Management Services Agreements

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This article briefly discusses the current trends in the practice management industry, as these trends may directly and indirectly affect both the management company and the healthcare entity. This overview of the services provided by practice management groups, is followed by a discussion of the competitive, reimbursement, regulatory, and technological environments in which practice management groups operate.

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Introduction

In consideration of the fair market value (FMV) for the provision of professional management services, this article briefly discusses the current trends in the practice management industry, as these trends may directly and indirectly affect both the management company and the healthcare entity. This overview of the services provided by practice management groups, is followed by a discussion of the competitive, reimbursement, regulatory, and technological environments in which practice management groups operate.

Overview of Practice Management Services

Medical practice management may be defined as "a growing business strategy intended to help [organizations] overcome the challenges of fluctuating markets and adapt to the ever-evolving needs of consumers."[1] Medical practice management companies, also known as management service organizations (MSO), carry out a variety of duties, including those related to:

1. Financial management
2. Business operations
3. Human resources management
4. Information management
5. Organizational governance
6. Patient care systems
7. Quality management
8. Risk management[2]

Although the foundation of practice management is to ensure that the healthcare entity is effectively carrying out day-to-day operations,[3] it is equally important that an MSO enables the entity to have the flexibility to adapt to market changes.[4]

Competitive Environment

Practice management has become popular in recent years among healthcare entities, due to pressures within the healthcare industry to reduce costs, implement new technologies, and comply with increasingly complex regulations.[5] Three (3) main types of MSO companies exist, including:

1. Large multi-specialty groups, which are publicly funded through stock
2. Large single-specialty groups, which receive investment from private equity funds
3. "Under the radar" larger single-specialty groups, which are often funded through private financing, such as loans or private investment, but are not large enough for market interest[6]

In the mid-1990s, many MSOs started investing in both independent physician practices and hospital-based physician groups; however, by 2002, 80 percent of the top ten public MSOs were in bankruptcy after failing to reach financial benchmarks.[7] It was not until after the 2010 passage of the Patient Protection and Affordable Care Act (ACA) that MSOs regained popularity, in part due to the ACA's restructuring of payment and delivery models, such as bundled payments and ACOs.[8] Not only are MSOs becoming more common, but they are also becoming larger, and raising capital for buyouts.[9]

Reimbursement Environment—Management Services Fees

There are a number of payment arrangements that an MSO can make with healthcare entities in regard to compensation for its services. Payment arrangements between an MSO and a healthcare entity include, but are not limited to: (1) fixed fee arrangements; (2) a percentage of an entity's revenues or profits; (3) a portion of cost savings that the MSO helped the entity realize; and, (4) a combination of the models listed above.[10] MSOs must be cautious as to what compensation arrangement will be made between itself and a healthcare entity, as such arrangements may be in violation of state laws that mandate how an MSO may structure its agreements.[11] For example, in New York, the New York State Department of Health questioned several hypothetical MSO payment arrangements, including: (1) "per visit" fees; (2) actual cost plus mark-up fees; and, (3) percentage of collection fees.[12]

Regulatory Environment

Healthcare enterprises face a range of federal and state legal and regulatory constraints, which affect their formation, operation, procedural coding and billing, and transactions. Federal fraud and abuse laws, specifically those related to the Anti-Kickback Statute (AKS) and physician self-referral laws (the Stark Law), may have the greatest impact on the operations of healthcare organizations. For example, MSOs must be particularly careful not to violate AKS through its fee structure. In a 1998 advisory opinion, the Office of Inspector General (OIG) expressed concern regarding MSOs receiving payment as a percentage of collections or revenue while performing marketing services.[13]

In addition to fraud and abuse laws, almost all states have provisions against the corporate practice of medicine (CPM).[14] Although the regulated content of CPM provisions vary across states, these laws generally prohibit unlicensed individuals or corporations from engaging in the practice of medicine by employing licensed physicians.[15] CPM was established with the intent of ensuring that licensed physicians could practice medicine without pressure from a lay person or being "subject to commercialization or exploitation."[16] CPM laws typically include exceptions, such as provisions allowing physicians to provide medical services via a professional corporation.[17] In summary, CPM laws dictate what type of relationship healthcare entities may have with physicians (i.e., employment versus independent contractor).[18]

Technological Environment

Research indicates that implementation of health information technology (HIT) may lead to improved efficiency and quality management.[19] HIT includes a variety of computer applications, such as billing software, staffing models, and electronic health records (EHR).[20] In recent years, there has been a rapid adoption of technological innovations in the U.S., largely due to regulatory and reimbursement changes in healthcare. The now ubiquitous presence of EHR in healthcare has fundamentally changed the way that healthcare is delivered.[21] Namely, EHRs are essential to data collection needed for compliance with the expanding number of initiatives related to value-based care reporting and clinical outcomes analysis,[22] which could financially benefit an MSO depending on the MSO's fee structure.

A practice management system (PMS) is software used by healthcare entities that has the ability to automate some of the recurring tasks that burden healthcare providers.[23] PMSs are typically used for administrative and financial tasks and are utilized most by small to medium-sized providers.[24] By automating these time-intensive tasks, physician and provider groups are able to operate more efficiently.[25] As of January 1, 2014, all public and private healthcare providers were required to adopt and demonstrate "meaningful use" of EHRs to maintain their existing Medicare reimbursement levels.[26] Of note, financial incentives to utilize EHRs as part of the "meaningful use" program was merged into the Merit-based Incentive Payment System (MIPS), a value-based reimbursement program implemented under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[27] Because of the increased use of EHRs and the overlap with PMSs, some providers may integrate the two, which may serve to streamline the workflow, resulting in higher revenues.[28]

With increased administrative burdens within the healthcare industry, more provider groups are opting for revenue cycle management (RCM) systems, designed to improve efficiencies and enhance financial performance.[29] RCM systems are more comprehensive than medical billing software in that they also include claim processing, denial management, patient payment, and revenue generation capabilities.[30] RCM systems can either be outsourced to an external vendor, or used in conjunction with an internal EHR system.[31] It is important to note that with the current shift in the reimbursement environment, from volume-based to value-based payment, RCM systems will now need to track and submit both cost and quality data, as well as accurately administer compensation based on the performance of these metrics.[32]

Valuation Considerations

There are numerous, generally accepted healthcare valuation approaches, methods, and procedures that may be utilized in the valuation of MSOs. The choice of approach(es) or method(s) depends primarily upon the purpose of the valuation report and the specific characteristics of the services being appraised. The objective and purpose of the engagement, the standard of value, the premise of value, and the availability and reliability of data must all be considered by the valuation analyst in the selection of applicable approaches and methods.

In addition to determining the FMV of management services, a valuation engagement may also include the opinion of the commercial reasonableness of the management services agreement (MSA) arrangement. While separate and distinct from the regulatory threshold related to the standard of FMV, the threshold of commercial reasonableness is critical to establish the legal permissibility of a subject healthcare transaction, and may be subject to a similar level of scrutiny by the Internal Revenue Service (IRS) and the OIG. The key components of a commercial reasonableness analysis include both a consideration of the qualitative factors that affect the commercial reasonableness opinion (e.g., the business purpose of the professional medical practice and the necessity of MSA, the experience and expertise of the MSO, various enterprise and organizational elements of the medical practice), as well as a quantitative analysis of the elements of the MSA.

Practice Management Industry Outlook

MSOs may face several challenges in the near future. The aging baby boomer population, and the associated rise in the number of chronic conditions suffered by this cohort, is expected to increase the number of individuals requiring services provided by healthcare providers in subsequent years, which may drive growth within the PM industry.[33] The primary challenge of MSOs may be staying compliant with current laws and regulations. For instance, the fee charged by an MSO to a physician group must be at FMV and be commercially reasonable, as to not violate federal and state Anti-Kickback, Stark, or CPM laws.[34] Further, professional physician practices may face an uncertain reimbursement environment, as public payors, notably Medicare and Medicaid, are switching from volume-based to value-based models of reimbursement.[35] In order to cope with uncertain reimbursement policies, as well as a potential increase in demand, healthcare entities, with the help of MSOs, will likely have to become more efficient, which may be achieved in part through the adoption of HIT.

As evidenced by these trends, the U.S. healthcare environment is complex and rapidly changing; to meet these challenges, successful MSOs must: (1) have expertise in the specialties of the medical practices that they manage; (2) strategically plan for future changes in the industry; (3) regularly assess the practice's performance; and, (4) provide guidance to the practice regarding mergers and acquisitions.[36] In an era of increasing regulatory scrutiny and growing healthcare transaction volume, an FMV and commercial reasonableness opinion, prepared by an experienced and independent valuation firm, can increase the defensibility, and regulatory compliance, of the proposed MSA arrangement.

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