Impact of Competitive Forces

Presenters

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ASA American Society of Appraisers™ Providing Value Worldwide Healthcare Special Interest Group

Friday, May 6, 2016
St. Louis, MO

Presenter Bio

Roger Strode, Esq., is a partner and health care business lawyer with Foley & Lardner LLP where his practice focuses on health care business transactions, including mergers, acquisitions, corporate restructurings and joint ventures, general corporate matters and health care regulation. His experience includes the representation of institutional health care providers (hospitals, health systems and integrated delivery systems), large physician groups, specialty providers (ASC development organizations), health care private equity firms and industry consultants. Mr. Strode is a member of the firm's Health Care Industry Team.

Mr. Strode has participated as lead counsel in numerous health care and corporate transactions, including the purchase and sale, or transfer of sponsorship of hospitals, health systems, physician practices and health maintenance organizations; the formation of specialty hospitals; and the formation of ancillary services joint ventures.

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Presenter Bio

Todd A. Zigrang, MBA, MHA, FACHE, ASA is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 20 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 1,000 transactions and joint ventures involving acute care hospitals and health systems; physician practices; ambulatory surgery centers; diagnostic imaging centers; accountable care organizations, managed care organizations, and other third-party payors; dialysis centers; home health agencies; long-term care facilities; and, numerous other ancillary healthcare service businesses. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "*The Adviser's Guide to Healthcare – 2nd Edition*" (AICPA, 2015), numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Accountant's Business Manual* (AICPA); *Valuing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies*; *Business Appraisal Practice*; and, *NACVA QuickRead*. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Bar Association (ABA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

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The American Society of Appraisers, is an international organization of appraisal professionals, founded in 1952 to provide a comprehensive, profession wide organization for appraisers and valuation engineers.

As a comprehensive body, the ASA pursues accurate valuation for all classes of property and hence examines multiple levels of economic activity. As such, the ASA seeks to foster cooperation between professionals of several valuation disciplines, and this spirit of cooperation may help engender multidisciplinary approaches to the art and science of valuation.

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The *Healthcare Special Interest Group* (HSIG) is a Subcommittee of the ASA's International Education Committee and dedicated to the advancement of multidisciplinary education in healthcare valuation.

HSIG views the field of healthcare valuation as a complex area affecting multiple disciplines and requiring unique approaches for study and solutions. At the same time, the field also holds much promise for those willing to pursue new, multidisciplinary answers an this ever-changing healthcare market environment.

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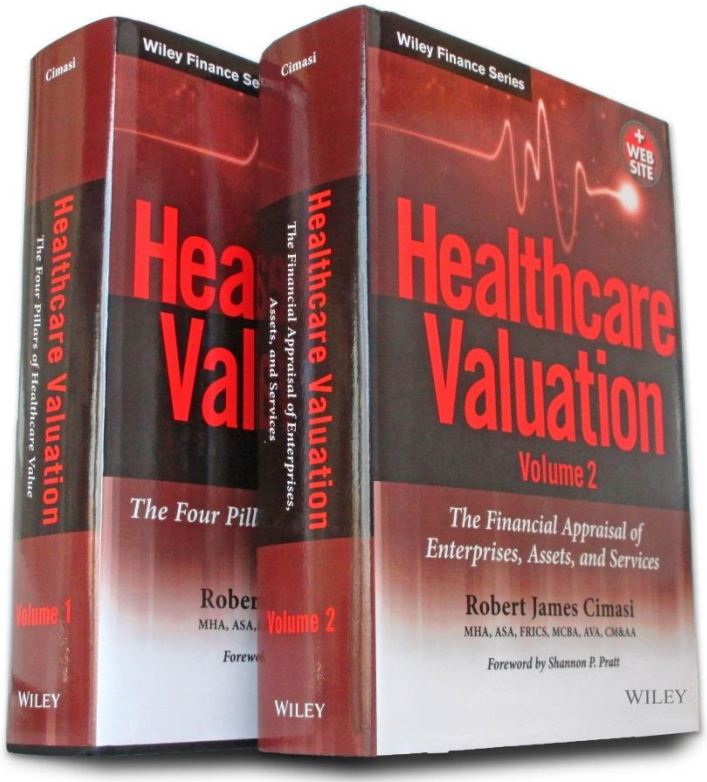
In-Person Course Session Textbook



The course session textbook page reference appears, for your reference, at the top left-hand corner of each slide.

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Overview of the Presentation

- The Economics of Healthcare
- Supply and Demand in Healthcare
- Barriers to Free Market Competition in Healthcare
- Historical Reform Efforts & Their Effect on Competition
- Pressures of Market Competition vs. Community Benefit
- Concluding Remarks

Healthcare Trends: The Four Pillars

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The Economics of Healthcare

The Economics of Healthcare

Healthcare Costs and GDP in the U.S.

- The portion of the U.S. *gross domestic product* (GDP) related to healthcare has risen from 5.0% in 1960 to 17.4% in 2013
  - Predicted to be 19.6% by 2024
- This discrepancy may be caused by the 2008 recession, which had a greater impact on GDP than on healthcare spending
- "…*the relative increase in healthcare costs compared with the rest of the economy is inevitable and ineradicable part of a developed economy. The attempt [to control relative costs] may be as foolhardy as impossible.*"

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"National Health Expenditure Projections 2014-2024" Centers for Medicare and Medicaid Services, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2014.pdf (Accessed 4/22/16); "Three Decades of Government-Financed Health Care in the United States" By Patrick Fleenor, Tax Foundation, August 1994, http://www.taxfoundation.org/files/bd006ece1a4b8166023dbc913175b7b7.pdf (Accessed 11/11/09);"Health Spending Projections Through 2018: Recession Effects Add Uncertainty to the Outlook," By Andrea Sisko et al., Health Affairs, Web Exclusive, Feb. 24, 2009, p. w346. "Do Health Care Costs Matter?" By William J. Baumol, The New Republic, Nov. 22, 1993, p. 16; "Table 1: National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Calendar Years 1960-2013" Center for Medicare & Medicaid Services, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (Accessed 4/21/2015).

The Economics of Healthcare

Factors affecting patient demand for healthcare:

- The aging "*Baby Boomer*" population
- Influx of newly insured individuals entering the market
  - Medicaid Expansion
  - Health Insurance Exchanges

The Economics of Healthcare

Productivity Growth Rates of Healthcare Services

- Three reasons healthcare services experience lower growth rates compared to other industry sectors:
  - Innovation has not made the same impact on healthcare productivity as other industries
  - Healthcare is complicated and local in nature and cannot be delegated to less expensive, unskilled workers
  - Consumers believe quality is correlated with amount of physician labor expended in providing an associated service

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"Do Health Care Costs Matter?" By William J. Baumol, The New Republic, Nov. 22, 1993, p. 17.

Supply and Demand in Healthcare

Supply and Demand in Healthcare

The Healthcare Competitive Model

- Historically, healthcare was dominated by groups of providers who attempted to justify anti-competitive behavior under the guise of quality control
- Laws regulating healthcare delivery system competition have been used to combat prices being set above competitive levels
  - Also used to prevent blocking of new entrants into market
- Under EMTALA, general hospital emergency departments are required to stabilize patients, regardless of the patient's ability to pay

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"Emergency Medical Treatment and Labor Act," 42 U.S.C. 1395dd, Pub. L. No. 111-49; "Could U.S. Hospitals Go The Way Of U.S. Airlines?" By Stuart H. Altman, David Shactman, and Efrat Eilat, Health Affairs, Vol. 25, No. 1, (Jan/Feb 2006), p. 11. "Why Competition Law Matters to Health Care Quality," By William M. Sage, David A. Hyman, and Warren Greenberg, Health Affairs, Vol. 22, No. 2, (March/April 2003), p. 35-36. "Emergency Medical Treatment and Labor Act," 42 U.S.C. 1395dd, Pub. L. No. 111-49; "Could U.S. Hospitals Go The Way Of U.S. Airlines?" By Stuart H. Altman, David Shactman, and Efrat Eilat, Health Affairs, Vol. 25, No. 1, (Jan/Feb 2006), p. 11.

Supply and Demand in Healthcare

Healthcare Services: Supply-Side

- No traditional relationship between supply and demand
- Private payor suppliers are private insurance companies, employers, and large hospital systems
- Payors operate as both suppliers and consumers of healthcare
- Highly concentrated U.S. medical insurance market
- Private payors see premium increases
- Mergers are not seen as creating excessive market concentrations

"Improving Health Care: A Dose of Competition: Executive Summary," A Report by the Federal Trade Commission and Department of Justice, July 2004, p. 5. "Statement of the American Medical Association to the Subcommittee on Health Committee on Ways and Means United States House of Representatives, RE: Health Care Industry Consolidation," American Medical Association, September 9, 2011. "Key Findings from HSC's 2010 Site Visits: Health Care Markets Weather Economic Downturn, Brace for Health Reform" By Laurie E. Felland, Joy M. Grossman, and Ha T. Tu, Center for Studying Health System Change Issue Brief, No. 135 (May 2011), p. 3; "Rising Hospital Employment of Physicians: Better Quality, Higher Costs?" By Ann S. O'Malley, Amelia M. Bond, and Robert A. Berenson, Center for Studying Health System Change Issue Brief, No. 136 (August 2011), p. 3-4. "Antitrust Guidelines for Collaborations Among Competitors" Federal Trade Commission and Department of Justice, April 2000, p. 6."

Supply and Demand in Healthcare

Healthcare Services: Supply-Side

- Smaller hospitals merge with larger ones to remain viable
- The "*geographic expansion race*" - Hospitals are looking to expand and compete for valuable insured patients
  - Acquiring existing full-service hospitals or building new ones
  - Building freestanding ambulatory surgery centers (ASCs)
  - Strengthening relationships with emergency medical transport systems or operating their own
- Patients in lower income communities may not see improvement in access to care

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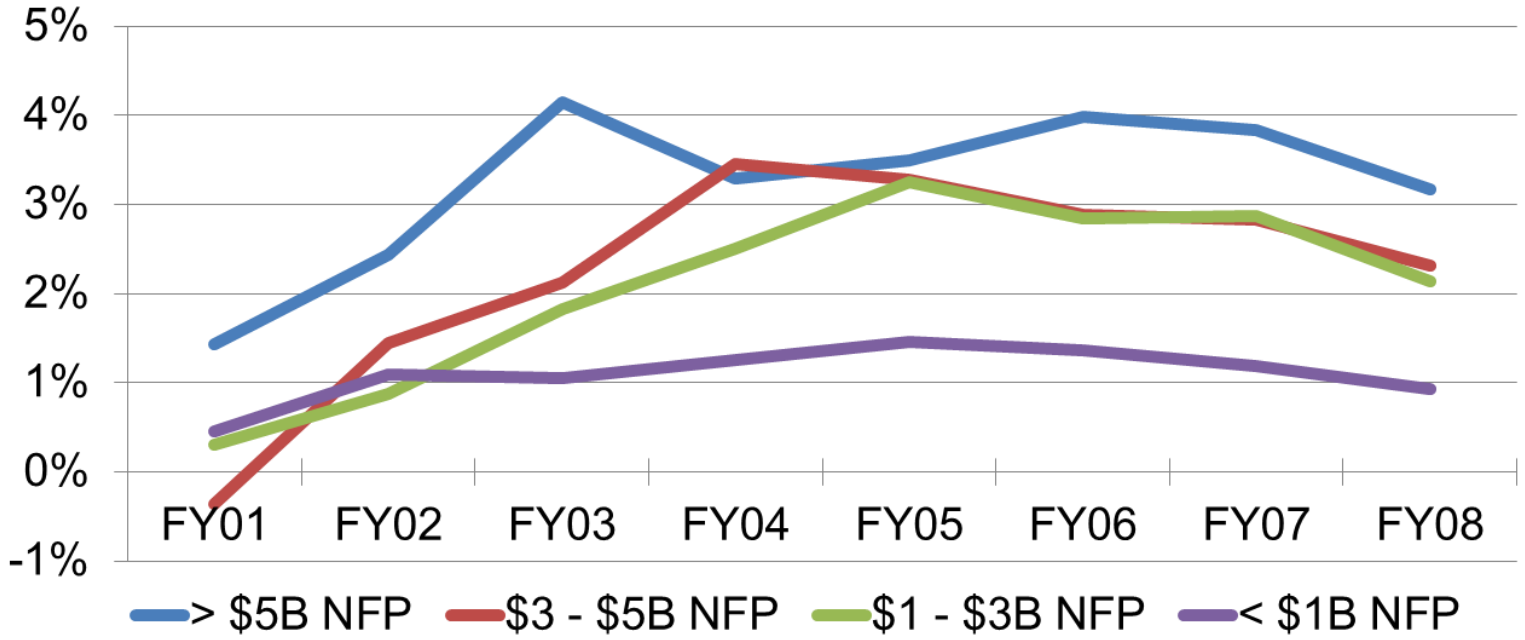
"Competition in Health Care: It's Evolution Over the Past Decade," by Paul B. Ginsburg, Health Affairs, Vol.24, No. 6, Nov/Dec 2005, p. 1521. "Hospitals' Geographic Expansion in Quest of Well-Insured Patients: Will the Outcome be Better Care, More Cost, or Both?" By Emily R. Carrier et al., Health Affairs, Vol. 31, No. 4 (April 2012), p. 827. "Suburban Poverty and the Health Care Safety Net" By Laurie E. Felland, et al., Center for Studying Health System Change, Research Brief, No. 13, July 2009.

Supply and Demand in Healthcare

Scale Matters: Largest Systems Have Clear Advantages



Advantages:

- Lower Supply Costs
- Lower Bad Debt Expense
- More Flexible Management of Labor Expenses
- Lower Cost of Capital
- Leveraging of IT Spending
- Highest Strategic Capital Spending

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"Access to Capital" by Robert Cimasi, David Cyganowski, and Kenneth Kaufman. Moderated by Patrick Ryan, 2009 HIGPA International Expo, Health Industry Group Purchasing Association & Health Industry Supply Chain Institute, Washington, D.C., Oct. 21, 2009, p. 23.

Supply and Demand in Healthcare

Healthcare Services: Demand-Side

- Third party payors shift direct financial risks to a third party who pays for services and management of risks (defined benefits model)
- Consumers are insulated from direct costs of the services needed to manage their health, and therefore most often do not consciously balance costs with benefits when making choices regarding their care
  - Results in an imperfect demand curve
  - Creates the diminishing applicability of a traditional supply and demand model
  - Insurance companies do not reap the full benefit or consequence of care provided

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"Improving Health Care: A Dose of Competition," A Report by the Federal Trade Commission and Department of Justice, July 2004, p. 5.

Supply and Demand in Healthcare

Demand-Side: Emerging Trends

- Many consumers utilizing *health savings accounts* (HSA) and *high deductible health plans* (HDHP)
- Providers now dealing more with patients that are looking at type, cost, and quality of procedures and services
  - Consumers have more impact on demand
- State health insurance exchanges (HIE) are designed to have an impact on competition between private payors
- By providing patients a portal to compare various options for coverage, patients have further impact on demand

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"All About HSAs," U.S. Treasury Department, July 22, 2007, p. 2, http://www.treas.gov/offices/public-affairs/hsa/pdf/all-about-HSAs_072208.pdf (Accessed 7/1/09). "Defined Contribution: From Managed Care to Patient-Managed Care," by E. Haavi Morreim, Cato Journal, Vol. 22, No. 1 (Spring/Summer 2002), p. 112.

Supply and Demand in Healthcare

Physician-Workforce Shortage: Demand Outpaces Supply

- Supply of physicians has not kept pace with demand for healthcare services
  - Gap between supply and demand is projected to increase
- Perceived oversupply in the 1980s, which culminated in an undersupply in the 1990s
- 17% increase in the demand for physicians' services by 2025
  - But the physician-to-population ratio is expected to decline going forward

"National Study of Internal Medicine Manpower" By Lu Ann Aday et al., Archives of Internal Medicine, Vol. 148, 1988, p. 1509. "A Shortage of Physicians or a Surplus of Assumptions?" By Jonathan P. Weiner, Health Affairs, Vol. 21, No. 1 (2002), p. 160. "The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand" Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services, December 2008, p. iv. "Why is There a Shortage of Primary Care Doctors?" Association of American Medical Colleges, https://www.aamc.org/linkableblob/70310-6/data/primarycarefs-data.pdf (Accessed 6/30/12). "Rural Research Focus: Rural Physician Shortages" By George E. Wright et al., Health Resources and Services Administration, ftp://ftp.hrsa.gov/ruralhealth/RRF-RHHA.pdf (Accessed 6/30/12); "The Complexities of Physician Supply and Demand: Projections from 2013 to 2025 Final Report" Association of American Medical Colleges, March 2015, https://www.aamc.org/download/426242/data/ihsreportdownload.pdf?cm_mmc=AAMC-_-ScientificAffairs-_-PDF-_-ihsreport (Accessed 4/21/2015).

Supply and Demand in Healthcare

Physician-Workforce Shortage: Demand Outpaces Supply

- Student interest in primary care field remains low
  - Existing workforce will undergo changes as many primary care practitioners (PCP) will retire in the near-term
  - Geographic differences are expected to exacerbate the problem regionally

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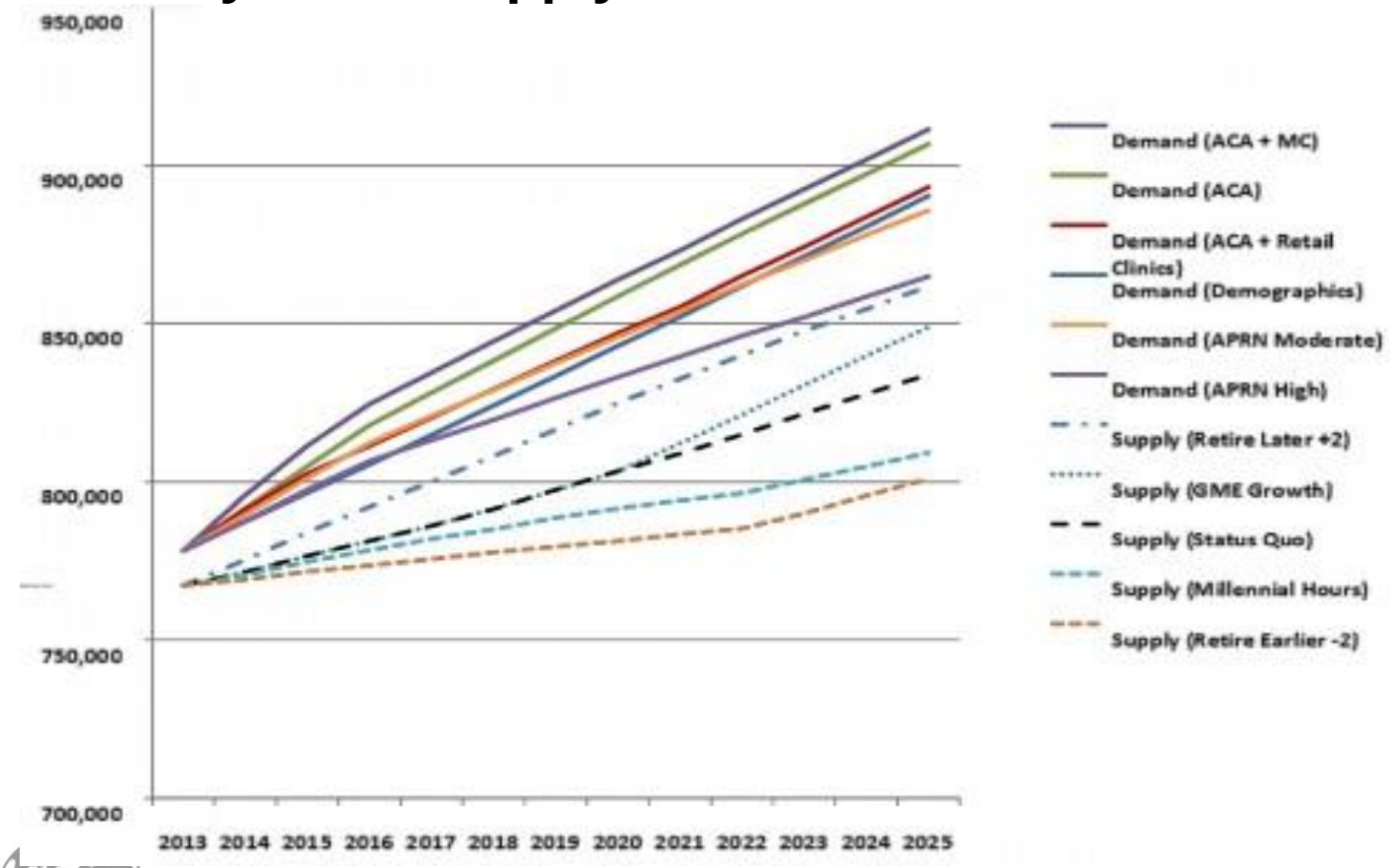
"National Study of Internal Medicine Manpower" By Lu Ann Aday et al., Archives of Internal Medicine, Vol. 148, 1988, p. 1509.
"A Shortage of Physicians or a Surplus of Assumptions?" By Jonathan P. Weiner, Health Affairs, Vol. 21, No. 1 (2002), p. 160.
"The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand" Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services, December 2008, p. iv.
"Why is There a Shortage of Primary Care Doctors?" Association of American Medical Colleges, https://www.aamc.org/linkableblob/70310-6/data/primarycarefs-data.pdf (Accessed 6/30/12). "Rural Research Focus: Rural Physician Shortages" By George E. Wright et al., Health Resources and Services Administration, ftp://ftp.hrsa.gov/ruralhealth/RRF-RHHA.pdf (Accessed 6/30/12).

Supply and Demand in Healthcare

Physician Supply and Demand 2013-2025



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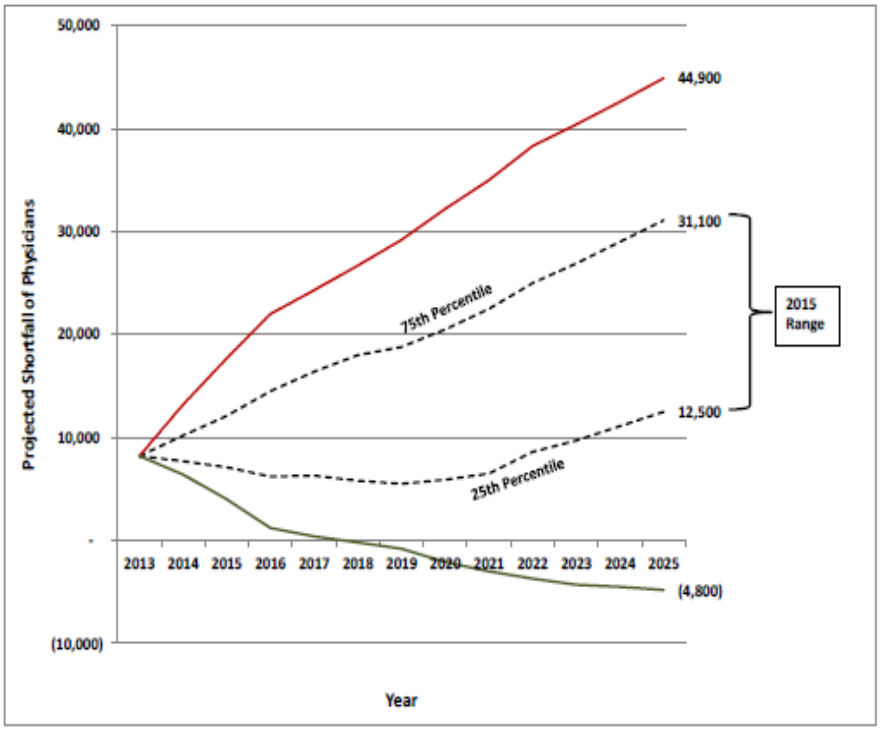
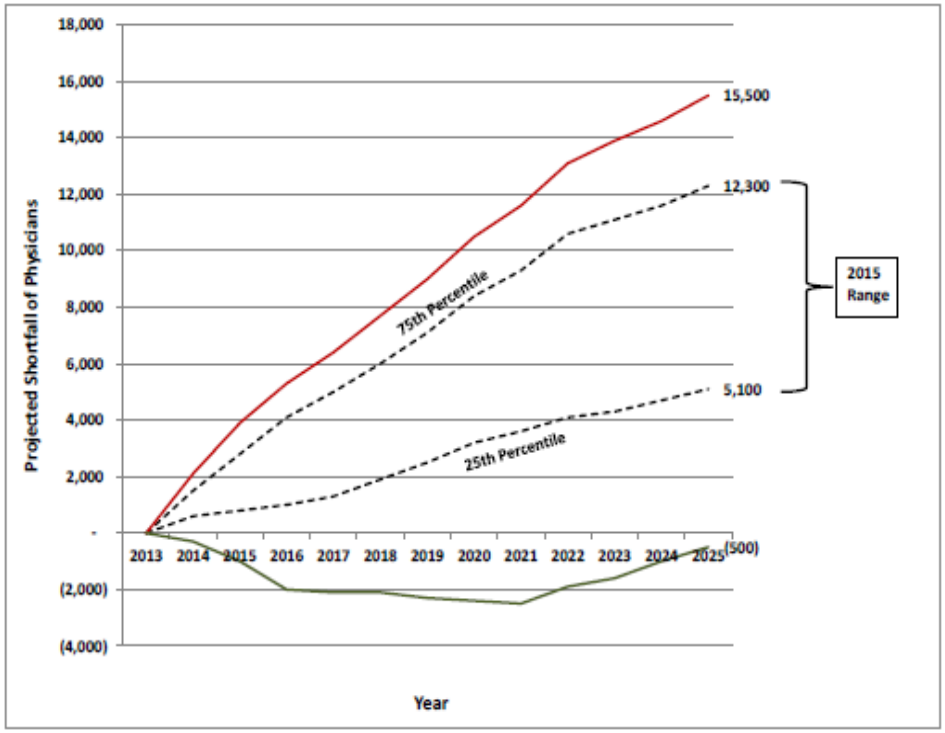
""The Complexities of Physician Supply and Demand: Projections from 2013 to 2025" By IHS, March 2015, https://www.aamc.org/download/426242/data/ihsreportdownload.pdf (Accessed 4/22/16) p. 30.

Supply and Demand in Healthcare

Physician Shortage 2013-2025



Primary Care Physician Shortage



Medical Sub-Specialist Shortage

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""The Complexities of Physician Supply and Demand: Projections from 2013 to 2025" By IHS, March 2015, https://www.aamc.org/download/426242/data/ihsreportdownload.pdf (Accessed 4/22/16) p. 34, 36.

Supply and Demand in Healthcare

Initiatives to curb physician shortage include:

- Increased funding for primary care students
- Increased incentives for physician movement to rural & underserved areas
- Less restrictive & expanded scope of practice laws for midlevel providers
- Expanded use of telemedicine in rural & underserved areas

"Patient Protection and Affordable Care Act" Pub. L. 111.148 (March 23, 2010).

"The Patient Protection and Affordable Care Act" Drinker Binddle & Reath LLP: Health Government Relations Group, April 2010, Accessed at http://www.drinkerbiddle.com/resources/publications/2010/the-patient-protection-and-affordable-care-act?Page=6&Section=SpeakingEngagements&Year=&Practice=0&Attorney=0 (Accessed 10/8/13), p. 2, 5.

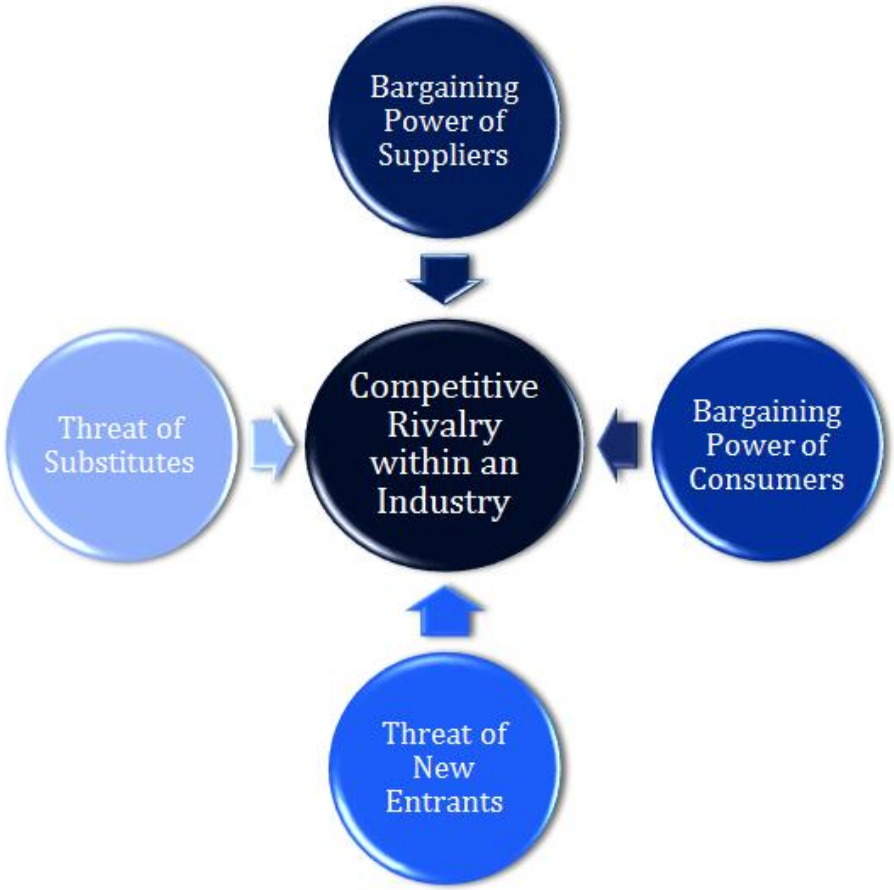
Supply and Demand in Healthcare

- Healthcare workforce continues to diversify to meet demand
  - Mid-level provider population will continue to grow
- Increase number of PCPs in markets
  - Tuition forgiveness and increased reimbursement benefits
- 15 U.S. institutions are developing new medical schools

"Patient Protection and Affordable Care Act" Pub. L. 111.148 (March 23, 2010).

"The Patient Protection and Affordable Care Act" Drinker Binddle & Reath LLP: Health Government Relations Group, April 2010, Accessed at http://www.drinkerbiddle.com/resources/publications/2010/the-patient-protection-and-affordable-care-act?Page=6&Section=SpeakingEngagements&Year=&Practice=0&Attorney=0 (Accessed 10/8/13), p. 2, 5; "A Snapshot of the New and Developing Medical Schools in the U.S. and Canada" Association of American Medical Colleges, 2012, https://members.aamc.org/eweb/upload/A%20Snapshot%20of%20the%20New%20and%20Developing%20Medical%20Schools%20in%20the%20US%20and%20Canada.pdf (Accessed 4/22/16), p. 6-7.

Porter's Five Forces of Competition



"Competitive Strategy: Techniques for Analyzing Industries and Competitors:," by Michael E. Porter The Free Press, 1980, p. 4.

Bargaining Power of Suppliers

- "*Suppliers of products, technology, and services to the health care sector include a wide range of companies producing a vast array of products*..."
- Power is affected by new technologies, standards of care and regulatory initiatives, and geographical reach
- Other suppliers may include:
  - Large employers
  - Landlords
  - Medical supply companies
  - Pharmaceutical companies
  - Billing outsourcers; maintenance firms
  - Insurance companies

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"Redefining Health Care: Creating Value-Based Competition on Results" By Michael E. Porter and Elizabeth Olmsted Teisberg, Boston, MA: Harvard Business School Press, 2006, p. 283.

Bargaining Power of Suppliers

- Bargaining power is directly influenced by the number and type of healthcare suppliers in the market
- Larger health systems with greater patient populations have more negotiating power
- Over the years, we have seen a shift from *"managed care"* to *"managed pay"*
- One of the prevalent types of healthcare industry supplier regulations is the *Food and Drug Administration's* (FDA) regulation of pharmaceuticals

Bargaining Power of Suppliers

Example: Pharmaceutical Industry

- Price of drugs set by Average Wholesale Price (AWP) benchmark
  - Many believe the benchmark is inflated
- The shift toward commercial-driven healthcare affected the bargaining power of pharmaceutical industry suppliers
- In 2013, the largest pharmaceutical company spent more than double its money on promotion than it did on innovation

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"One Pill, Many Prices: Variation in Prescription Drug Prices in Select Government Programs" By Dawn M. Gencarelli, National Health Policy Forum, Issue Brief No 807, August 29, 2005, p. 3, 4. "Pharmaceutical research and development: what do we get for all that money?" By Donald W Light and Joel R Lexchin, British Medical Journal, Aug. 7, 2012, http://www.bmj.com.ezp.slu.edu/highwire/filestream/597113/field_highwire_article_pdf/0/bmj.e4348 (Accessed 10/2/13), p. 2; "Pharmaceutical industry gets high on fat profits" By Richard Anderson, BBC News, November 6, 2014, http://www.bbc.com/news/business-28212223 (Accessed 4/22/16) (referring to Johnson & Johnson spending $8.2 billion on R&D vs. $17.5 billion on sales and marketing).

Bargaining Power of Buyers

- Healthcare services primarily paid for by private or government insurance
  - Most private healthcare insurance purchased through employers
  - Prior to the *Patient Protection and Affordable Care Act* (ACA), businesses did not receive discounts on health insurance plans
    - On average, small firms paid up to 18% more in premiums

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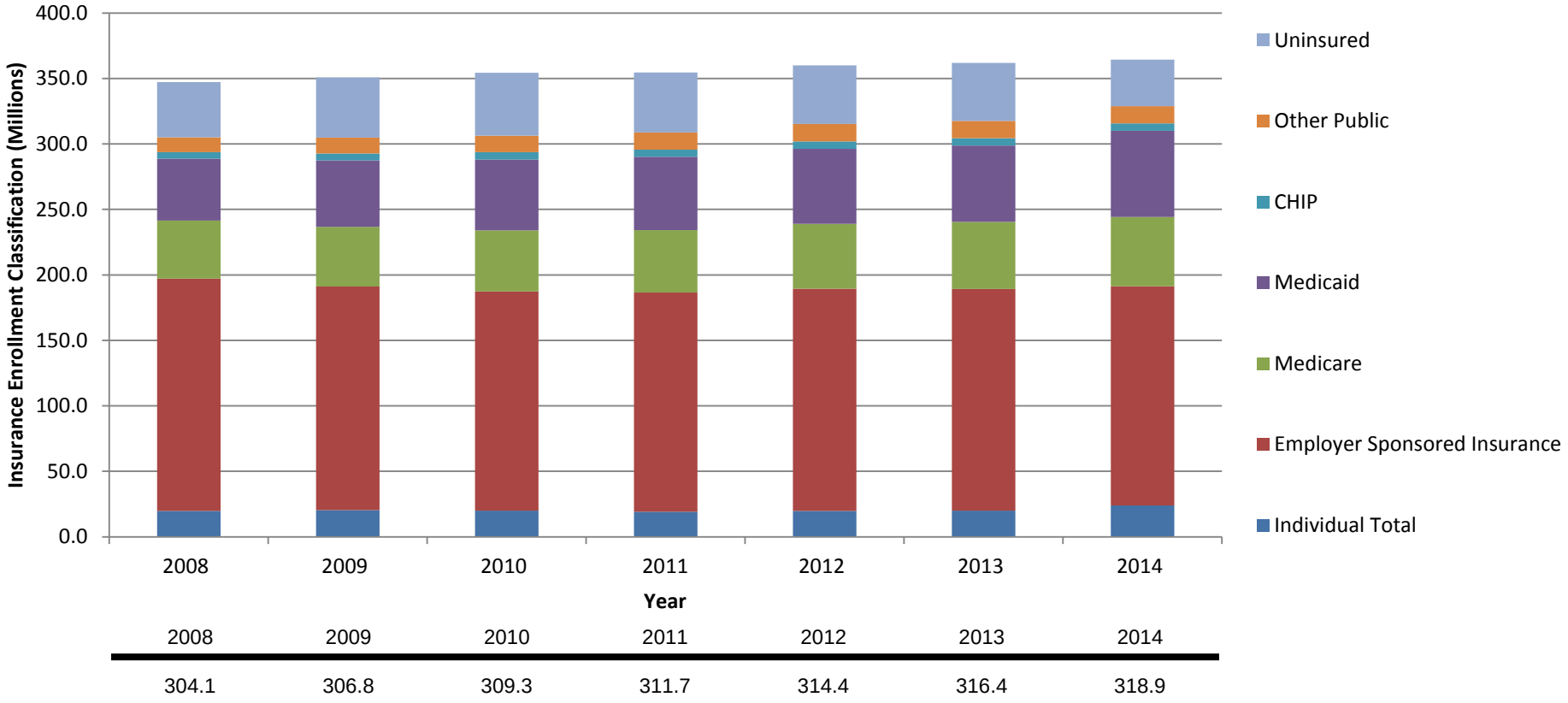
"Small Business Tax Credits. The Affordable Care Act Offers Incentives so that More of These Companies Will Help Provide Their Employees with Health Insurance" By Amanda Cassidy, Health Affairs: Health Policy Brief, January 14, 2011.

Notable Buying Trends

Health Insurance Enrollment by Payor



2008	2009	2010	2011	2012	2013	2014
304.1	306.8	309.3	311.7	314.4	316.4	318.9

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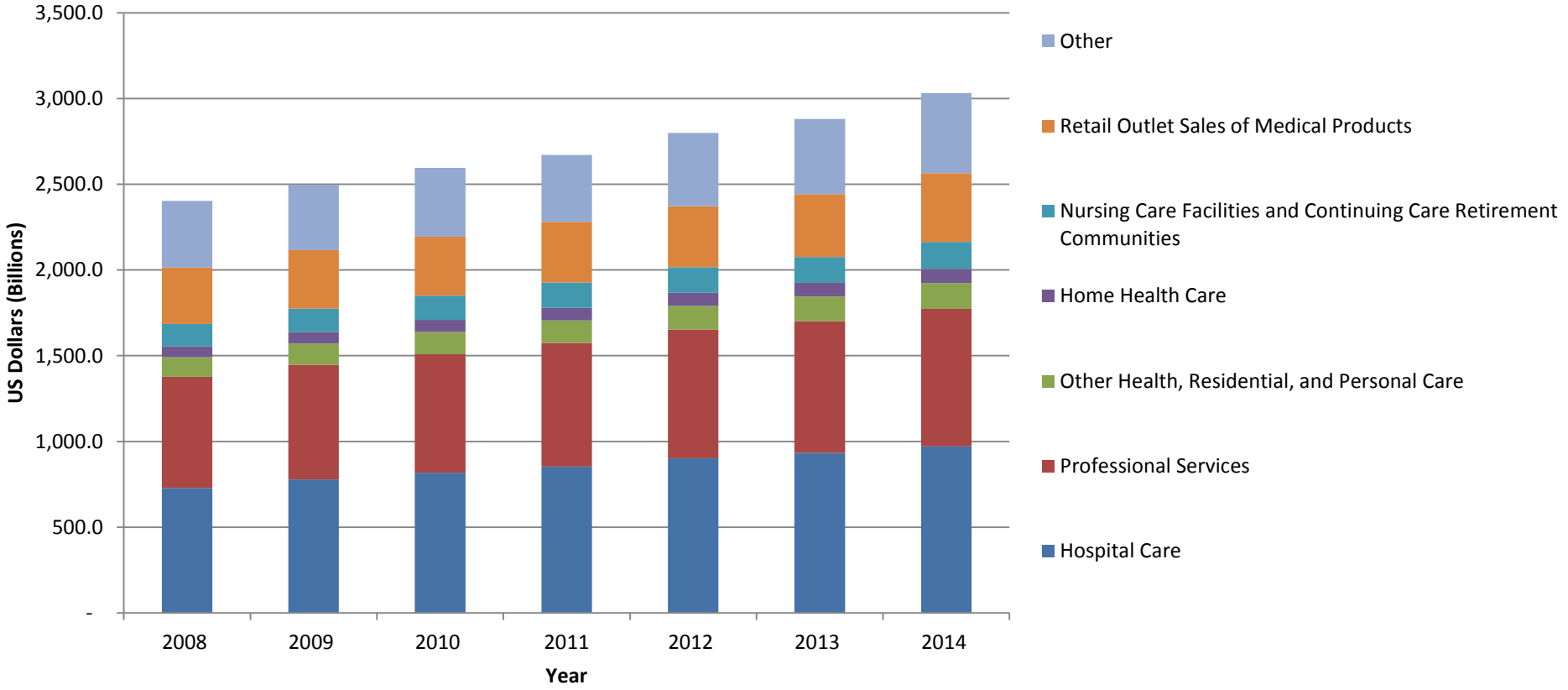
"National Health Expenditures Tables" Centers for Medicare and Medicaid Services, December 3, 2015, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (Accessed 4/26/2016), Table 22; "Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2015 (NST-EST2015-01)" U.S. Census Bureau, http://www.census.gov/popest/data/national/totals/2015/index.html (Accessed 4/26/2016); "Intercensal Estimates of the Resident Population by Sex and Age for the United States: April 1, 2000 to July 1, 2010" U.S. Census Bureau, http://www.census.gov/popest/data/intercensal/national/nat2010.html (Accessed 4/26/2016).

Notable Buying Trends

National Health Expenditures by Type of Expenditure



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"National Health Expenditures Tables" Centers for Medicare and Medicaid Services, December 3, 2015, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (Accessed 4/26/2016), Table 4.

Bargaining Power of Buyers

ACA Implications

- Traditional means of procuring insurance may change dramatically
  - State health insurance exchanges
  - Small Business Health Options Program (SHOP)
    - Increasing regulatory scrutiny of the bargaining power of insurance companies
  - Medical Loss Ratio (MLR)
    - Individual/Small Group Markets - Insurance companies must spend 80% of premiums on medical care and healthcare quality improvement
    - Large Group Markets – Insurance companies must spend 85% of premiums on medical care and healthcare quality improvement

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"The 80/20 Rule: How Insurers Spend Your Health Insurance Premiums," Centers for Medicare and Medicaid Services, http://www.cms.gov/CCIIO/Resources/Files/Downloads/mlr-report-02-15-2013.pdf, (Accessed 4/14/2014).

Threat of New Market Entrants

- Historically, healthcare providers believed there was little to no risk of new market competitors due to entry barriers (e.g., certificate of need, state licensure)
- Technology and communication advancements mean new entrants no longer have to be based in local market, e.g. outsourcing of x-ray film readings, use of telemedicine
- Goals of charity, education, and community service make some decisions in the business of healthcare seem financially or economically irrational
  - The interest(s) held by society in the consolidation and creation of new entrants represents a *positive social externality*

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Threats from Substitute Products or Services

- Non-traditional healthcare providers (e.g., alternative providers, emerging healthcare organizations) are increasingly competing with traditional healthcare providers
- Technology fuels the entry of new competitors
  - Access to medical advice via internet as a substitute for in-office physician services
  - Low cost pharmaceuticals create an alternative to surgery and other means of care
  - Outsourcing of x-ray film readings in contrast to a physician performing the reading in-office

Threats from Substitute Products or Services

- Robotic technologies are a popular feature of many minimally invasive procedures
  - FDA's approval of the *da Vinci robot* in 2000 represented a substantial progression in field of minimally invasive surgery
- New market entrants may pose less of a threat if payors are timid about reimbursing providers for new technologies before there is evidence of improved outcomes

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"Robot-Assisted Surgery," Mayo Clinic, 2009, http://www.mayoclinic.org/robotic-surgery/ (Accessed 4/6/09).

Porter's Strategies for Competition

Porter recommends three generic strategies to out-perform competitors or maintain a market position against competition:

- Overall cost leadership
- Differentiation
- Market niche/segmentation

"Lessons From Market Competition in Healthcare: Love Everyone, Trust No One & Paddle Your Own Canoe" By Robert James Cimasi, CBC, American College of Health Care Executive 2000, Congress on Healthcare Management: Chicago, IL, March 29, 2000, p. 14; "On Competition" Michael E. Porter, Boston, MA: Harvard Business School Publishing Corporation, 2008.

Porter's Strategies for Competition

Overall Cost Leadership

- Organizations seek to produce similar quality at less cost than anyone else, while attempting to earn greater profits through volume or, during strong price competition, merely stay in the market, profitably, through reduced prices
  - Typically, there is an inverse ratio between price & quality, otherwise the ability to differentiate is lost
- This strategy may revolutionize a firm where industry competition has been weak

"Lessons From Market Competition in Healthcare: Love Everyone, Trust No One & Paddle Your Own Canoe" By Robert James Cimasi, CBC, American College of Health Care Executive 2000 Congress on Healthcare Management, Chicago, Illinois, March 29, 2000, p. 14; "On Competition" Michael E. Porter, Boston, MA: Harvard Business School Publishing Corporation, 2008.

Porter's Strategies for Competition

Differentiation

- Focuses on the production of a higher quality or more desirable product or service
- Cost is secondary, but companies exist throughout the continuum between the pure theoretical strategies of cost, quality, and differentiation

Lessons From Market Competition in Healthcare: Love Everyone, Trust No One & Paddle Your Own Canoe," By Robert James Cimasi, CBC, American College of Health Care Executive 2000 Congress on Healthcare Management, Chicago, Illinois, March 29, 2000, p. 14; "On Competition" Michael E. Porter, Boston, MA: Harvard Business School Publishing Corporation, 2008.

Porter's Strategies for Competition

Market Niche/Segmentation

- Companies focus on a section or group of buyers, a segment of a product line, or a specific area of a geographic market
- Based on premise that, by focusing on a narrow target, companies can provide value to customers more effectively than rivals who compete more broadly

Lessons From Market Competition in Healthcare: Love Everyone, Trust No One & Paddle Your Own Canoe" By Robert James Cimasi, CBC, American College of Health Care Executive 2000 Congress on Healthcare Management: Chicago, IL, March 29, 2000, p. 14; "On Competition" Michael E. Porter, Boston, MA: Harvard Business School Publishing Corporation, 2008.

Barriers to Free Market Competition in Healthcare

Barriers to Free Market Competition in Healthcare

Three main reasons for barriers:

- The nature of healthcare creates an unpredictable, urgent, and "infinite" level of demand
- The ubiquitous involvement of insurance companies, employers, and exchanges as intermediary organizations in the purchase of healthcare interferes with or may influence consumer motivations
- The difficulties in measuring healthcare quality and beneficial outcomes and the lack of information on the relative costs of healthcare providers and service differentiation inhibit consumer selection

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Barriers to Free Market Competition in Healthcare

Patients	Patients Do Not Purchase Services Directly from Providers
	Patients Do Not Compare Prices Between Providers
Payors	The Government is the Largest Purchaser of Healthcare
	Private Purchasers Often Lack Market Power
Providers	Many Providers Have Monopoly or Near Monopoly Power (Yet Antitrust Laws Prevent Some Potentially Beneficial Integration)
	Providers are Rewarded for Increasing Costs
	Capital Investments are Overly Subsidized
	Certificate of Need, Regulation, and Licensing Laws are Entry Barriers for Competing and Substitute Providers and Services
	Exit Barriers Protect Low Quality Providers
Patients, Purchasers, and Providers Lack Information	

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Barriers to Free Market Competition in Healthcare

Intermediary Role of Insurance

- Payors are traditionally consumers of healthcare services, but may also be seen as suppliers of *"coverage"*
  - Affords payors significant market leverage over providers in the healthcare industry
  - Many ACA provisions address concerns related to the rising cost of insurance premiums
    - Forces greater price transparency within the insurance market

Barriers to Free Market Competition in Healthcare

Intermediary Role of Insurance

- Government's role as single largest payor for healthcare services exerts enormous pressure on providers to reduce costs due to various regulatory initiatives
  - Government is quickly shifting towards Value Based Reimbursement (VBR); paying for value not volume.
    - Rapid growth of VBR post Affordable Care Act (ACA), including pay-for-reporting (P4R) and pay-for performance (P4P) programs.

"Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume" Centers for Medicare & Medicaid Services, January 26, 2015, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html (Accessed 2/26/2016).

"Pay for Reporting: Quality Assessments Only Methodology" By Eugene J. Nuccio, PhD, University of Colorado Denver, Division of Health Care Policy and Research, July 2, 2014, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/Pay-for-Reporting-Quality-Assessments-Only-Methodology.pdf (Accessed 2/26/2016), p. 1.

"Pay-for-Performance in Health Care" By Jim Hahn, Congressional Research Service, December 12, 2006, http://www.allhealth.org/briefingmaterials/crsreportingforcongress-pay-for-performanceinhealthcare-501.pdf (Accessed 2/26/2016), p. 2.

Barriers to Free Market Competition in Healthcare

Difficulties in Measuring Quality & Outcomes

- These difficulties inhibit consumer selection
  - Lack of information related to the relative costs of healthcare providers and services
- Difficulties may be reduced with transparency initiatives and *electronic health record* (EHR) technologies
- Current value-based purchasing initiatives tying reimbursement to quality and cost metrics will likely incentivize providers to utilize *health information technologies* (HIT)

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Barriers to Free Market Competition in Healthcare

Certificate of Need (CON) Programs

- A state government determines where, when, how, and at what scope, capital projects for healthcare facilities, service line expansion, and major equipment acquisition may be undertaken
- Based on the theory that, in an unregulated market, healthcare providers will provide the latest costly technology and equipment, regardless of duplication or need

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"Certificate of Need: State Health Laws and Programs," By National Conference of State Legislatures, April 30, 2009, http://www.ncsl.org/IssuesResearch/Health/CONCertificateofNeedStateLaws/tabid/14373/Default.aspx (Accessed 6/24/09).

"Improving Health Care: A Dose of Competition: Chapter 8: Miscellaneous Subjects," A Report by the Federal Trade Commission and Department of Justice, July 2004, p. 2.

Barriers to Free Market Competition in Healthcare

Certificate of Need (CON) Programs

- Arguments against CON regulatory policy
  - Intervention disrupts natural market forces & is anti-competitive
  - Viewed by many healthcare economists as a strong disincentive to the introduction of potentially advantageous innovations and technologies
- Arguments for CON regulatory policy
  - May prevent overutilization due to physician self-referral to physician-owned facilities
  - May support continued viability of community hospitals' charity care policies

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"The Attack on Ancillary Service Providers at the Federal and State Level" By Robert James Cimasi, Orthopedic Clinics of North America, Vol. 39, No. 1, January 2008, p. 105.

Barriers to Free Market Competition in Healthcare

Physician-Owned Healthcare Facilities

- Historically, physicians and hospitals each provided distinct services to patients
  - Physicians provided physician services
  - Hospitals provided surgical and other related services to referred patients
  - Under this dynamic, little competition existed between physicians and hospitals
- Shifted as physicians became owners and investors in surgical facilities such as ambulatory surgery centers (ASCs) and specialty hospitals

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"The Effect of Physician-Owned Surgicenters On Hospital Outpatient Surgery," By William J. Link and Carina S. Longley, Health Affairs, Vol. 21, No. 4 , (July/Aug 2002), p. 215;

"Hospital-Physician Relations: Cooperation, Competition, or Separation?" By Robert A. Berenson, Paul B. Ginsburg, and Jessica H. May, Health Affairs, Web Exclusive, (Dec. 5, 2006), p. w31.

"Hospital-Physician Relations: Cooperation, Competition, or Separation?" By Robert A. Berenson, Paul B. Ginsburg, and Jessica H. May, Health Affairs, Web Exclusive, (Dec. 5, 2006), p. w31.

Barriers to Free Market Competition in Healthcare

Physician-Owned Healthcare Facilities

- Controversial due to potential for ethical violations related to physician referrals and perception that physician-owned hospitals (POHs) often *"cherry-pick"* patients
- Proponents cite statistics demonstrating that patients are more satisfied with their care at physician-owned hospitals and often receive higher quality care
- Stark Law prohibits physicians from referring their patients to facilities in which they have a financial interest
- Recent studies have found POHs have comparable chronic disease and predicted mortality scores as non-POHs, as well as, treat minority or Medicaid patients

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"Physician-owned hospitals: Endangered species?" By Chris Silva, American Medical News, June 28, 2010, http://www.ama-assn.org/amednews/2010/06/28/gvsa06028.htm. (Accessed 7/10/2012).

"The Future of Physician-owned Hospitals" By James Ellis and Aaron Razavi, Healthcare Finance News, March 14, 2012. http://www.healthcarefinancenews.com/blog/future-physician-owned -hospitals. (Accessed 7/10/2012).

"Access, quality, and costs of care at physician owned hospitals in the United States: observational study" By Daniel M. Blumenthal, E. John Orav, Anupam B. Jena, David M. Dudzinski, Sidney T. Le, and Ashish K. Jha, August 6, 2015. http://www.bmj.com.ezp.slu.edu/content/bmj/351/bmj.h4466.full.pdf

Barriers to Free Market Competition in Healthcare

Other legislative actions against physician ownership:

- *Health Net of New Jersey, Inc. v. Wayne Surgical Center* - Physicians who refer their patients to an ASC in which they have an ownership interest violates the 1989 Codey Act prohibitions against self-referral
- Stark III updates prohibit *"under arrangements"* and *"per click"* leasing ventures
- Various state tax acts (applicable only to ASCs, Independent Diagnostic Testing Facilities (IDTF), and cancer treatment centers)
- CMS restrictions against IDTFs sharing practice locations, operations, & diagnostic testing equipment with other Medicare-enrolled providers

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"New Jersey Court Sends Blow to Doctor-Owned Facilities, By: Amy Lynn Sorrel, AMANews, American Medical Association January 14, 2008; Garcia v Health New of New Jersey, Inc. 2009 WL 3849685 (November 17, 2009). "Potential Impact of 2008 Medicare Physician Fee Schedule Proposed Rules on Imaging Arrangements," By Thomas W. Greeson and Heather M. Zimmerman, Reed Smith LLP, Health Lawyers Weekly, http://www.reedsmith.com/files/Publication/35d37740-1927-4945-9672-147f9210bdb5/Presentation/PublicationAttachment/13e1f98f-9764-4f93-be39-b76053eaaf85/Potential_Impact_of_2008_Medicare_Physician_Fee_Schedule.pdf (Accessed 9/25/07). "2008 Physician Fee Schedule Regulations Include Anti-Markup and IDTF Rule Change, McDermott Newsletters, McDermott Will & Emery, November 16, 2007.

Barriers to Free Market Competition in Healthcare

Exclusionary Boycotts

- Hospitals engage in exclusionary activities by:
  - Refusing to assist or cooperate with specialty hospitals
  - Pressuring other members of the medical staff and/or community physicians not to engage in business with specialty hospitals
  - Pressuring payors to exclude specialty hospitals from payors' networks
  - Limiting or terminating physician-investors' privileges and medical staff membership

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"Antitrust Implications of Competition Between Physician-Owned Facilities and General Hospitals: Competition or Exclusion?" By William E. Berlin, Esq., The Health Lawyer, American Bar Association, Vol. 20, No. 5 (June 2008), p. 4.

Barriers to Free Market Competition in Healthcare

- Exclusionary boycotts occur when:
  - Specialty hospitals are owned in whole or in part by physicians
  - Specialty hospital competes with general hospital either on inpatient or outpatient basis
  - Many general hospitals have engaged in activities that attempt to shut the physician-owned facility out of the market
- Antitrust laws protect against entities with market power using their power to pressure other hospitals and payors into agreeing to exclude a competitor from the market

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"Antitrust Implications of Competition between Physician-Owned Facilities and General Hospitals: Competition or Exclusion?" By William E. Berlin, American Bar Association, The Health Lawyer 20, no. 5 (June 2008), p. 5.

Antitrust Regulations

- Purpose
  - To prevent monopolies, predatory pricing, and encourage competition in the marketplace
- Substantial regulation has the capacity to limit free market competition in the healthcare industry
- Traditionally used to combat:
  - Anticompetitive behavior arising from provider- and payor-imposed barriers to competition
  - Consolidations (either by collaboration or merger) by provider groups and health systems

"Physician-Hospital Clinical Integration: Navigating the Complexities," Webinar Presented by Strattford, October 10, 2010.
"Improving Health Care: A Dose of Competition: Executive Summary," A Report by the Federal Trade Commission and Department of Justice, July 2004, p. 4-5.

Historical Reform Efforts & Their Effect on Competition

Managed Competition

- Originally, competing healthcare entities, particularly payors, were to be monitored by a supervisory structure that:
  - Established equitable rules
  - Created price-elastic demand
  - Avoided uncompensated risk selection
- Not a far cry from the emerging structure of the ACO/payor relationships

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"The History and Principles of Managed Competition" By Alain C. Enthoven, Health Affairs, Vol. 12, no. suppl 1, 1993, p. 24, 30-35.

The Four Phases of Managed Competition

1st Generation	2nd Generation	3rd Generation	4th Generation
Managed Access	**Managed Benefits**	**Managed Care**	**Managed Outcomes**
▪ Emphasis on managing/restricting patient access ▪ Administrative burdens (e.g., pre-certification, significant co-pays) ▪ Reliance primarily on non-clinical reviewers ▪ Physician totally outside system	▪ Emphasis on managing benefits ▪ Pre-certification primary and treatment planning secondary ▪ Cost Containment emphasized over clinical management ▪ Traditional treatment models employed ▪ Physicians "*included*," but their care delivery "*inspected*"	▪ Greater emphasis on treatment planning and quality management ▪ Focus on most appropriate care in most appropriate setting ▪ Patients managed through continuum of care ▪ Clinical management of network; provider-care manager collegiality ▪ Shift to improving access and benefits to reduce costs	▪ operational, clinical, and financial integration ▪ Locally responsive delivery systems and services based on national standards and capabilities ▪ Mutually beneficial partnerships with the physician community ▪ Effective use of technology to measure, report, and enhance quality and outcomes ▪ Proof of value for customers ▪ Full accountability for costs and quality

"The History and Principles of Managed Competition" By Alain C. Enthoven, Health Affairs, Vol. 12, no. suppl. 1, 1993, p. 24, 30-35.

Reform of the Insurance Industry

- From 2000 to 2009, over 400 health insurance company mergers occurred
  - Reason for consolidation trend
    - Lack of legislation concerning merger agreements
  - Resulted in a highly consolidated market and negative consequences for consumers; this trend has continued since, and is anticipated to remain through 2016
- Mergers, without strong enforcement of antitrust laws, have permitted a variety of anticompetitive behaviors by major insurance companies
  - Resulted in higher costs, compromised patient care, and a record high level of uninsured in the U.S.

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"The Next Antitrust Agenda: The American Antitrust Institute's Transition Report on Competition Policy to the 44th President of the United States," By The American Antitrust Institute, Albert A. Foer, Ed., Vandeplas Publishing (2008), p. 323; Citing "Consolidation in the Pennsylvania Health Insurance Industry: The Right Prescription? Hearing Before the Subcomm. On Antitrust, Competition Policy and Consumer Rights of the S. Comm. on the Judiciary," 110th Cong. (2008) (Testimony of David Balto) http://judiciary.senate.gov/testimony.cfm?id=3522&wit_id=7367 (Accessed 8/27/2012).; "Hospital Consolidation 2016 Forecast: 'More of the Same'" By John Commins, HealthLeaders Media, January 15, 2016, http://www.healthleadersmedia.com/leadership/hospital-consolidation-2016-forecast-more-same (Accessed 4/29/2016).

Reform of the Insurance Industry

- Some suggest that the federal antitrust exemption for insurance companies contained in the *McCarran-Ferguson Act* has allowed for insurance companies to consolidate
  - Reform initiatives have been advanced to modify or repeal the exemption
    - Application of the Act to healthcare has drawn criticism from the Department of Justice (DOJ) and lawmakers
      - Claim the exemption has led to anticompetitive behavior

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"The McCarran-Ferguson Act," 15 U.S.C. § 1011 et seq. (2006). "Senate Panel Hearing Airs Criticisms of Health, Malpractice Insurer Exemption," By Cecelia M. Assam, Bureau of National Affairs Health Law Reporter, Vol. 18, No. 41, Oct. 22, 2009, p. 1397; "Repeal McCarran-Ferguson- Before it's too late" By David A. Balto, The Hill, http://thehill.com/blogs/congress-blog/economy-a-budget/292405-repeal-mccarran-ferguson-before-its-too-late# (Accessed 4/22/16).

Reform of the Insurance Industry

Pharmaceutical Benefit Management (PBM) Industry

- Expansion of the PBM industry has experienced both positive and negative response from the healthcare industry
- In order to reverse the trend of payor consolidation, healthcare reform proposals have included provisions for identifying exclusionary conduct by private payors

Chapter 7: Industry Snapshot and Competition Law: Pharmaceuticals," in "Improving Health Care: A Dose of Competition," by the Federal Trade Commission and the Department of Justice, July 2004, p. 11, 15.

The Commoditization of Healthcare

- Healthcare services have evolved into *homogenous*, *fungible* units that are bought and sold
- ***"Commoditization"***: The process of making an item, which is not distinguished by a brand name or label, into something that can be purchased in bulk quantities and sold by retailers at a standardized per unit basis

Medicare Hospital Prospective Payment System: How DRG Rates Are Calculated and Updated," by the Office of the Inspector General, Office of Evaluation and Inspections, Region IX (OEI-09-00-00200), August 2001, 1, 5

The Commoditization of Healthcare

Evidence of the commoditization of the US healthcare system:

- Standardized per unit cost Medicare reimbursement systems
  - Examples: The Resource Based Relative Value Scale (RBRVS), the Current Procedural Terminology (CPT)
- The marketplace for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
  - DMEPOS manufacturers submit competing bids to Medicare based on the charge per unit
    - The lowest is then chosen to be the only Medicare provider of DMEPOS in different metropolitan areas

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"Medicare DME Bidding Program Set to Relaunch in 2010," By Chris Silva, American Medical News, May 4, 2009, http://www.ama-assn.org/amednews/2009/05/04/gvsd0504 (Accessed 11/10/09); "Overview of the DMEPOS Competitive Bidding Program" CMS, April 17, 2012, http://www.dmecompetitivebid.com/palmetto/cbic.nsf/vMasterDID/79NTSG0132 (Accessed 4/22/16)' "Competitive Bidding Program" CMS, https://www.medicare.gov/what-medicare-covers/part-b/competitive-bidding-program.html (Accessed 4/22/16).

The Commoditization of Healthcare

- The healthcare industry is becoming more of a retail industry through:
  - Rising healthcare costs
  - Customers' increased access to health information
  - Evidence-based medicine approaches
  - Increased scope of practice considerations for midlevel providers (i.e., including physician assistants and nurse practitioners)

Affiliation Arrangements

Structural Arrangements	Pay-For-Service Arrangements

Joint ventures around:
• Diagnostic and surgical centers
• Physician hospital organizations,
• Operations councils to enhance service lines
• Management services organizations
• CEO physician cabinets
• Virtual integration with independent practice association
• Co-development agreements
• Creation of medical foundations
	• Stipends for:
	  • Emergency Department Call
	  • Medical directorships for specialized units (e.g., Intensive Care Unit)
	  • Targeted initiatives (e.g., quality directors, informatics directors, innovation officers)
	• Expansion of stipends for medical staff leaders

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Affiliation Arrangements

Expanded Contracting Arrangements

- Exclusive clinical services arrangements (e.g., radiology, pain management, anesthesiology), contracts for specific physician services (e.g., hospitalists, laborists, surgicalists, intensivists) and/or for specific diagnostic services (e.g., the interpretation of EKGs), leased practices, and a surge in the direct employment of physicians

Provider Consolidation

- The mid-1990s experienced a frenzy of physician practice acquisitions by hospitals, health systems, and large integrated groups as managed care organizations (and HMOs) boomed
- Consolidation efforts have rekindled in recent years due to:
    - Reimbursement cuts
    - Restrictions on physician ownership
    - Increased regulatory scrutiny
    - Increased technological demands for reporting (i.e., ICD-10 conversion)
    - Changing physician demographics and demands

Provider Consolidation

- The once well-defined, relatively stable business landscape of U.S. healthcare delivery now presents an unpredictable milieu of new provider configurations, strategies, & tactics
- Physicians and hospitals becoming more integrated through *co-management arrangements*
  - Re-emerged in recent years as an alternative care model
  - Incentivizes physicians for development, management, and improvement of quality and efficiency, as well as for making the service line more competitive in the target market

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"Clinical Co-Management: Hospitals and Oncologists Working Together," By Paul F. Danello, Journal of Oncology Practice, Vol. 2 No. 1, 2006.

Organizational Models of Alignment Emerging Models in an Era of Reform

Degree of Hospital Control

LEAST

MOST

Model	Description
Solo Practice	Physicians practice independently.
Independent Practice Association (IPA)	Legal entities of independent physicians that contract with health insurance companies to provide medical services.
Physician Hospital Organization (PHO) ("Clinically Integrated Network")	Unites Hospital with Physician through a contractual relationship. Usually owned by Physicians and Hospitals.
Professional Service Agreement (PSA)	An Agreement in which an entity contracts with a physician practice, requiring the physician practice to provide professional medical services on behalf of the contracting entity.
Physician Practice Management Company (PPMC)	Company specializing in physician practice management with the goal of earning a profit; often purchase or affiliate with physicians, offering capital, management experience, economies of scale, and economic security.
Management Services Agreement (MSA)/Organization (MSO)	A legal entity that provides administrative and practice management services to physician entity that is owned by participating physicians and that contracts with the MSO for services.
Accountable Care Organization (ACO) Participant	A legal entity recognized and authorized under applicable State, Federal, or Tribal Law that is identified by a Taxpayer Identification Number (TIN) and is formed by one or more ACO participant(s).

"A Guide to Consulting Services for Emerging Healthcare Organization," By Robert James Cimasi, John Wiley & Sons, New York, NY, 1999, p. 51-56, 163.

Organizational Models of Alignment Emerging Models in an Era of Reform

Degree of Hospital Control

LEAST

MOST

Model	Description
Service Line Co-Management	An arrangement between a hospital and a physician practice in which certain services are provided by the hospital and certain services are provided by the physician practice in the management of a specific hospital service or service line
Foundation Model	A hospital creates, but does not own, a nonprofit medical foundation, which owns and operates the physician clinics
Joint Ventures	A relationship established between two business entities for a specific purpose and point of time
Equity Model	Hospital acquires ownership interest in existing physician practice through friendly physician employee, in contrast to asset transaction
Integrated Delivery System (IDS)	Vertically integrated and composed of insurers, hospitals, physicians, and other entities offering medical care to a defined population
Fully Integrated Medical Group Practice	Medical group organized as a single legal entity
"Captive Practice"	A physician is employed by a Captive PC or Health Foundation that is controlled by a Hospital Entity
Direct Employment	A physician is directly employed by a Hospital Entity to provide professional medical services

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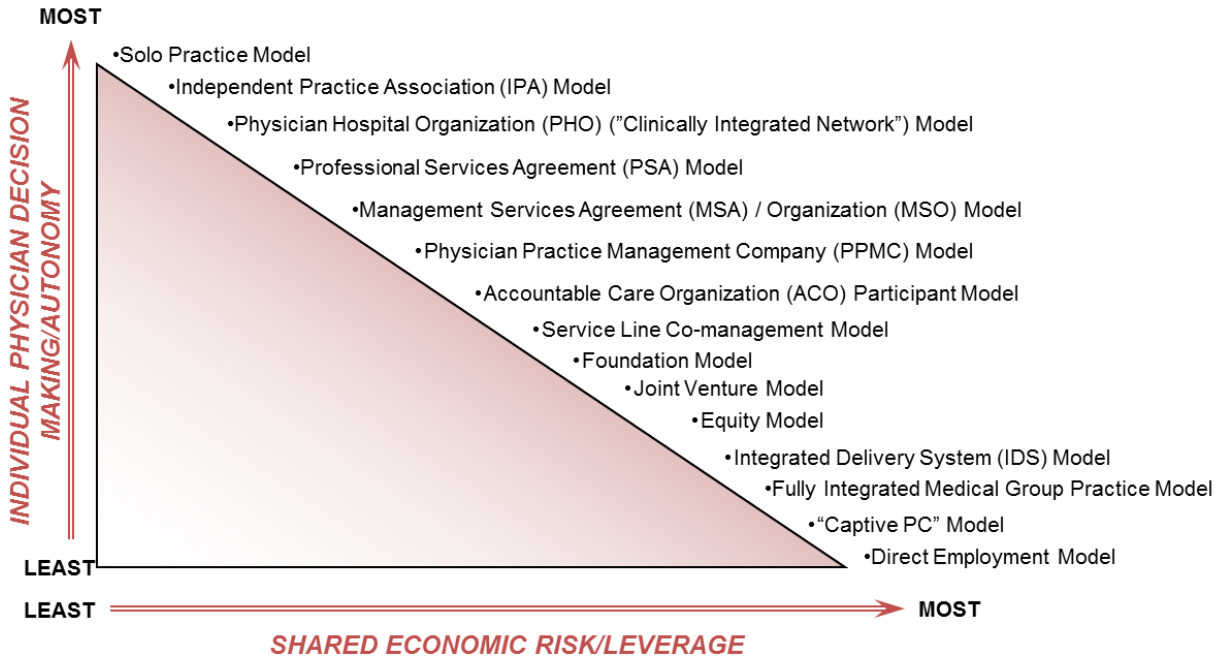
Sources: "Hospital/Physician Integration: Three Key Models," By Michael A. Cassidy, American Health Lawyers Association, October 2011; "A Guide to Consulting Services for Emerging Healthcare Organization," By Robert J. Cimasi, John Wiley & Sons, New York, NY, 1999, p. 51-56, 80-90, 163; "The Financial Management of Hospital and Healthcare Organizations," By Michael Nowicki, Foundation of the American College of Healthcare Executives, Chicago, IL, 2004, p. 55-56.

Textbook Reference
Vol. 2 ● Ch. 1 ● *Healthcare Services*
Page 878-888
Healthcare Valuation
Financial Appraisal of
Enterprises, Assets & Services
by Robert James Cimasi

Autonomy/Leverage of Various Integration Methods

- **AUTONOMY / PRACTICE INDEPENDENCE**
- **HOSPITAL DEPENDENT**
- **PRACTICE FLEXIBILITY**
- **OPERATING EFFICIENCIES (SHORT TERM)**



- **MANAGED CARE ATTRACTIVENESS**
- **SECURE REFERRAL SOURCES**
- **OPERATING EFFICIENCIES (LONG TERM)**
- **PRACTICE STABILITY**
- **FINANCIAL REWARDS**
- **START-UP CAPITAL/FINANCIAL COMMITMENT**
- **DEGREE OF FINANCIAL/OPERATING RISK**
- **COMPLEXITY (LEGAL, OPERATIONAL)**

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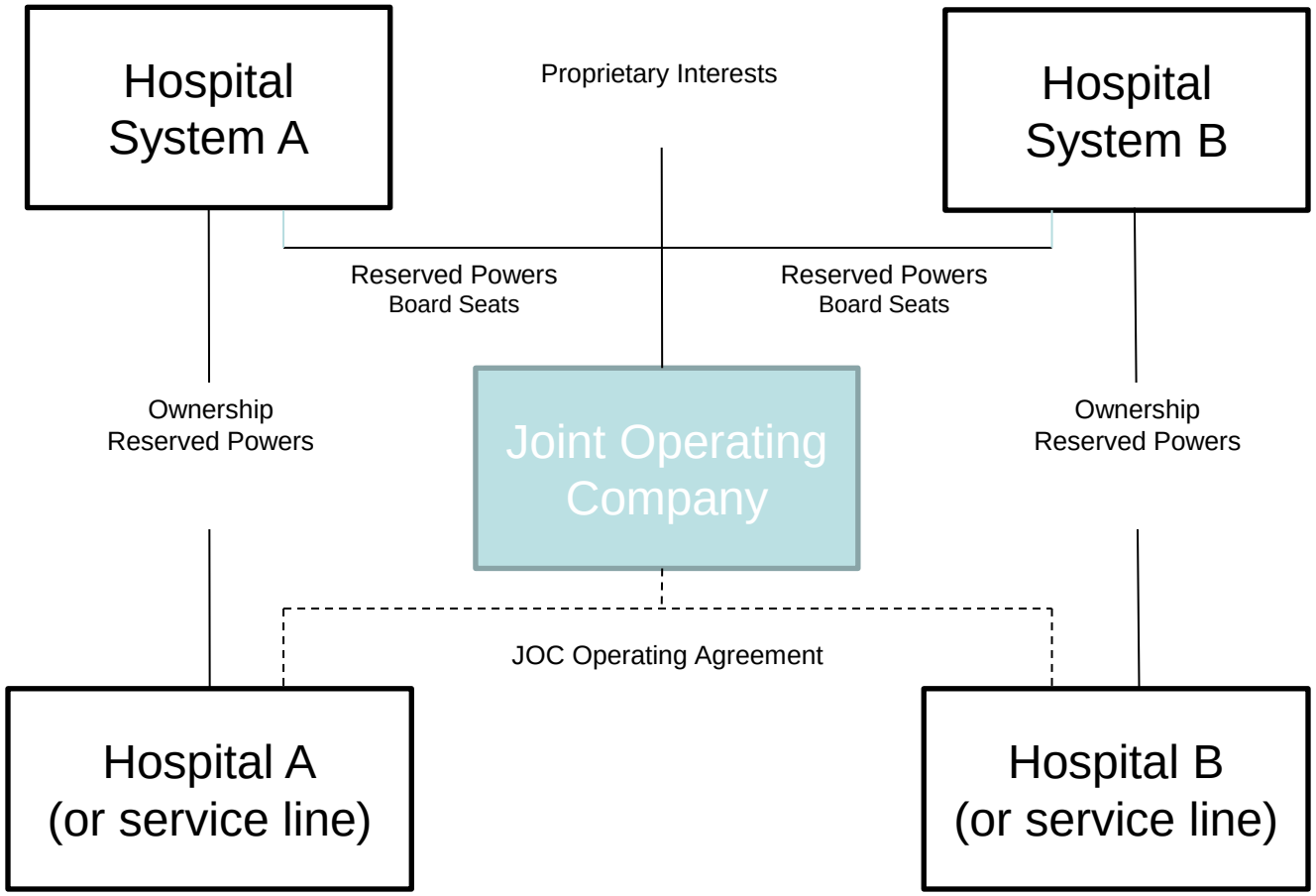
Joint Operating Company Model



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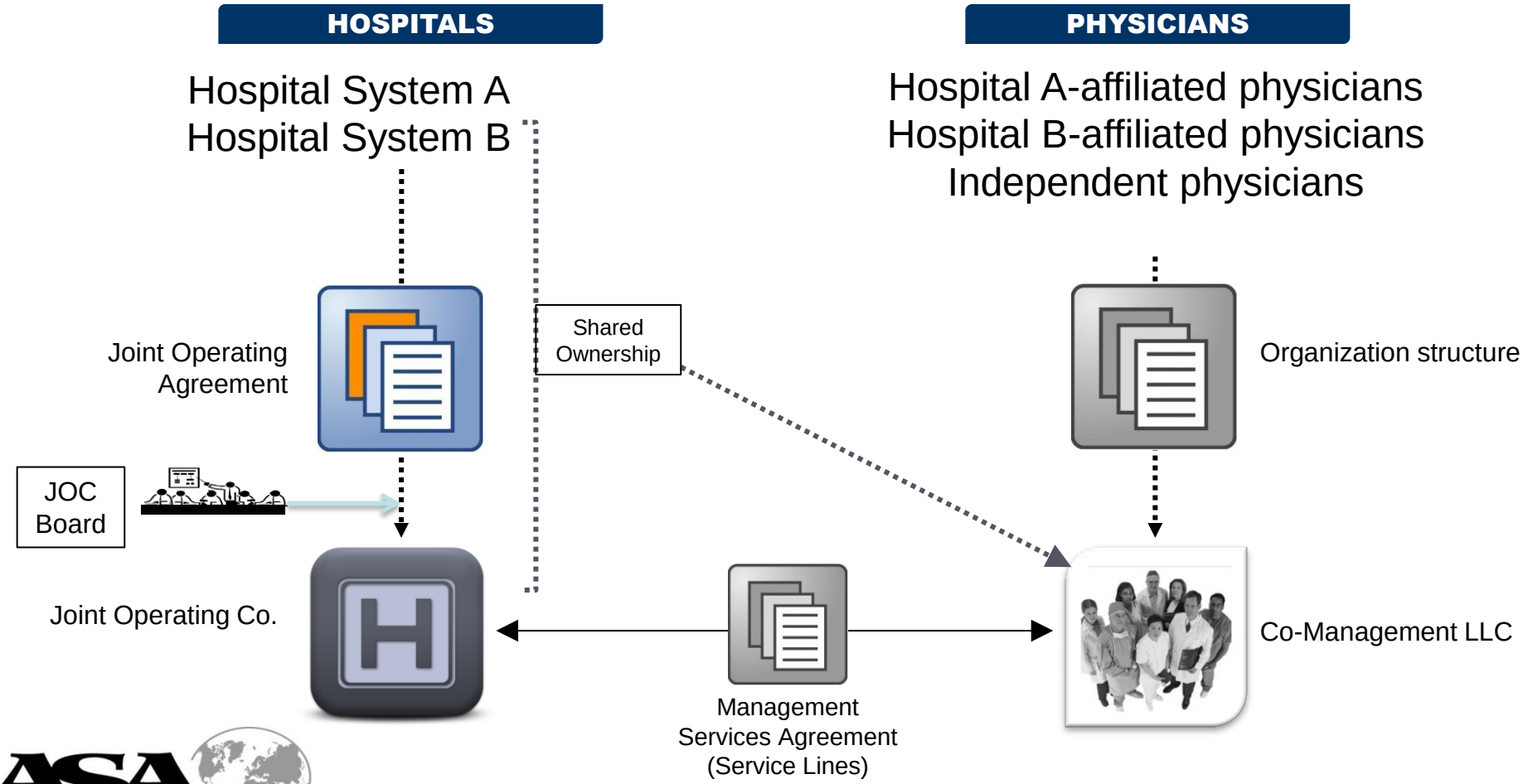
JOC Co-Management Model



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Provider Consolidation

Accountable Care Organizations (ACOs)

- The latest iteration in an ongoing dialogue about how to manage the rising cost of healthcare in a manner that addresses both *cost* and *quality*
- The success or failure of ACOs will be in their ability to achieve the required cost reductions and quality goals

Provider Consolidation

Accountable Care Organizations (ACOs)

- Healthcare organizations with a coordinated set of providers
  - Provider mix dependent on whether it is a federal or commercial ACO structure
- Share responsibility and accountability for the continuum of care
  - Clinical accountability – Quality of care
  - Financial responsibility – Cost of care

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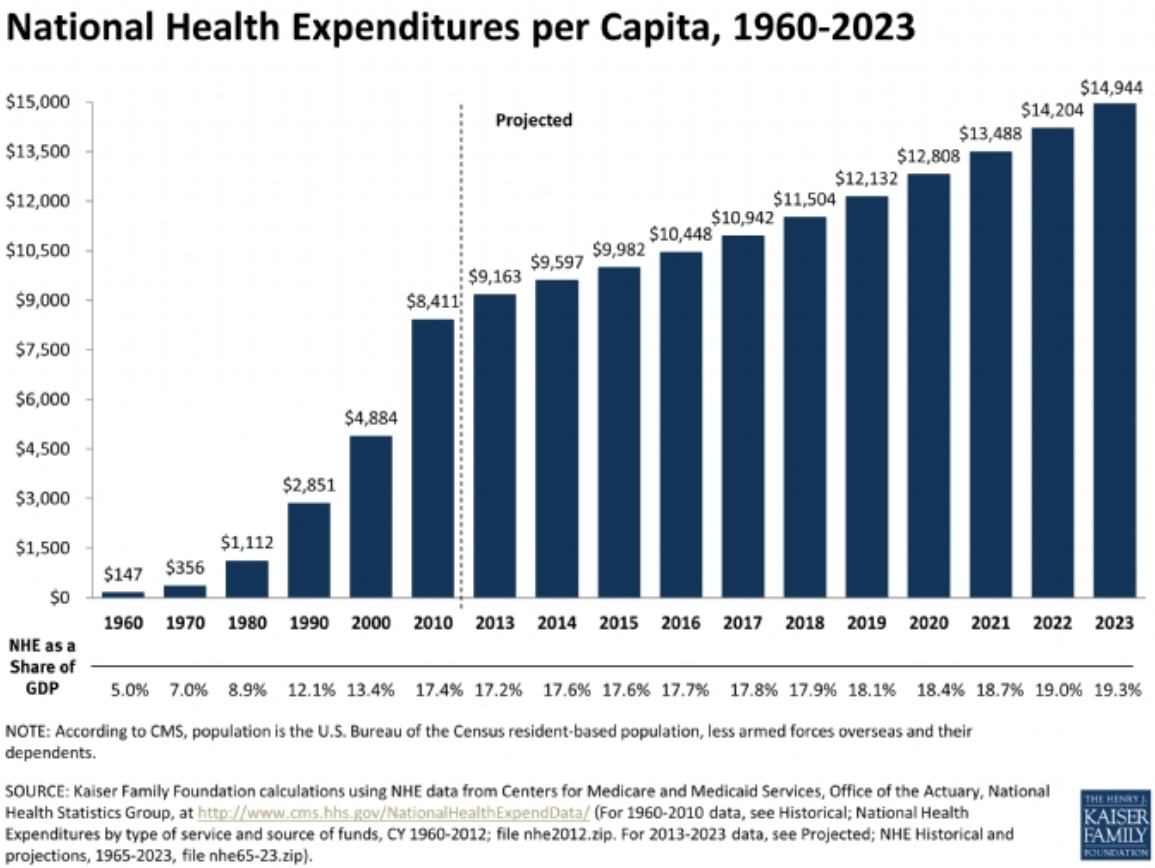
"Perspectives on Accountable Care Organizations-ACO Overview" by Robert James Cimasi, 2011 International Expo, Health Industry Group Purchasing Association & healthcare Industry Supply Chain Institute, Washington, D.C.: Oct. 12-14, 2011, p. 2.

Why Accountable Care?



NOTE: According to CMS, population is the U.S. Bureau of the Census resident-based population, less armed forces overseas and their dependents.

SOURCE: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (For 1960-2010 data, see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2012; file nhe2012.zip. For 2013-2023 data, see Projected; NHE Historical and projections, 1965-2023, file nhe65-23.zip).

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National Health Expenditures per Capita, 1960-2023

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"National Health Expenditures per Capita, 1960-2013" Kaiser Family Foundation, Centers for Medicare & Medicaid Services, National Health Statistics Group, http://www.allhealth.org/sourcebookcontent.asp?CHID=179 (Accessed 4/22/16).

History of Accountable Care

1st Generation	2nd Generation	3rd Generation	4th Generation
Managed Access	**Managed Benefits**	**Managed Care**	**Managed Outcomes**
• Emphasis on managing/restricting patient access • Administrative burdens (e.g., Pre-certification, significant co-pays) • Reliance primarily on non-clinical reviewers • Physician totally outside system	• Emphasis on managing benefits • Pre-certification primary and treatment planning secondary • Cost containment emphasized over clinical management • Traditional treatment models employed • Physicians *"included,"* but their care delivery *"inspected"*	• Greater emphasis on treatment planning and quality management • Focus on most appropriate care in most appropriate setting • Patients managed through continuum of care • Clinical management of network; provider-care manager collegiality • Shift toward improving access and benefits to reduce costs	• Operational, clinical, and financial integration • Locally responsive delivery systems and services based on national standards and capabilities • Mutually beneficial partnerships with physician community • Effective use of technology to measure, report, and enhance quality and outcomes • Proof of value for patients • Full accountability for costs and quality

"Perspectives on Accountable Care Organizations-ACO Overview" by Robert James Cimasi, 2011 International Expo, Health Industry Group Purchasing Association & healthcare Industry Supply Chain Institute, Washington, D.C.: Oct. 12-14, 2011, p. 5.

Beyond ACOs

- Federal Trade Commission (FTC) advisory opinion approving proposal for clinical integration of *Norman Physician Hospital Organization* (PHO)
  - Potential to increase interdependence & cooperation
  - May improve efficiency
- Provides guidance to other provider networks that may choose to forego an ACO model in lieu of alternate clinical integration network (CIN) structures

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"Clinical Integration Beyond ACOs: The New Frontier," Health Capital Topics, Vol. 6, Issue 3, March 2013; "Re: Norman PHO Advisory Opinion," By Markus H. Meier, Federal Trade Commission, February 13, 2013, p. 2.

Pressures of Market Competition vs. Community Benefit

Pressures of Market Competition vs. Community Benefit

- Gatekeeper HMOs and Patient Protection Legislation
- For Profit vs. Not-For-Profit Healthcare
- Physician Participation in Managed Care and Level of Charity Care

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"Lessons From Market Competition in Healthcare: Love Everyone, Trust No One & Paddle Your Own Canoe" By: Robert James Cimasi, CBC, American College of Health Care Executive 2000 Congress on Healthcare Management, Chicago, Illinois, March 29, 2000. p. 4.

Gatekeeper HMOs and Patient Protection Legislation

- Patients may not consult specialists without first obtaining a referral from a primary care physician
- A prevalent cost containment measure impacting the practice of medicine

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Gatekeeper HMOs and Patient Protection Legislation

- Health plan designs are offering more consumer choices, especially "open access, specialty based" models which do not rely on PCPs as gatekeepers
- Employ other medical management tools to allow patients to see the most appropriate provider for their condition

"Lessons From Market Competition in Healthcare: Love Everyone, Trust No One & Paddle Your Own Canoe" By: Robert James Cimasi, CBC, American College of Health Care Executive 2000 Congress on Healthcare Management, Chicago, Illinois, March 29, 2000. p. 4.

Gatekeeper HMOs and Patient Protection Legislation

- Patient protection legislation, including limited direct access to specialists, continues to be debated by Congress
- The result of public outcry against the restrictions of managed care including the gatekeeper system

"Lessons From Market Competition in Healthcare: Love Everyone, Trust No One & Paddle Your Own Canoe" By: Robert James Cimasi, CBC, American College of Health Care Executive 2000 Congress on Healthcare Management, Chicago, Illinois, March 29, 2000. p. 4.

For Profit vs. Not-For-Profit Healthcare

- In general industry, as well as in healthcare, there has been a longstanding discussion on the relative efficiencies of for profit businesses versus not-for-profit businesses
- This concerns the very merits of competition itself

"Lessons From Market Competition in Healthcare: Love Everyone, Trust No One & Paddle Your Own Canoe" By: Robert James Cimasi, CBC, American College of Health Care Executive 2000 Congress on Healthcare Management, Chicago, Illinois, March 29, 2000. p. 4.

For Profit vs. Not-For-Profit Healthcare

New England Journal of Medicine (NEJM) study

- Compared Medicare spending in markets with only non-profit hospitals, only for profit hospitals, and those with both types
- The study found that the government spent more for every type of service measured in areas with only for-profit hospitals for each of the years studied (1989, 1992, and 1995)

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"Lessons From Market Competition in Healthcare: Love Everyone, Trust No One & Paddle Your Own Canoe" By Robert James Cimasi, CBC, American College of Health Care Executive 2000 Congress on Healthcare Management, Chicago, Illinois, March 29, 2000, p. 4. "The Association between For-Profit Hospital Ownership and Increased Medicare Spending." By Elaine M. Silverman, et al., The New England Journal of Medicine, Vol. 341, no. 6 (Aug. 5, 1999), p. 420.

For Profit vs. Not-For-Profit Healthcare

New England Journal of Medicine (NEJM) study

- For the period of the study, 1989-1995, areas where all hospitals were non-profit, and remained so, had cost increases of $866 compared with $1,295 for areas where non-profits converted to for-profit status
- This reported effect, if real, may be considered by many to be detrimental to the public good

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"Lessons From Market Competition in Healthcare: Love Everyone, Trust No One & Paddle Your Own Canoe" By Robert James Cimasi, CBC, American College of Health Care Executive 2000 Congress on Healthcare Management, Chicago, Illinois, March 29, 2000, p. 4.

For Profit vs. Not-For-Profit Healthcare

- In 1995, annual Medicare spending was $732 higher per enrollee in markets with only for-profit hospitals than in non-profit markets
- This difference may be extrapolated to $5.2 billion dollars in total extra annual costs to Medicare
- Other studies have examined these cost differences and have found them to result from increased administrative and ancillary services costs

"Lessons From Market Competition in Healthcare: Love Everyone, Trust No One & Paddle Your Own Canoe" By Robert James Cimasi, CBC, American College of Health Care Executive 2000 Congress on Healthcare Management, Chicago, Illinois, March 29, 2000, p. 5.

For Profit vs. Not-For-Profit Healthcare

- Discrepancy in Medicare spending per enrollee for each market decreased, but remained, in the past decade
- 2009 study surveyed the top 10 states with highest concentrations of for-profit hospitals, and top 10 states with the same for non-profit hospitals
  - Average Medicare spending per enrollee for for-profit group was $10,058
  - Average Medicare spending per enrollee for not-for-profit group was $9,785
- The difference may be extrapolated to $1.85 billion dollars in total extra annual costs to Medicare

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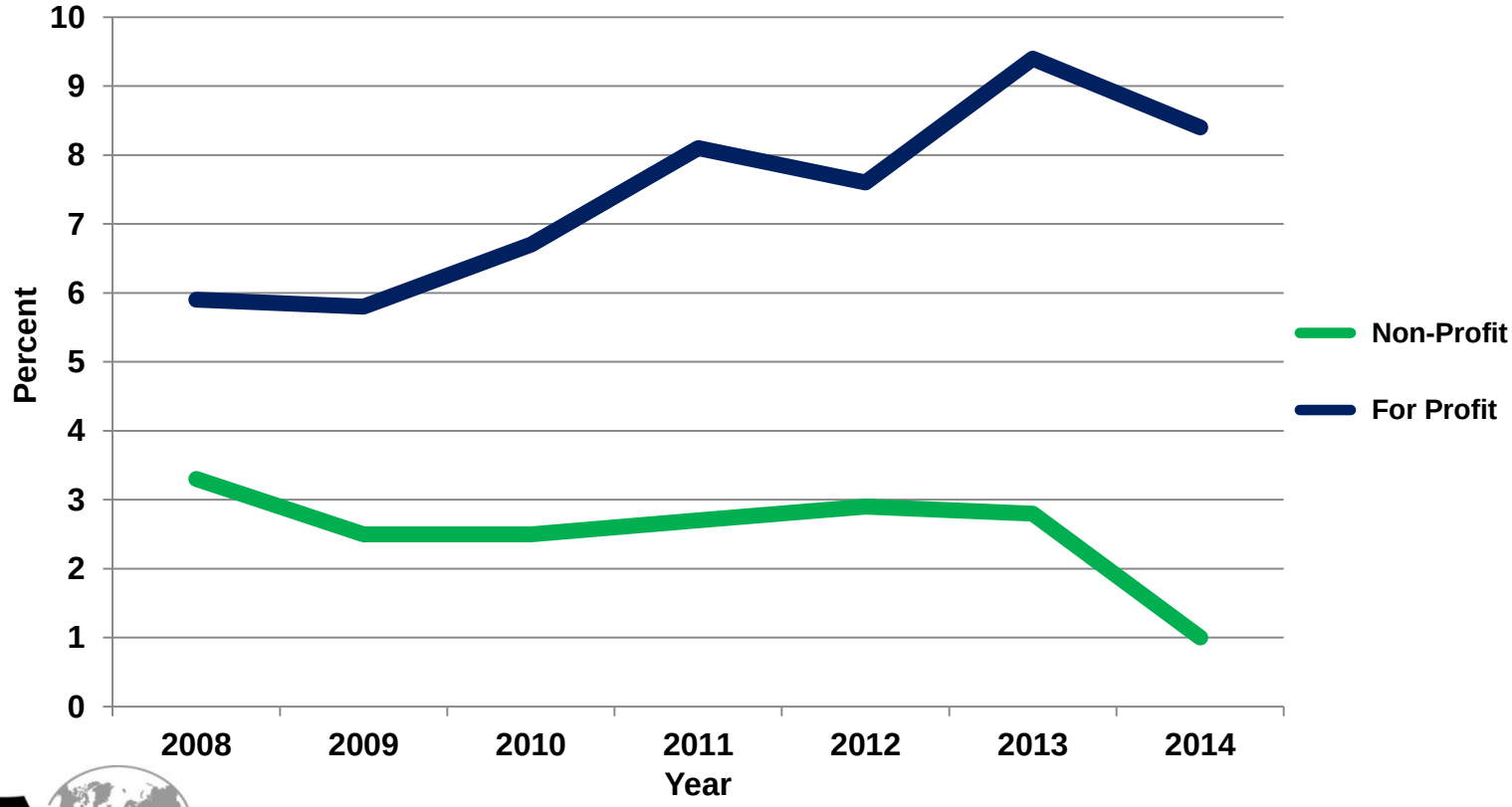
"The Impact of For-Profit Medicine on Medicare" Office of Senator Chris Murphy, August 15, 2014.

Diverging Profitability Between Largest For-Profit & Not-For-Profit Health Systems

Operating Profits



Sources: "The Annual Statement Studies: Financial Ratio Benchmarks, 2014-2015," Risk Management Association, Philadelphia, PA: 2014, p.1452-1455; "The Annual Statement Studies: Financial Ratio Benchmarks, 2012-2013," Risk Management Association, Philadelphia, PA: 2012, p.1506, 1508.

Physician Participation in Managed Care and Level of Charity Care

Center for Analyzing Health System Change Study

- Researchers studied the effect of competition and managed care on charity care provided by physicians
- Further illustrated the negative effects of dysfunctional competition in healthcare

"Lessons From Market Competition in Healthcare: Love Everyone, Trust No One & Paddle Your Own Canoe" By: Robert James Cimasi, CBC, American College of Health Care Executive 2000 Congress on Healthcare Management, Chicago, Illinois, March 29, 2000, p. 5. "Managed care and physicians' provision of charity care." By P.J. Cunningham, et al. JAMA, Vol. 281 (1999), p. 1087; "Proportion of Doctors Giving Charity Care Declines" By Ceci Connolly, Washington post, March 23, 2006, http://www.washingtonpost.com/wp-dyn/content/article/2006/03/22/AR2006032202052.html (Accessed 4/29/2016).

Physician Participation in Managed Care and Level of Charity Care

Center for Analyzing Health System Change Study

- An inverse relationship was found between the amount of physician revenue derived from managed care and the amount of time spent providing charity care
- Researchers attributed these practice differences with increasing financial pressures faced by physicians because of increased competition and their reduced ability to cost shift excess charges from paying patients to those unable to pay

"Lessons From Market Competition in Healthcare: Love Everyone, Trust No One & Paddle Your Own Canoe" By: Robert James Cimasi, CBC, American College of Health Care Executive 2000 Congress on Healthcare Management, Chicago, Illinois, March 29, 2000, p. 5.
"Managed care and physicians' provision of charity care." By P.J. Cunningham, et al. JAMA, Vol. 281 (1999), p. 1087.

Concluding Remarks

Concluding Remarks

Pursuing Interdisciplinary Collaboration

Healthcare Industry Specific Appraisal Assignments

Real Estate Appraisal • Machinery & Technical Specialties

Personal Property • Business Valuation • Intangible Assets/IP

Separate and Distinct Disciplines in the Same Profession

- Similar Tools to Solve Similar Problems
- Shared Clients
- Interdisciplinary Approach Yields Significant Benefit to Both Clients and Appraisers

We CAN Work Together!

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Concluding Remarks

We Can (and should) All Work Together!

- To obtain the requisite background for forecasting the future performance of healthcare enterprises, assets, and services in the current dynamic era of healthcare reform, valuation professionals should develop and maintain an in-depth understanding of the history and the development of healthcare delivery, as well as, the unique dynamics of those often complex business arrangements that comprise newly emerging healthcare organizations and the various elements of property value involved in each.

- A multidisciplinary project team of appraisers has the potential to provide an enhanced scope and diversity of knowledge and breadth of experience to the benefit of both the appraisers and the client.

Concluding Remarks

We Can (and should) All Work Together!

- When developing an understanding of the forces and stakeholders that have the potential to drive healthcare markets, valuation professionals must examine the subject enterprises, assets, and services as they relate to and within the context of:
- ***"The Four Pillars of the Healthcare Industry"***
    - Reimbursement
    - Regulatory
    - Competition
    - Technology
- These four elements serve as a conceptual framework for analyzing the viability, efficiency, efficacy, and productivity of the subject property interest(s)

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Concluding Remarks

We Can All Work Together!

- More informed and uniform valuation practice would benefit the users of healthcare valuations and improve public confidence in appraisers
- To enhance competency, significant specialized education and training is an important benefit for healthcare appraisers and clients
- Given these issues, a multidisciplinary approach toward advanced education related to healthcare industry valuation is an important initiative of the ASA, as the premiere multidisciplinary valuation society of professional appraisers

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		A	B	C	D	E	F	G	H	I	J	
			Session Details			Time				Speakers		
		Program Events	Course Title	Presentation Day	Time of Day	Date	Start	End	Duration	Presenter	Co-Presenter	
1	DAY 1	Registration and Breakfast		Friday	Morning	5/6/2016	7:30 AM	8:15 AM	45 Minutes			1
2		Session 1	*Overview of Healthcare Industry*	Friday	Morning	5/6/2016	8:15 AM	9:15 AM	1 Hour	Bob Cimasi, ASA		2
3		Session 2	*Regulatory Environment of the Healthcare Industry*	Friday	Morning	5/6/2016	9:15 AM	10:30 AM	1 Hour 15 Minutes	Mark Mattioli, Esq.	Todd Zigrang, ASA	3
4		Break		Friday	Morning	5/6/2016	10:30 AM	10:45 AM	15 Minutes			4
5		Session 2	*Regulatory Environment of the Healthcare Industry*	Friday	Morning	5/6/2016	10:45 AM	12:30 PM	1 Hour 45 Minutes	Mark Mattioli, Esq.	Todd Zigrang, ASA	5
6		Lunch		Friday	Afternoon	5/6/2016	12:30 PM	1:30 PM	1 Hour			6
7		Session 2	*Regulatory Environment of the Healthcare Industry*	Friday	Afternoon	5/6/2016	1:30 PM	2:15 PM	45 Minutes	Mark Mattioli, Esq.	Todd Zigrang, ASA	7
8		Session 3	*Impact of Competitive Forces*	Friday	Afternoon	5/6/2016	2:15 PM	3:15 PM	1 Hour	Roger Strode, Esq.	Todd Zigrang, ASA	8
9		Break		Friday	Afternoon	5/6/2016	3:15 PM	3:30 PM	15 Minutes			9
10		Session 3	*Impact of Competitive Forces*	Friday	Afternoon	5/6/2016	3:30 PM	5:00 PM	1 Hour 30 Minutes	Roger Strode, Esq.	Todd Zigrang, ASA	10
11	DAY 2	Breakfast		Saturday	Morning	5/7/2016	7:30 AM	8:00 AM	30 Minutes			11
12		Session 5	*Technology Development*	Saturday	Morning	5/7/2016	8:00 AM	11:00 AM	3 Hours	Col. Geoff Ling, MD, PhD	Bob Cimasi, ASA	12
13		Lunch		Saturday	Afternoon	5/7/2016	11:00 AM	12:00 PM	1 Hour 15 Minutes			13
14		Session 5	*Healthcare Reimbursement Environment in an Era of Reform*	Saturday	Morning	5/7/2016	12:00 PM	3:00 PM	3 Hours	Shari Ling, MD	Bob Cimasi, ASA	14
15		Break		Saturday	Afternoon	5/7/2016	3:00 PM	3:15 PM	15 Minutes			15
16		Session 6	*Q & A - Discussion Conclusion and Course Review*	Saturday	Afternoon	5/7/2016	3:15 PM	3:45 PM	30 Minutes	Bob Cimasi, ASA		16
17		Session 6	*Examination*	Saturday	Afternoon	5/7/2016	3:45 PM	4:45 PM	1 Hour			17