market control and profit agendas, thereby further detracting from physician autonomy and eroding physician control over their own quality and treatment protocols.

The Centers for Medicare and Medicaid's (CMS) April 2005 "*Physician Group Practice Demonstration*", which offered participating physician practices financial "*reward*" payments for improvements made in quality and cost-efficient healthcare delivered to Medicare fee-for-service beneficiaries.[7] While initially viewed as a positive step in addressing the medical error epidemic plaguing the U.S., there is a growing concern as to the great potential for abuse of this voluntary reporting system. As stated in a recent *New England Journal of Medicine* November 2006 article,;

"Perhaps the greatest fear is that implementation of pay for performance could cause more harm than good. For instance, unless physicians are firmly convinced that risk adjustment is sufficient, they could decide that the easiest way to achieve high scores is to avoid sick of challenging patients (those who need them the most); systems serving the disadvantaged could see their revenues fall (undermining our tattered safety-net programs); and the emphasis on financial incentives could further undermine morale and the core professional value of altruism that is already threatened by the increasing commercialization of medicine."[8]

Perhaps the best prescription for understanding the impact of P4P is to "*stay tuned for further updates*."

Stark II, Phase III Regulations

On September 5, 2007, CMS issued the final rule establishing the Stark II, Phase III regulations, which contains many changes that are predicted to have a significant impact on existing, as well as future, healthcare provider relationships.[9] The changes with perhaps the most significant expected impact are those related to provider compensation arrangements. To comply with the Stark regulations, entities with certain financial arrangements must be classified as having an indirect compensation arrangement or fall within one of the Stark exceptions. One requirement, as set out in the phase I regulations, stipulated that there exist at least two financial relationships in between the physician and the designated health services (DHS) entity. The Phase III regulations change the definition of an indirect compensation arrangement so that physician members, employees and contractors of the *physician organization* are now deemed to have identical (i.e. direct) compensation arrangements as the physician organization itself. A hospital that has a contract for professional services with a physician group (considered indirect under the Phase I regulations because there was a financial relationship between individual physicians and their group practice as well as a relationship between the group practice and the hospital) is considered to have a direct compensation arrangement. The effect of this change is that a physician organization will not be considered an intervening entity for purposes of establishing an indirect compensation arrangement, and to avoid Stark liability will need to fall within a different Stark exception.[10]

If a valid indirect arrangement agreement was signed prior to September 5, 2007, CMS will allow this arrangement to continue until the term of the arrangement expires. It should be noted that this change only applies to physician organizations, while other arrangements, e.g., an arrangement between a DHS entity, a leasing company, and a physician are analyzed as an indirect compensation arrangement.[11]

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[7] "Medicare Physician Group Practices: Innovations in Quality and Efficiency," The Commonwealth Fund, http://www.cmwf.org/publications/publications_show.htm?doc_id=428880, (Accessed 12/28/06); "CMS Large0Group P4P Demonstration Resulting in Enhanced Care, Physician Changes," Healthcare Financial Management Association News, December 6, 2006 (Accessed 12/18/06)

[8] "Paying for Performance – Risk and Recommendations," By Elliott S. Fisher, M.D., M.P.H., Perspective, the New England Journal of Medicine, www.nejm.org, November 2, 2006.

[9] "Phase III Regulations Result in Dramatic Changes to Stark Law," J. Kelly Barnes, et al., BNA Health Law Reporter, Vol. 16, No. 40, October 11, 2007, p. 1220.

[10] "Phase III Regulations Result in Dramatic Changes to Stark Law," J. Kelly Barnes, et al., BNA Health Law Reporter, Vol. 16, No. 40, October 11, 2007, p. 1220.

[11] "Phase III Regulations Result in Dramatic Changes to Stark Law," J. Kelly Barnes, et al., BNA Health Law Reporter, Vol. 16, No. 40, October 11, 2007, p. 1220.

Under Arrangement Per Click & Block Leases

Certain physician - hospital relationships referred to as *"under arrangements"* and *"per click"* leasing ventures have come under increasing regulatory scrutiny. An under arrangements transaction occurs when the hospital contracts with a third party (typically a joint venture owned, at least in part, by physicians who may refer) to provide a hospital service, and the hospital then bills and is reimbursed by Medicare for those services and pays the supplier, or joint venture.

Under per-click or block leasing arrangements, hospitals lease equipment and facilities to a physician group for specific time blocks, or share space and equipment with other lessees.[12] The physicians using the facility pays a small lease fee, and then the physician bills the payor as if the physician provided the services, keeping the monetary difference between the lease payment and insurance reimbursement. Through the arrangement, the technical fee that used to be paid solely to the imaging center is now being shared with the referring physicians.[13]

Currently, this type of "*arrangement*" is permitted under Stark as the "*entity*" to which the physicians refer patients is the hospital, not the joint venture, i.e., the "*entity*" is deemed to be the entity that submits the reimbursement claim to Medicare.[14] However, buried in the July 2, 2007, 2008 Medicare Physician Fee Schedule proposed rule, CMS has included revisions to the Stark regulations which would prohibit space and equipment lease arrangements where per-click payments are made to a physician lessor who refers patients to the lessee.[15] Specifically, CMS has proposed to broaden the definition of "*entity*" to include the person or entity that performs the designated health services. Of note, CMS has criticized certain types of these arrangements as "*inherently susceptible to abuse because the physician lessor has an incentive to profit from referring a higher volume of patients to the lessee*." The public comment period expired on August 31, 2007, however the final rule has not yet been released. While the proposed Stark provisions contained in the 2008 Physician Fee Schedule proposed rule do *not* appear to currently apply to arrangements where the physician is the lessee and rents space from a hospital or other entity on a per-click basis, CMS is considering whether or not to prohibit these arrangements as well.

Increased Scrutiny of Physician Compensation Arrangements[16]

On September 27, 2007, the Office of Inspector General (OIG) issued Advisory Opinion No. 07-10 regarding physician compensation for providing on-call coverage, stating that the key inquiry for determining whether the compensation arrangement for providing emergency on-call coverage violates the anti-kickback statute "*is whether compensation is: (i) fair market valuein an arm's length transaction for actual and necessary items or services; and, (ii) not determined in any manner that takes into account the volume or value of referrals or other business generated between the parties.*"

The subject arrangement involved a non-profit hospital experiencing a shortage of physicians providing emergency department and follow-up care due to the high volume of indigent patients unable to pay for services. Some hospitals have responded to certain specialists' refusal to provide services without compensation by paying per diem rates to physicians who entered into a two (2) year contract to provide care in the emergency department.

While the OIG found that the subject arrangement did *not* fit the safe harbor for personal services and management contracts because the amount of compensation was not set in advance and varied monthly, the compensation arrangement was deemed low risk because: (1) the per diem rates were at fair market value without regard to referrals, and the physicians were required to treat the patient until discharge with no additional compensation. Physicians were also required to treat any patient that entered the emergency department, and had to annually volunteer uncompensated time as well; (2) since the emergency department was understaffed prior to on-call compensation, the likelihood that the arrangement was instituted to provide remuneration to physicians for referrals was minimized; and (3) since all physicians were required to work the same number of hours each month, majority of payments.

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[12] "Outpatient Imaging Centers: Building Blocks for Survival," By Tor Valenza, Imaging Economics, April 2007; "Accreditation Ensures Quality, Guarantees Payment," By Dana Hinesly, Imaging Economics, March 2007.

[13] "Assault on Lease Deals Could Bring Their Demise," Anne M. Haule, Diagnostic Imaging, April 2007, p. 1.

[14] "Potential Impact of 2008 Medicare Physician Fee Schedule Proposed Rules on Imaging Arrangements," By Thomas W. Greeson and Health M. Zimmerman, Reed Smith LLP, Health Lawyers Weekly, available at http://www.reedsmith.com/_db/_documents/Potential_Impact_of_2008_Medicare_Physician_Fee_Schedule.pdf (Accessed 9/25/07).

[15] "Potential Impact of 2008 Medicare Physician Fee Schedule Proposed Rules on Imaging Arrangements," By Thomas W. Greeson and Health M. Zimmerman, Reed Smith LLP, Health Lawyers Weekly, available at http://www.reedsmith.com/_db/_documents/Potential_Impact_of_2008_Medicare_Physician_Fee_Schedule.pdf (Accessed 9/25/07).

[16] "Advisory Opinion No. 07-10," Office of Inspector General, Department of Health and Human Services, September 27, 2007, p. 1-12.

ASC Payment Structure Revision

On July 16, 2007, CMS issued a final rule revising the payment structure for ambulatory surgery center (ASC) reimbursement, which allows ASCs to be paid for any procedure not requiring an overnight stay that CMS determines does not pose a significant safety risk to Medicare beneficiaries by being performed in an ASC and that does not require an overnight stay. It is expected that an additional 790 procedures will be available to beneficiaries beginning in 2008 because of this rule.[1]

New ASC Payment System

Beginning in 2008, CMS is implementing a revised ASC payment system using the hospital outpatient prospective payment system (HOPPS) as a guide, whereby CMS has in the proposed rule set the payment rates for independent free-standing ASC at sixty-five (65) percent for the 2008 implementation. of the OPPS rates for the same procedures performed in a hospital outpatient department (HOPD) setting.[2] Those ASC services that are currently paid at higher than 65% of the HOPPS rate will face significant cuts in reimbursement, for procedures in such specialties as. gastroenterology.

[1] "CMS Revises Payment Structure for Ambulatory Surgical Centers and Proposes Policy and Payment Changes for Hospital Outpatient," Centers for Medicare and Medicaid Services, July 16, 2007, http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2285&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=false&cboOrder=date (Last Accessed October 23, 2007).

[2] "CMS Revises Payment Structure for Ambulatory Surgical Centers and Proposes Policy and Payment Changes for Hospital Outpatient," Centers for Medicare and Medicaid Services, July 16, 2007, http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2285&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=false&cboOrder=date (Last Accessed October 23, 2007).

Potential Impact of CHAMP Section 651 Provisions on Valuation

The July 2007 Federal reauthorization of the State Children's Health Insurance Program (SCHIP) under the Children's Health and Medicare Protection Act of 2007 (CHAMPS) passed by the US House of Representatives [Bill # H.R.3162] contained initiatives in Section 651 aimed at eliminating the *whole hospital exception*. Although these provisions were not included in the final legislation vetoed by President Bush, there are indications that Section 651 language will again be proposed and, if enacted as part of future legislation, these provisions would have significant effects on physician investment time horizons and the valuation of surgical and specialty hospital enterprises.

Specifically, the CHAMP Section 651 provisions may obviate the economic ownership interests of physicians in legally held property under the valuation standard of *Fair Market Value* and the valuation premise of *value-in-use as a going concern*, resulting instead in lower values under the premise of *value-in-exchange* through *forced liquidation* (in contrast to orderly disposition) because of the insufficient exposure to market due to the 18 month compliance period.

"CHAMP Section 651 provisions may obviate the economic ownership interests of physicians in legally held property"

Additionally, CHAMP Section 651 provisions would put subsequent remaining physician investors' holdings in a minority position, resulting in an inability of physicians to control invested capital. The resulting lack of physician -investor control could affect investors' perceptions as to *risk* of the subject enterprise as related to future quality of care; convenience of provider and patient scheduling; and, the enterprise's ability to incorporate future technological innovations into the venture. There is also the possibility of the loss of significant intangible asset value related to highly qualified, trained and assembled workforce in place, which physicians have excelled in developing, if physician participation in the surgical hospital investor pool is limited or prohibited, and general hospital systems or corporate buyers (to whom such workforce may be considered redundant) remain as the most probable owners.

With enactment of the proposed CHAMP Section 651 provisions, there may also be significant disruption of loan covenants guaranteed by physicians and their group medical practices which have invested in existing physician invested enterprises. This may have the unintended cascade-like consequence in visiting a catastrophic financial impact on the viability of those physicians' medical practices and may also result in personal loss of physician credit standing. Consequently, this may, in some cases, have an impact on the ability of physician owned facilities to maintain liquidity and, ultimately, creditworthiness and solvency, due to the disruption of working capital necessary to meet financial obligations, including the deleterious impact on the capital structure of physician invested hospitals resulting from the forced liquidations of physician equity which would change the balance of working capital and related lines of credit.

It should be noted that, aside from the proposed CHAMP Section 651 provisions, several states are also now moving forward with their own initiatives to limit physician ownership in surgical hospitals and other specialty providers, through such means as *Certificate of Need* (CON) and State self-referral regulations.

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Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, serves as President of **HEALTH CAPITAL CONSULTANTS** (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

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Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious "*Shannon Pratt Award in Business Valuation*" conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows.

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