Site Neutrality and the Impact on Hospital-Physician Alignment

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February 20, 2020
AGENDA

I. Site Neutral Payments Overview
II. Impact on Physician-Hospital Alignment
III. Conclusions/Q&A
SITE NEUTRAL PAYMENTS OVERVIEW
INDUSTRY TRENDS DRIVING CHANGE

- Consolidation (survival of the fittest)
- Data-directed consumer decision making
- Virtual and retail medicine
- Regulatory scrutiny over new transactions
- Bundled reimbursement/shared savings models
- Political tensions and policy implications
- Coordination of care for value-based reimbursement
- Private equity interest
- High deductible health plans
Medicare historically used two different payment methodologies for outpatient procedures based on the site of service (facility portion only)

- Hospital Outpatient Prospective Payment System ("OPPS") for Hospital Outpatient Departments ("HOPDs") – 250 yards from hospital, started in 2000
- Medicare Physician Fee Schedule ("PFS") for freestanding clinics

Hospital-based procedures received higher reimbursement than ambulatory and office-based procedures

- PFS resulted in 75% less reimbursement than OPPS rate

Hospitals were incentivized to acquire independent sites, switching the designation to HOPD and receiving higher reimbursement

HOPD billings effectively doubled between 2006 and 2016

The increase created pressure to find a solution – both for Medicare and its beneficiaries
POLICY PRECURSORS

- **The Bipartisan Budget Act of 2015, Section 603 (President Obama):**
  - Off-campus provider-based sites that began billing under the OPPS on or after November 2, 2015 would not be paid for most services under OPPS after January 1, 2017
  - Facilities are now paid under the PFS unless provided at a dedicated emergency department

- **21st Century Cures Act (President Obama):**
  - Revised the site neutral payment policy of the Bipartisan Budget Act to exclude additional facilities (i.e. facilities with plans in place)

- **2017 OPPS:**
  - Implementation of the above for small group of “non-excepted” HOPDs to 40% of the OPPS rate
  - Excepted HOPDs can be shifted to site neutral payment as a result of facility relocation, remodeling or change in ownership (not due to “extraordinary circumstances”)

In 2019, CMS finalized the site neutral payment policy for off-campus provider-based departments as part of the final rule for OPPS.

CMS stated in 2019 it would start paying hospital outpatient departments a PFS-equivalent rate for clinic visit services (Go463).

- Go463 accounted for more than half of all codes billed at HOPDs in 2017.

This would be phased in over a two-year period:

- 2018: Average payment of $116 for Go463 to HOPDs
- 2019: 30% reduction to $81
- 2020: 60% reduction to $46

CMS argues these routine clinic visits could be just as easily performed in a physician office setting.

All other services still paid historical rules:

- On-Campus Facilities (less than 250 yards): Not impacted
- Excepted HOPD: Receives full HOPPS rate
- Non-Excepted HOPD: Receives 40% of HOPPS for all services
CMS, the Medicare Payment Advisory Commission ("MedPAC"), and American Medical Association ("AMA") have long criticized the payment difference of OPPS. Specifically, CMS noted the rate of growth (approximately 8% per year) for OPPS suggests payment incentives, rather than patient acuity or medical necessity, were affecting the choice of site-of-service. CMS projected the site neutral payments would reduce Medicare spending by over $300M in 2019 for these routine visits. Additionally, Medicare beneficiaries will pay $7 less in copayments for clinic visits at the off-campus provider-based departments ($80M). The goal is to create competition based on quality of care, rather than location of care. Thus, site neutral payments should give patients more options for their care. CMS used its authority under § 1833(t)(2)(F) of the Social Security Act (42 U.S.C. § 1395l(t)(2)(F)) to make this adjustment.
The financial impact to hospitals will vary greatly based on their specialty breakdown and their outpatient presence, but will likely be in the millions for many organizations (approximately a $760M hit to hospitals in 2019).

Hospitals should evaluate their budgets based on prospective reduction to reimbursement for outpatient services.

Hospitals will likely need to reconsider their physician strategies, as employment in off-campus settings may not be as practical or financially viable.

As reimbursement decreases, hospitals may also need to evaluate their physician compensation to ensure it is still commercially reasonable based on the new dynamics.

Hospitals, especially those with high levels of employed primary care providers in the outpatient setting (i.e. internal medicine and family medicine), may consider moving some services back on campus to mitigate the impact.

Medicare patients’ access to care may be negatively impacted as hospitals pull back.

*Source: Modern Healthcare*
Private practices may become more popular again, as hospitals lose the competitive edge from higher reimbursements in the outpatient setting.

This may result in an uptick in disengagement from hospitals, as well as an increase in alternatives to employment.

- Note this was already becoming a more common discussion point as value-based reimbursement increased in prevalence.

Private practices will now have the upper hand in value-based reimbursement models with emphasis on cost transparency and mitigation.
The American Hospital Association ("AHA"), the Association of American Medical Colleges ("AAMC") and various other private groups have argued fervently against this policy.

- Hospitals believe they should receive additional reimbursement as it is inherently more expensive to run their outpatient departments based on the standards they are held to as a hospital.
- Further, hospitals believe this will negatively impact care quality and create issues in the shift to value-based care.

“The new policy does not account for different patient types need and receive care from physician offices and hospitals.” – Dr. Bruce Siegel, President/CEO, America’s Essential Hospitals

“CMS lack an understanding about the reality in which hospitals and health systems operate daily to serve the needs of their communities” - AHA

CMS “exceeded its statutory authority when it reduced payments for hospital outpatient services provided in grandfathered off-campus provider-based departments” – AHA/AAMC lawsuit
In September 2019, AHA/AAMC filed an opinion to halt the policy.

US District Judge Rosemary M. Collyer ruled against the policy, stating CMS could not reduce rates for certain hospital outpatient services in a non-budget-neutral manner:
- CMS agreed to repay 2019 reimbursements affected under the 2019 policy.
- Specifically, the ruling “affirmed that cuts directly undercut the clear intent of Congress to protect hospital outpatient departments because of the many real and crucial differences between them and other sites of care.”

In December 2019, AHA filed a second opinion arguing against the 2020 OPPS Rule (which included the site neutral payment adjustment).
- Judge Collyer denied this request, stating her previous decision did not speak to the 2020 prospective cuts, just the 2019 payments.
- Hospitals will therefore receive the reduced reimbursement in 2020 and will then be required to file their complaint again.
- However, she stated CMS continuing with the policy “calls its argument into serious question and appears to set the agency above the law.”

Meanwhile, CMS has announced plans to appeal Collyer’s original decision.
WHAT NEXT?

- Hospitals should continue to monitor updates to this case; however, they should prepare for the payment adjustment to ensure they are financially viable under the new model.
- Further, while CMS has not announced plans to expand the site neutral payment adjustments, it has clearly shown its determination to implement the previous decision and it is possible this may expand beyond G0463 in future years.
- Potential future changes:
  - Expanded services impacted
  - Changes to rules on “grandfathering”
  - Additional facilities (i.e. off-campus EDs, etc.)
- Further, this has had bipartisan support and will likely be pervasive regardless of the political dynamics.
IMPACT ON PHYSICIAN-HOSPITAL ALIGNMENT
Consolidation in the healthcare industry continues to rise

Avalere Health Study:
- Between July 2012 and January 2018, the number of hospital employed physicians increased by 78% (from 94,700 to 168,800); increase of 26% to 44% of total physicians
- Hospital-owned practices doubled; 14% to 31%

As stated previously, even before site neutral payment adjustments, some physicians (even those currently employed) were seeking alternatives to employment due to the pressures on cost

Thus, alternatives have been popular:
- Professional Services Agreement (“PSAs”)
- Clinically Integrated Networks (“CINs“)/Accountable Care Organizations (“ACOs“)
- Mergers
- Private Equity (“PE“)

Still, the transition away from the historical model of solo practitioners or small, physician-owned practices is clear and will continue in virtually all areas of the country
# Alignment Overview

<table>
<thead>
<tr>
<th><strong>Limited Integration</strong></th>
<th><strong>Moderate Integration</strong></th>
<th><strong>Full Integration</strong></th>
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<tbody>
<tr>
<td><strong>Managed Care Networks (Independent Practice Associations, Physician Hospital Organizations):</strong></td>
<td><strong>Service Line Management:</strong> Management of all specialty services within the hospital</td>
<td><strong>ACO/CIN/QC:</strong> Participation in an organization focused on improving quality/cost of care for governmental or non-governmental payers; may be driven by practices or hospital/groups</td>
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<tr>
<td>Loose alliances for contracting purposes</td>
<td></td>
<td><strong>Employment “Lite”:</strong> Professional services agreements (PSAs) and other similar models (such as the practice management arrangement) through which hospital engages physicians as contractors</td>
</tr>
<tr>
<td><strong>Recruitment/EPPM/PSM:</strong> Economic assistance for new physicians</td>
<td><strong>MSO/ISO:</strong> Ties hospitals to physician’s business</td>
<td>*<em>Employment</em>: Strongest alignment; minimizes economic risk for physicians; includes a “PE-Like” model</td>
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<tr>
<td><strong>Group (Legal-Only) Merger:</strong> Unites parties under common legal entity without an operational merger</td>
<td><strong>Clinical Co-Management:</strong> Physicians become actively engaged in clinical operations and oversight of applicable service line at the hospital</td>
<td><strong>Group (Legal and Operational) Merger:</strong> Unites parties under common legal entity with full integration of operations</td>
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<tr>
<td><strong>Call Coverage Stipends:</strong> Pay for unassigned ED call</td>
<td><strong>Joint Ventures:</strong> Unites parties under common enterprise; difficult to structure; legal hurdles</td>
<td><strong>Private Equity Affiliation:</strong> Ties entities via legal agreement; sale to private investor/operator</td>
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<tr>
<td><strong>Medical Directorships:</strong> Specific clinical oversight duties</td>
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Typically
- Physician-to-Physician
- Physician-to-Hospital

Typically
- Physician-to-Physician or Physician-Hospital

Either
- Physician to Private Investor

*employment*
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<th>PSA OVERVIEW</th>
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<tr>
<td><strong>Traditional PSA</strong></td>
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<tr>
<td>• Hospital contracts with physicians for professional services; hospital employs staff and “owns” administrative structure</td>
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<tr>
<td><strong>Global Payment PSA</strong></td>
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<tr>
<td>• Hospital contracts with practice for Global Payment; practice retains all management responsibilities</td>
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<tr>
<td><strong>Practice Management Arrangement</strong></td>
</tr>
<tr>
<td>• Practice entity retained and contracts with hospital; administrative management and staff not employed by hospital, but physicians are employed</td>
</tr>
<tr>
<td><strong>Hybrid Model</strong></td>
</tr>
<tr>
<td>• Hospital employs/contracts with physicians; practice entity spun-off into a jointly-owned MSO/ISO</td>
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- Flexibility in structure
- Opportunity to increase and enhance bottom-line for both hospital and the practice
- Stability in relationship with hospital
- Bonus opportunities for exceptional performance
- Opportunities to expand services together without being fully aligned (i.e., employment and/or clinical integration)
- Easier segue to full employment for physicians and staff
TRADITIONAL PSA

PRACTICE MANAGEMENT

HOSPITAL
• Hospital employs support staff, owns equipment and assumes real estate leases

Practice contracts with hospital for professional services

Hospital pays Practice for professional services and benefit expenses (payable in a lump sum to the Practice)

PHYSICIAN PRACTICE
• Practice employs physicians (partnership stays intact)

PSA Management Committee
GLOBAL PSA

HOSPITAL
- Hospital completes contracting, owns A/R, and likely outsources billing functions*

PHYSICIAN PRACTICE
- Practice controls all management/overhead

Practice contracts with hospital for professional services
Hospital pays Practice for an aggregate payment for overhead and compensation

*Third-party agent for billing or FMV rate to practice
No sale of practice, per se

- Tangible assets may be sold or leased via the PSA
- Practice may sell ancillaries separately at FMV (may retain)
- PSA rates based on group rate per wRVU
- Similar to going to a single payer contract where PSA rate with the hospital ultimately becomes the sole source of revenue
- Practice may retain risk and overhead obligations
- Often, utilized by surgical specialists or proceduralists where reimbursement and ancillary reimbursement has declined
- Multiple PSAs could exist simultaneously
▪ Primary focus of a CIN/ACO is to create a high degree of interdependence among participating providers through care coordination and data transfer/sharing/application.

▪ Network of interdependent healthcare facilities and providers that collaboratively develop and sustain clinical initiatives and performance metrics/goals on an ongoing basis through a centralized, coordinated strategy:
  — Patient-centric
  — Structures may vary from provider to provider
  — Heavily reliant on robust IT infrastructure

▪ Centralized contracting is an essential element.
CIN VS. ACO

<table>
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<tr>
<th>CIN</th>
<th>ACO</th>
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<tr>
<td>• Interdependent healthcare facilities form a network with providers that collaboratively develop and sustain clinical initiatives</td>
<td>• Participating hospitals, providers, and other healthcare professionals collaborating to deliver quality and cost-effective care to Medicare (and other) patient populations</td>
</tr>
<tr>
<td>• Incentive (i.e. at risk) compensation based on achievement of pre-determined measures</td>
<td>• Incentive (and punitive) financial impacts based on cost savings and quality</td>
</tr>
<tr>
<td>• No “official” process to become approved as a CIN – must meet FTC parameters</td>
<td>• Formal process for applying through CMS for approval</td>
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**Legal Merger**

- The development of a new legal entity either through the creation of a “NewCo,” or Practice A “merging” into Practice B (or vice versa)
- All groups under one TIN but operating much the same as today, with some exceptions
- A “pod” mentality often exists under a legally merged structure

**Operational Merger**

- Operations, economics, governance are consolidated within NewCo
- Once established, standardization across most functional areas (clinical and business) within NewCo occurs
- A full operational merger can be effectuated by an initial legal merger phase followed by operational merger that occurs over time
- Private equity entity is an investment firm using institutional capital to purchase operating entities.
- Main goal is to purchase an enterprise with compelling base value and then grow through add-on acquisitions (using additional leveraged capital) and upon expansion of EBITDA, eventually sell those aggregated assets.
PE DEAL CHARACTERISTICS

- Upfront value is created through the application of a physician compensation reduction (or “haircut”)*
- Compensation “haircut” is treated as newly created EBITDA
- Newly created EBITDA is applied in a discounted cash flow (DCF) model that determines enterprise value
  - Or a multiple can be applied to this newly created EBITDA, thus resulting in “market value” from this calculation
- A multiple is applied to the transaction value (derived from the “haircut”)
- “Haircut” is permanent, but physicians receive post-Transaction the value of the reduced income in upfront dollars
- Some offset to the “haircut” may be realized through improved access to services and organic growth, post-Transaction
- Practice will likely be sold or further consolidated based on owner preferences - a spin-off MSO can be established and exist going forward and may also be “sold” separately
- Usually, only a percentage (majority interest) of the practice is sold to the PE firm; the physicians may get a “second bite of the apple” via subsequent sale

*Fundamentally, most practices distribute all their excess earnings each year to their partners; hence, no retained earnings or “book” equity exists
**VALUATION ILLUSTRATION**

<table>
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<tr>
<th>Acquisition by PE Firm</th>
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<tbody>
<tr>
<td>Practice Revenue (Collected)</td>
<td><em>$13,000,000</em></td>
</tr>
<tr>
<td>Total Physician Compensation (Pre-Haircut)</td>
<td><em>$6,900,000</em></td>
</tr>
<tr>
<td>Total Number of Physicians</td>
<td>10</td>
</tr>
<tr>
<td>Haircut</td>
<td>10%</td>
</tr>
<tr>
<td>Reduced Comp per Physician</td>
<td>$69,000</td>
</tr>
<tr>
<td>Multiple on Haircut</td>
<td>7.0</td>
</tr>
<tr>
<td>Transaction Value</td>
<td>(7x$690,000)</td>
</tr>
<tr>
<td>Proceeds of Transaction per Physician</td>
<td>$483,000</td>
</tr>
</tbody>
</table>

*Practice revenue and physician compensation per MGMA data for orthopedics*
PE-LIKE ACQUISITION

- Similar to a private equity transaction, however a hospital is acting as the investor
- Purchases are still made at a multiple up front, however less so than with a traditional PE firm
CONCLUSIONS/Q&A
CONCLUSIONS

- The industry (both from government/policy changes and commercial impetuses) is continuing to seek ways to reduce costs across the healthcare industry.
- The most recent change affecting hospitals has been site neutral payment adjustments.
- While this specific update may not be permanent, it is critical to consider your current alignment strategy and begin seeking alternatives.
- Thus, it is important to understand that employment is not the only option, nor is traditional employment – there are a multitude of options available.
- PE models, PSAs, Mergers, and CINs/ACOs are increasing in prevalence and can provide options for physicians that are seeking specific outcomes:
  - PSAs: Provide continued autonomy and independence and can be unwound relatively easily.
  - CINs/ACOs: Allow for joint contracting and better reimbursement, while also expanding care continuum and responding to value-based care expectations.
  - Mergers: Capitalize on economies of scale and find “strength in numbers”.
  - PE Models: Offer an opportunity for physicians to receive money for a transaction upfront and give over business management of practice.
- So long as organizations work hand in hand with experts, there are countless methods available to explore.
Any questions?
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