



The Leadership Institute: April 2023 Roundtable

April 14, 2023
8:00 – 8:45am

Jim Daniel, Partner

Hancock, Daniel & Johnson P.C.

Policy

- PHE unwinding has begun
- Drug price controls
- Vertical consolidation

Workforce

- Physician realignment
- Rise of a new labor movement
- Shifting employer-employee power dynamics

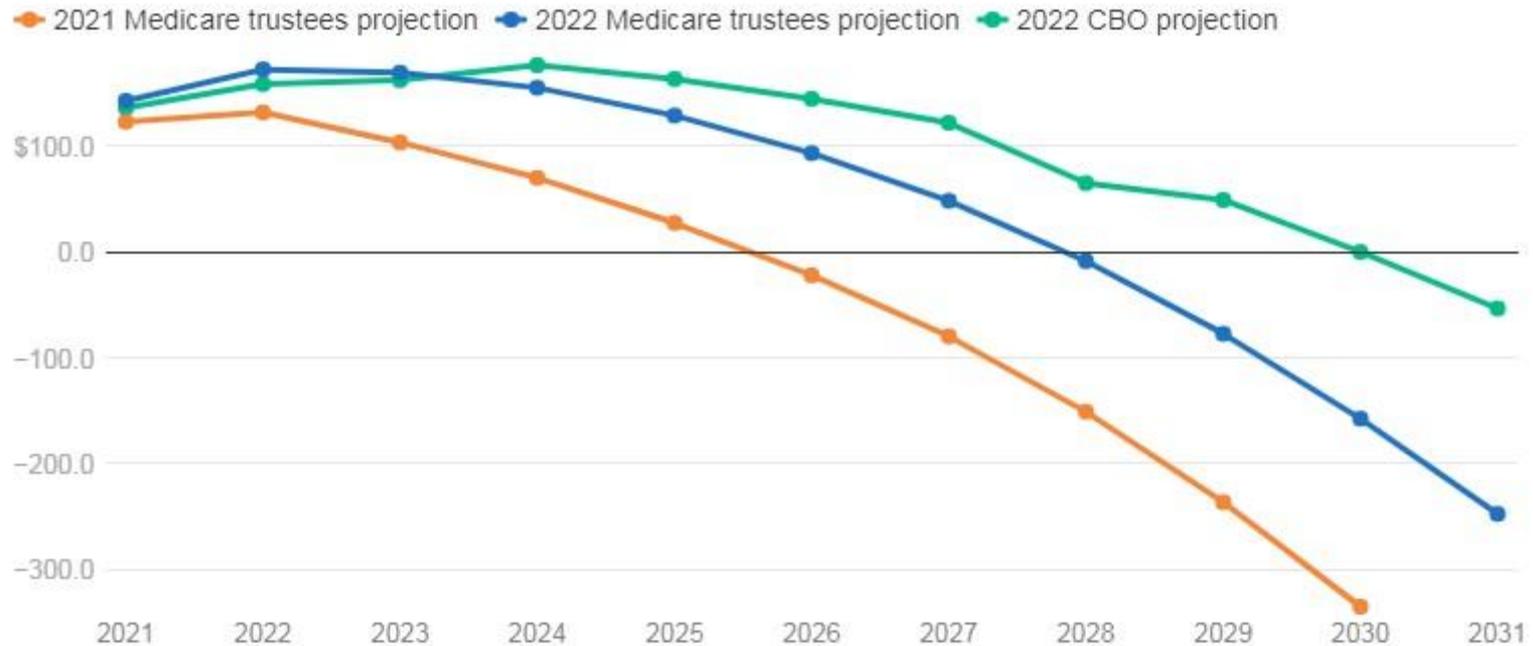
Patients

- Increasing cost-sensitivity
- Transformation of Medicare
- Incoming case mix shifts

Medicare Trustees Project Medicare's Hospital Insurance Trust Fund (Part A) to be Insolvent by 2028

The Medicare Trustees Currently Project Depletion of the Medicare Hospital Insurance Trust Fund in 2028, 2 Years Later than Their 2021 Projection, but 2 Years Earlier than CBO's Current Projection

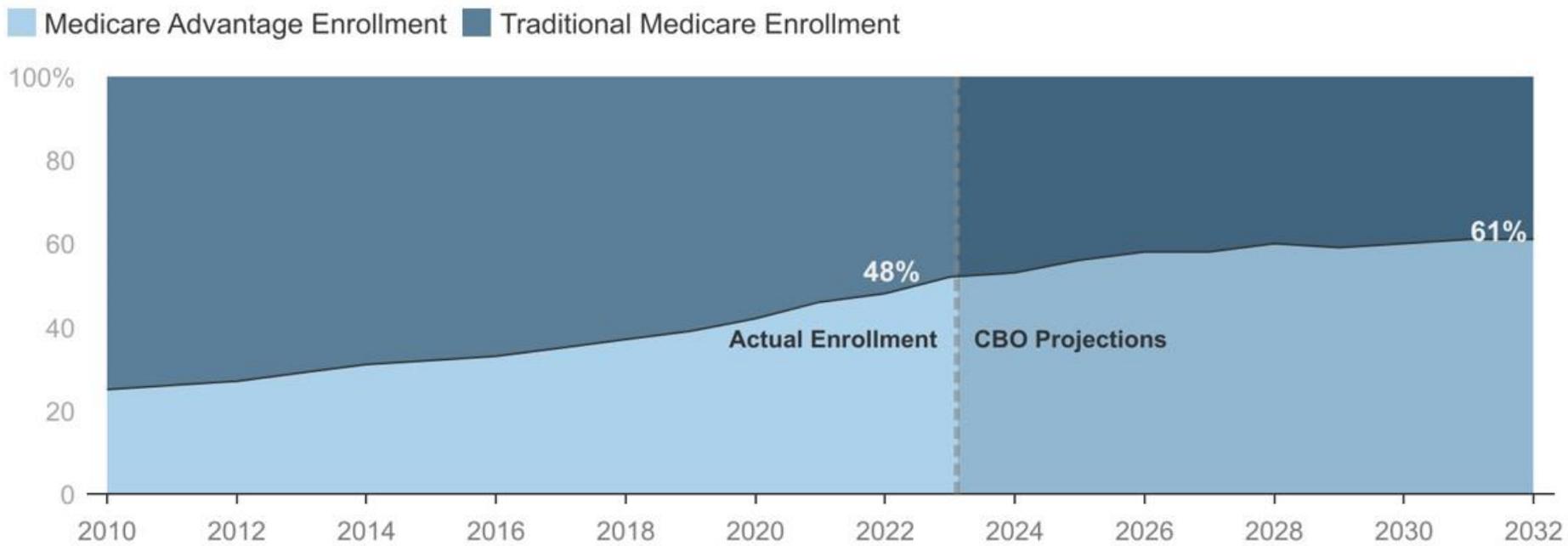
Balance in the HI trust fund at the end of the year (in billions)



NOTE: HI is Hospital Insurance. 2021 Medicare trustees: actual data for 2020 and projected data for 2021-2030. 2022 Medicare trustees: actual data for 2021 and projected data for 2022-2031. CBO: actual data for 2021 and projected data for 2022-2031.

SOURCE: KFF analysis of data from the 2021 and 2022 Annual Report of the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Trust Funds, and the Congressional Budget Office (CBO), 10-year Trust Fund Projections, May 2022. • PNG

Medicare Advantage and Traditional Medicare Enrollment, Past and Projected



NOTE: Medicare enrollment is based on individuals who are enrolled in Part B, according to the CBO baseline. This is designed to include only individuals who are eligible for Medicare Advantage and exclude those who only have Part A only (~5 million people in 2023) and cannot enroll in Medicare Advantage. However, it may include some individuals who have Part B only and also are not eligible for Medicare Advantage.

SOURCE: KFF analysis Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2017; CCW data from 20 percent of beneficiaries, 2018; and Medicare Enrollment Dashboard 2019-2022. Enrollment numbers from March of the respective year. Projections for 2023 to 2030 are from the May Congressional Budget Office (CBO) Medicare Baseline for 2022.



- CMS expects all traditional Medicare beneficiaries to be treated by a provider in a value-based care model by 2030.
- Five new CMS Strategies (2021 Announced by CMMI)



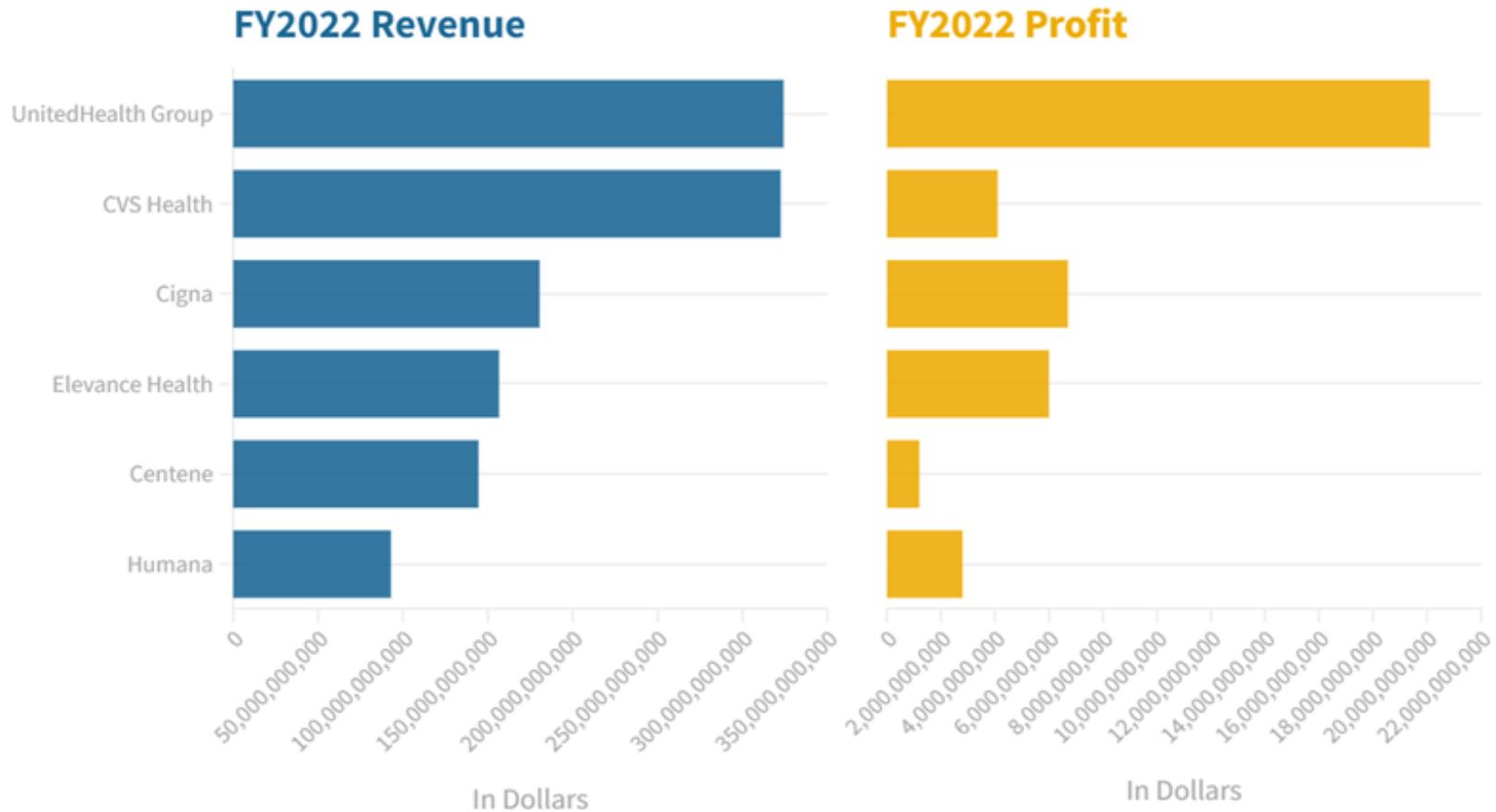
Current Environment: Moody's Outlook for Nonprofit Hospitals

NFP Q3 2022

System	Q3 Income (Loss)
CommonSpirit Health	(\$227mm)
Cleveland Clinic	(\$469.2mm)
Mayo Clinic	\$157mm
Providence	(\$161mm)
SSM Health	(\$93.3mm)
University of Colorado Health	(\$157.5mm)
Banner Health	(\$26mm)

Insurers' Full-Year 2022 Results

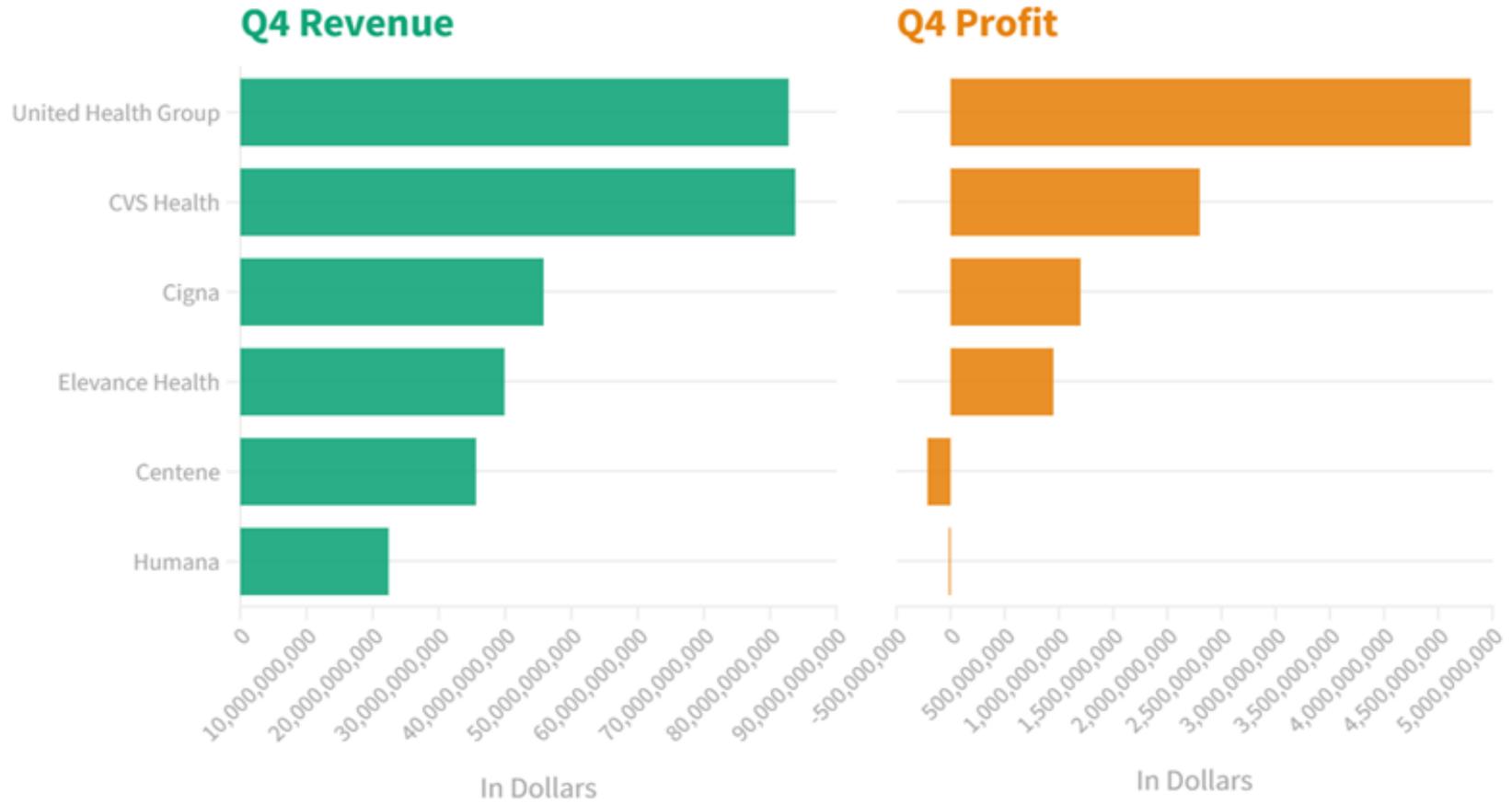
Each of the payers we analyzed turned a profit last year.



Source: Company earnings reports

Insurers' Q4 Earnings

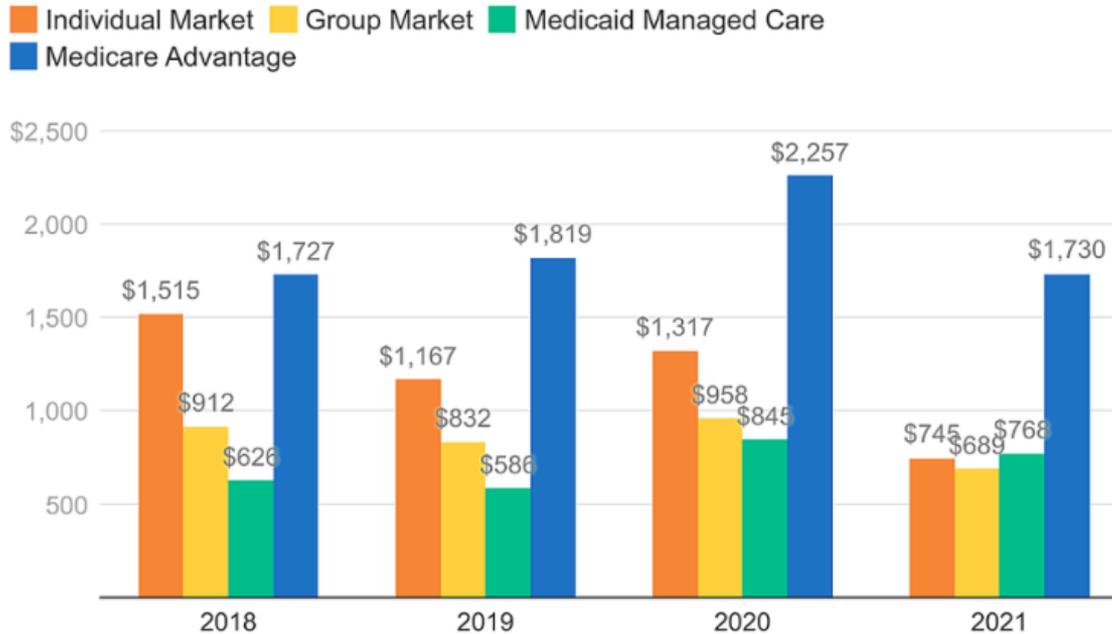
Two major national payers posted losses in the fourth quarter of 2022.



Source: Company earnings reports

Trends: Recent Health System Acquisitions

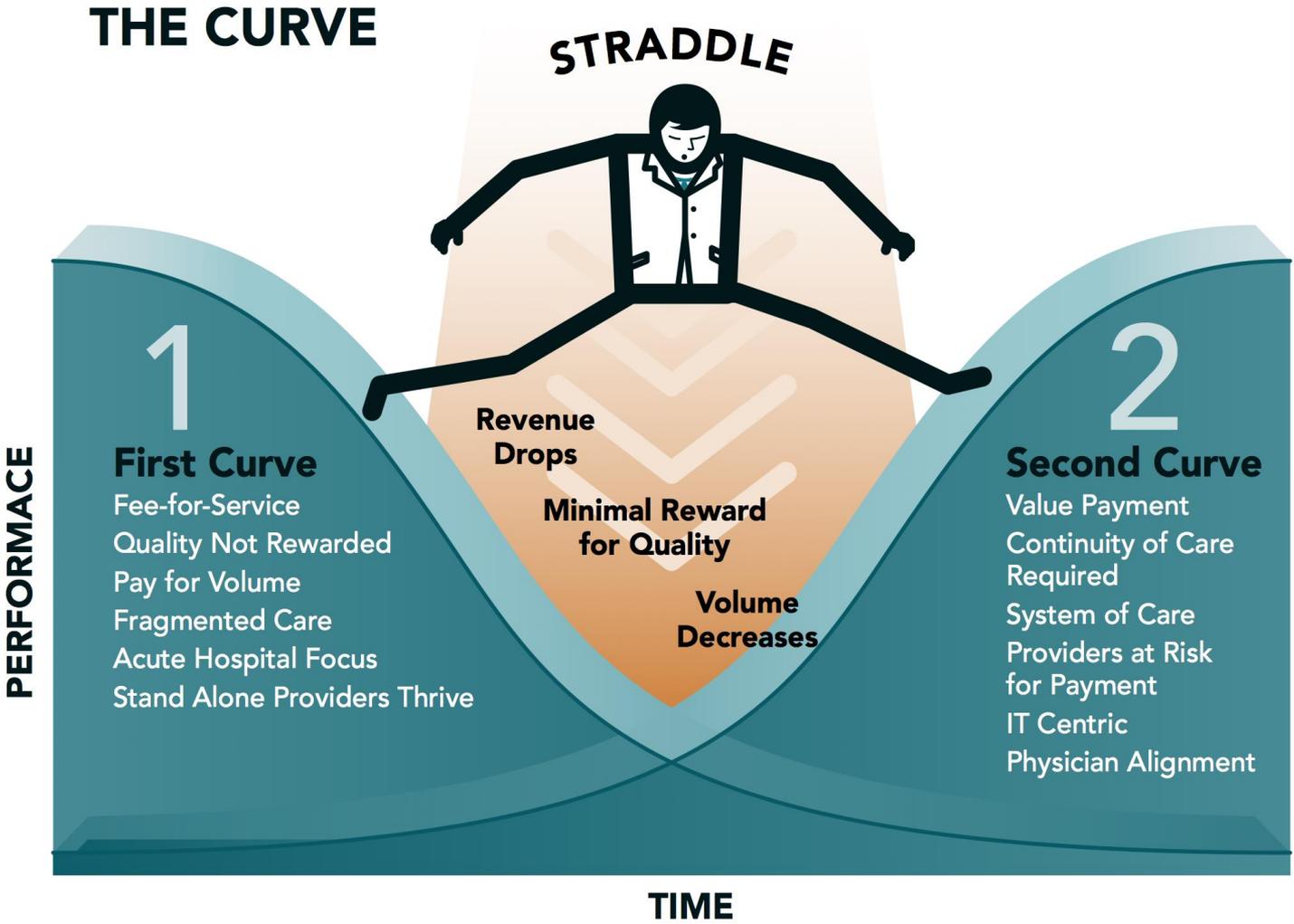
Gross Margins Per Enrollee, 2018-2021



NOTE: Gross margins per enrollee are the amount by which total premium income exceeds total claims costs, divided by the number of enrollees. Gross margins include administrative costs, tax liability, and profits.

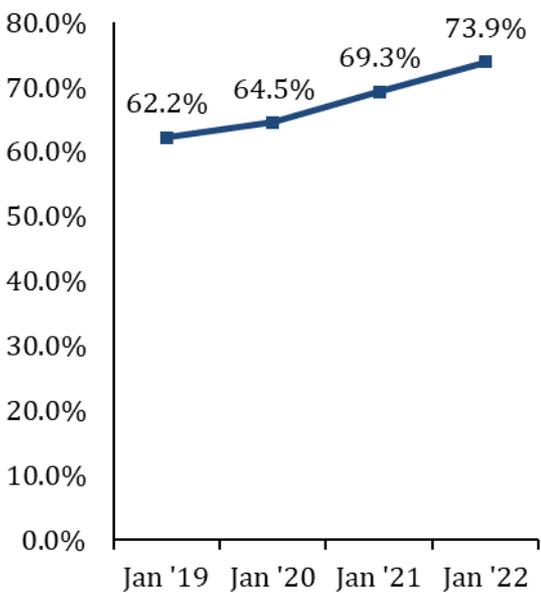
SOURCE: KFF analysis of data from Mark Farrah Associates Health Coverage Portal TM.



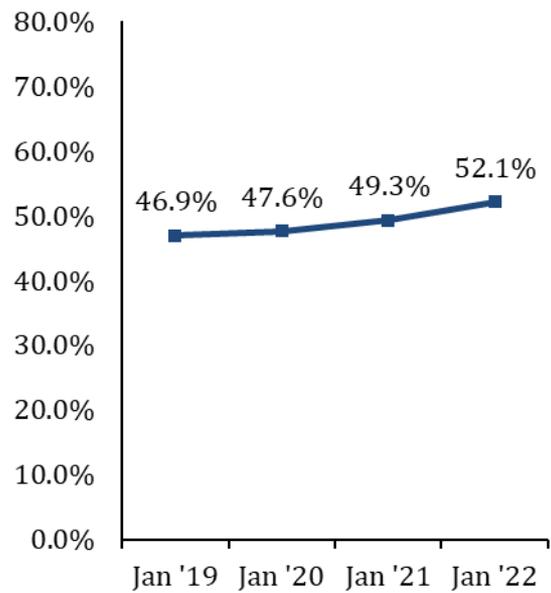


With COVID-19 accelerating the pace, 74% of physicians are now employed by hospitals or corporate practices.

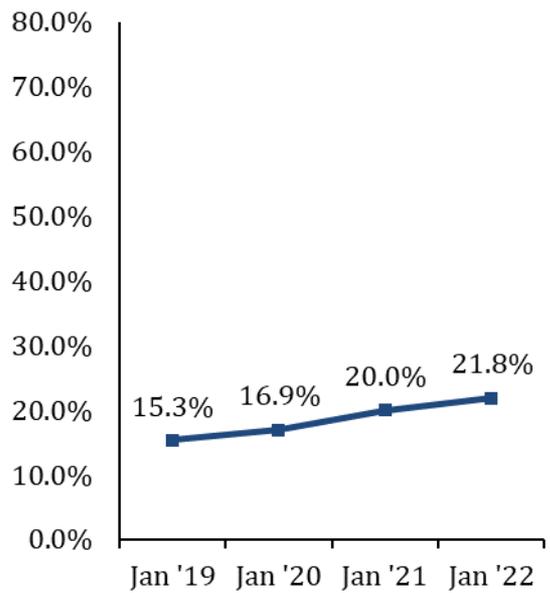
% of Physicians Employed by Hospitals or Corporate Entities



% of Physicians Employed by Hospitals



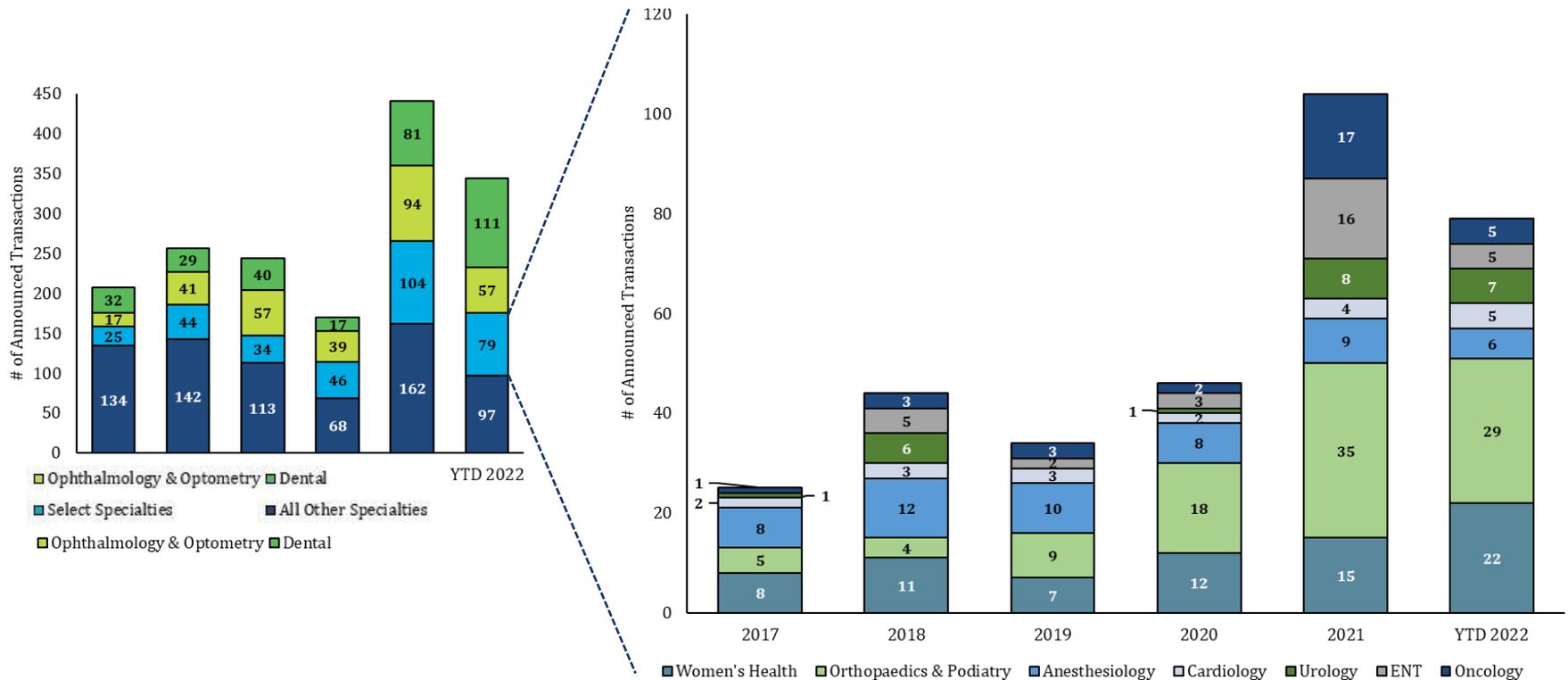
% of Physicians Employed by Corporate Entities



Source: Physicians Advocacy Institute, Avalere Analysis of IQVIA OneKey Database, April 2022.

Specialties by Year

PE interest in physician specialties, which has driven a significant portion of the transaction activity, continues to evolve.



Sources: Irving Levin, Pitchbook, Transaction Press Releases, Matrix Analysis. YTD is through mid-August 2022.

Illustrative Example

- 6 Cardiologists
- Average salary of \$550,000

Total Revenue	\$	6,000,000
<i>Less: Total Expenses</i>	\$	(5,400,000)
Net Income	\$	600,000
<i>Plus: Interest</i>	\$	100,000
<i>Plus: Depreciation and amortization</i>	\$	200,000
Historical EBITDA	\$	900,000
<i>Plus: Physician Base Salary (6*\$550,000)</i>	\$	3,300,000
EPBC	\$	4,200,000
30% Capitalization	\$	1,260,000

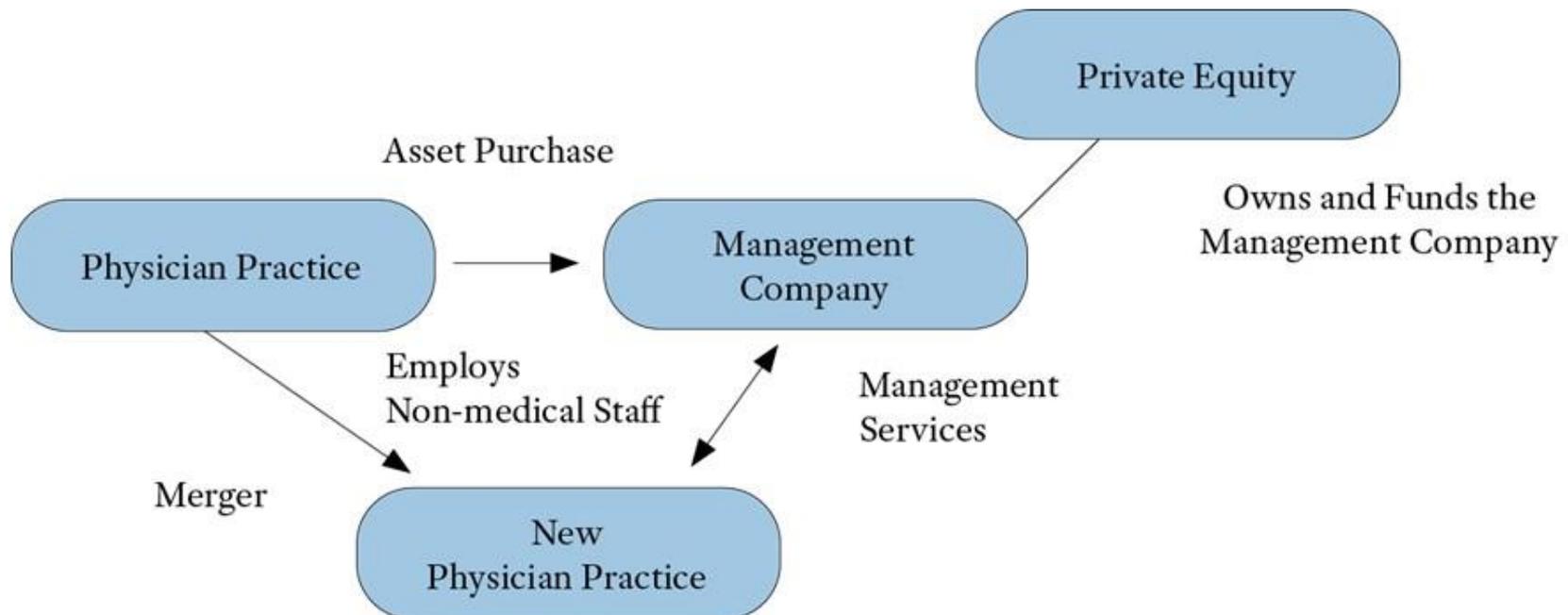
Adjusted EBITDA Calculation

Historical EBITDA	\$	900,000
<i>Plus: Normalized Compensation</i>	\$	1,260,000
<i>Plus: Other Non-Recurring/ Non-Operating Expenses</i>	\$	150,000
<i>Plus: Other Income</i>	\$	100,000
Adjusted EBITDA	\$	2,410,000
<i>Times: Transaction Multiple</i>		6.0X
Implied Purchase price	\$	14,460,000
<i>Adjusted Provider Compensation</i>	\$	340,000

Upfront Purchase Price Proceeds (87.5%)	\$	12,652,500.00
Rollover Equity Proceeds (12.5%)	\$	1,807,500.00

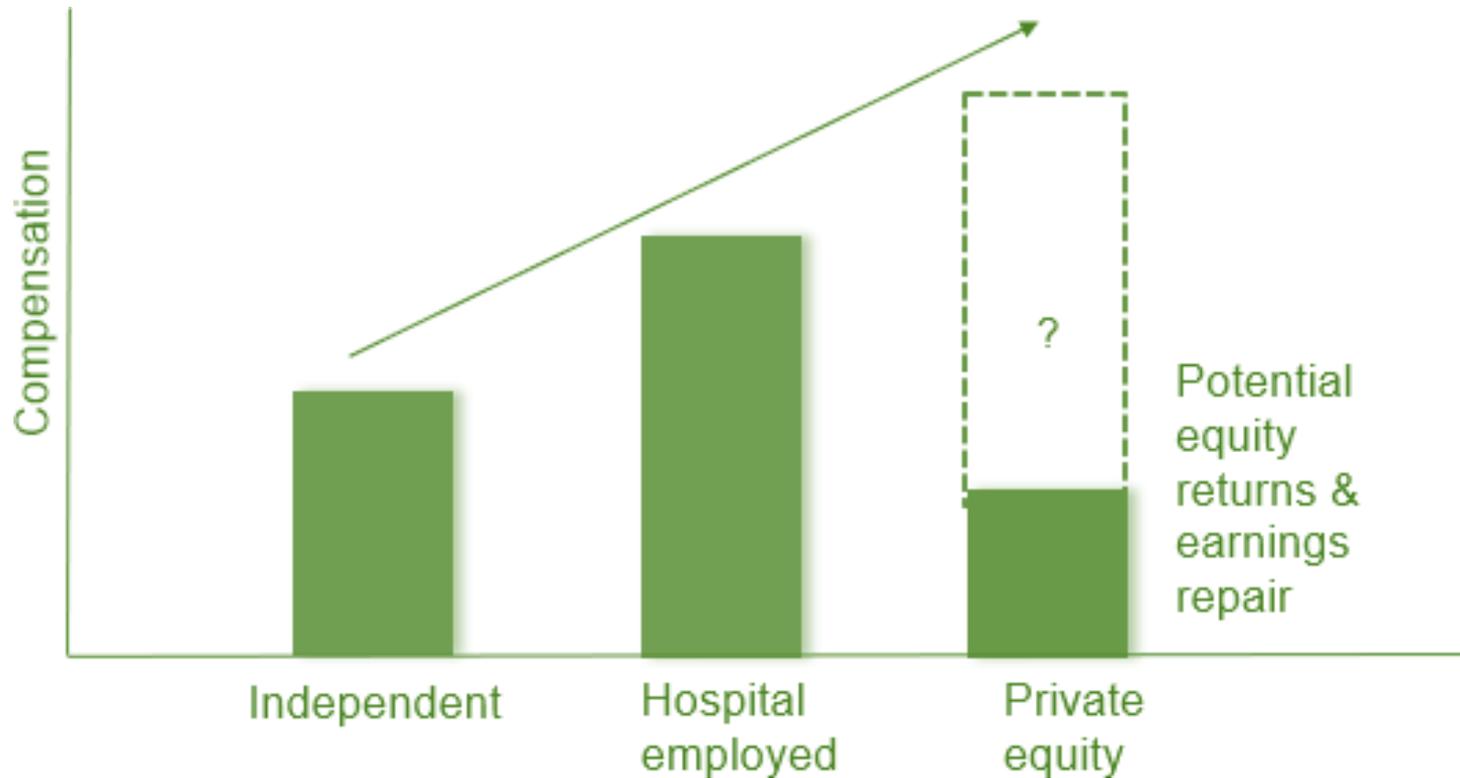
Transaction Structure

Asset purchase transaction involving a merger of the target physician practice with the new physician practice

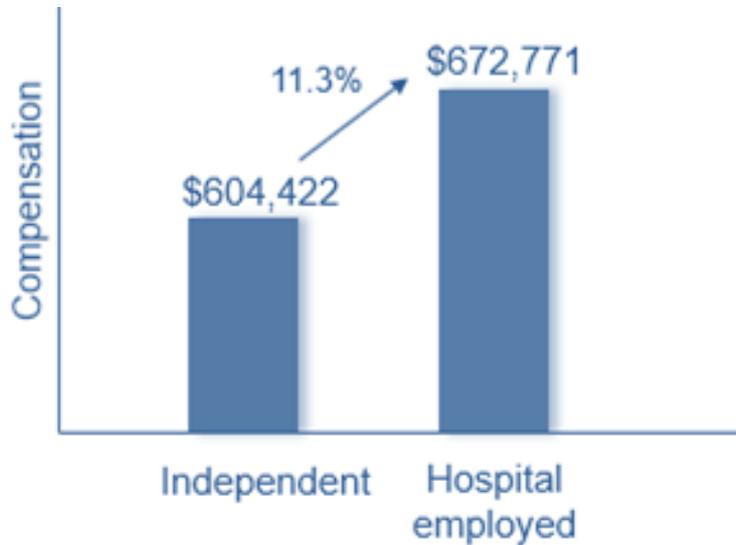


The model illustrated in Example 3 may be used if both the target entity and the new physician practice have value that should be combined, there are no actual or known contingent liabilities that may negatively impact the physician practice on a going-forward basis, or for tax reasons. This model is usually not advisable due to the problems of integrating the combined entities.

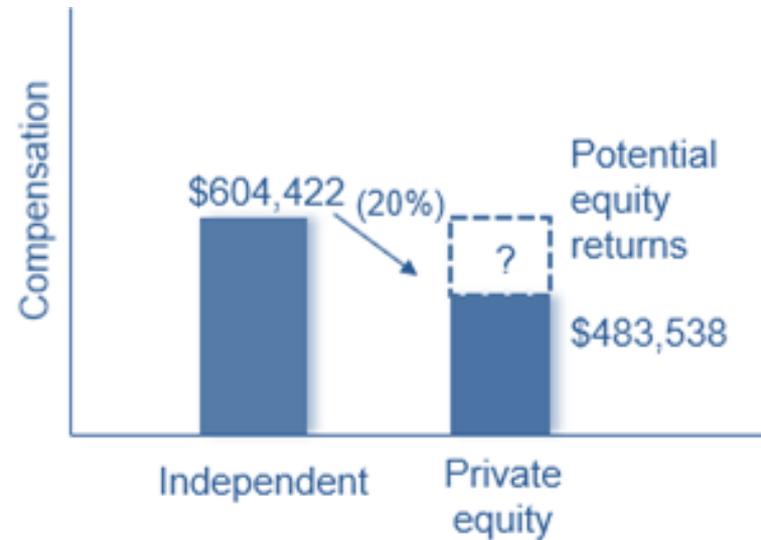
Comparison of Compensation



Long-Term Planning: Comparison of Compensation



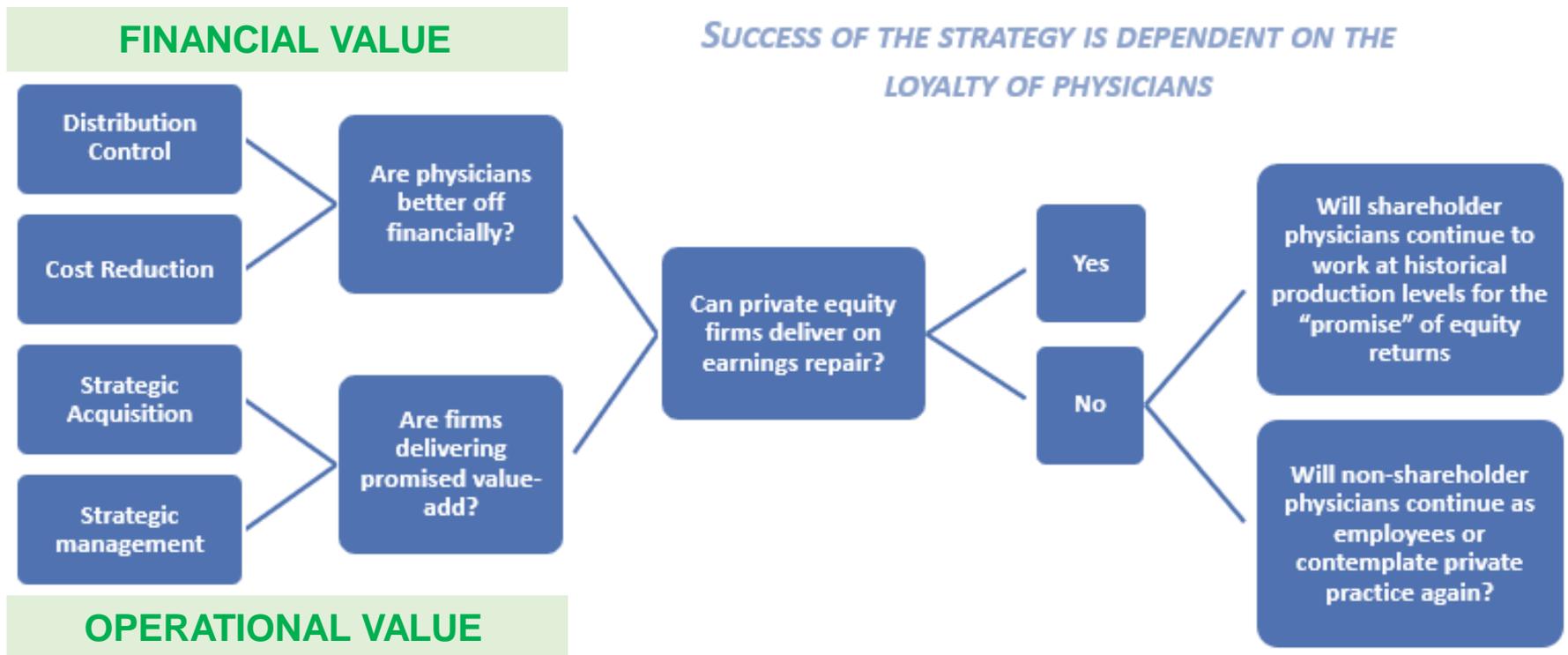
COMPENSATION INCREASE



COMPENSATION DECREASE

- Transactions with the PE firm will include a 'scrape' or revenue reinvestment that is put back into the company.
- Average is 30% (can range from 30-50%)
- PE firms will work to 'repair' scrape loss over 3-5 years through growth levers

Equity Returns and Earnings Repair



Employment

PSA

Recruitment/
Income
Guarantee



Financial
Pressures



Changing
Market
Dynamics

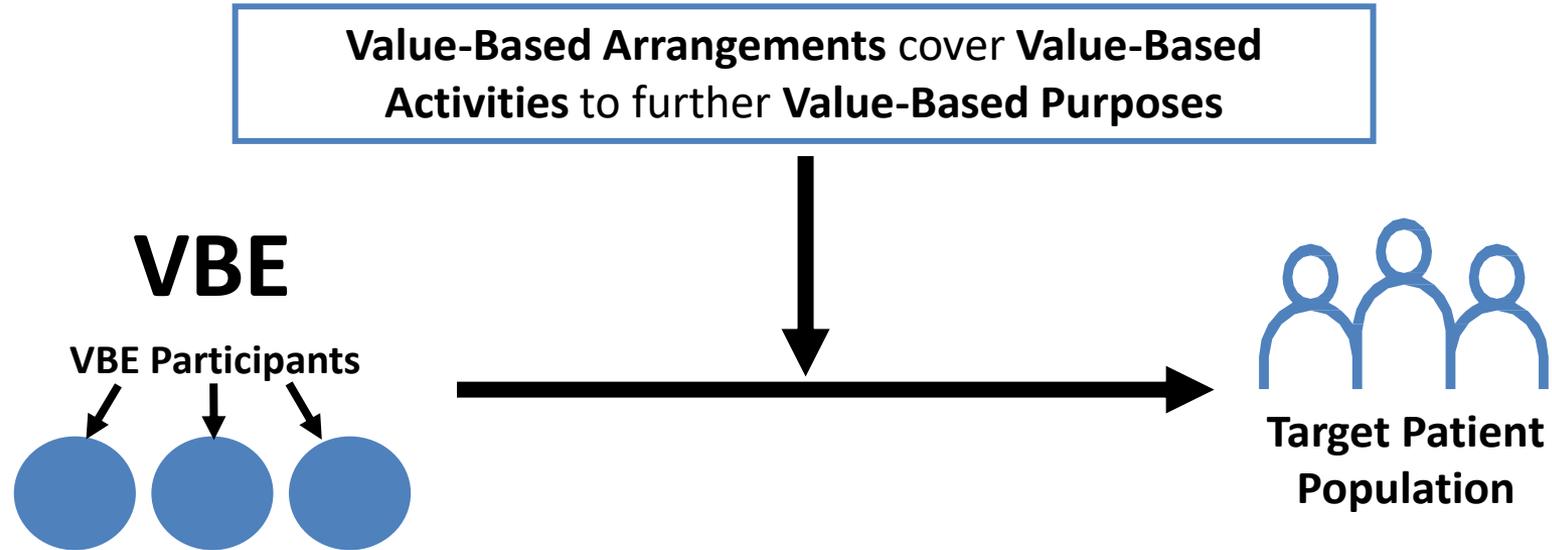


Rethinking
the
Physician
Enterprise

Employ

Partner/Co-
Invest

Tiered
Network



Value-Based Enterprise (VBE)

two or more value-based participants collaborating to achieve value-based purpose, using a value-based arrangement and has an accountable body or person and governing document

Value-Based Arrangement

an arrangement for a value-based activity by the value-based enterprise and/or its value-based participants

Target Patient Population

an identified patient population selected by value-based enterprise or its value-based participants using “legitimate and verifiable criteria” set out in writing, in advance

Stark Exceptions

Full Financial Risk – value-based enterprise assumed full financial risk from payor for patient care for target patient population

Meaningful Downside Financial Risk exception – value-based arrangement where physician at downside risk for failure to achieve value-based purpose

Value-based arrangement exception – any value-based arrangement (satisfying certain requirements)

Anti-Kickback Safe Harbors

Full Financial Risk – Value-based enterprise financial responsible for all costs covered by payor for each patient in target patient population

Substantial Downside Financial Risk – value-based enterprise has assumed less than full downside financial risk for *failure of VBE to achieve value-based purpose*

Care Coordination Safe Harbor – coordination arrangements to improve quality, health outcomes, and efficiency

Health System Sponsored CINs Must Do All Three Things

Right care, right time, right place, right price erodes inpatient volumes without targeted growth and network strategies.



Intramural Utilization



Expanding Attributed Population



Tertiary / Quaternary Growth

Providing the Right Care in the Right Place at the Right Price Requires New Behavior and New Approaches

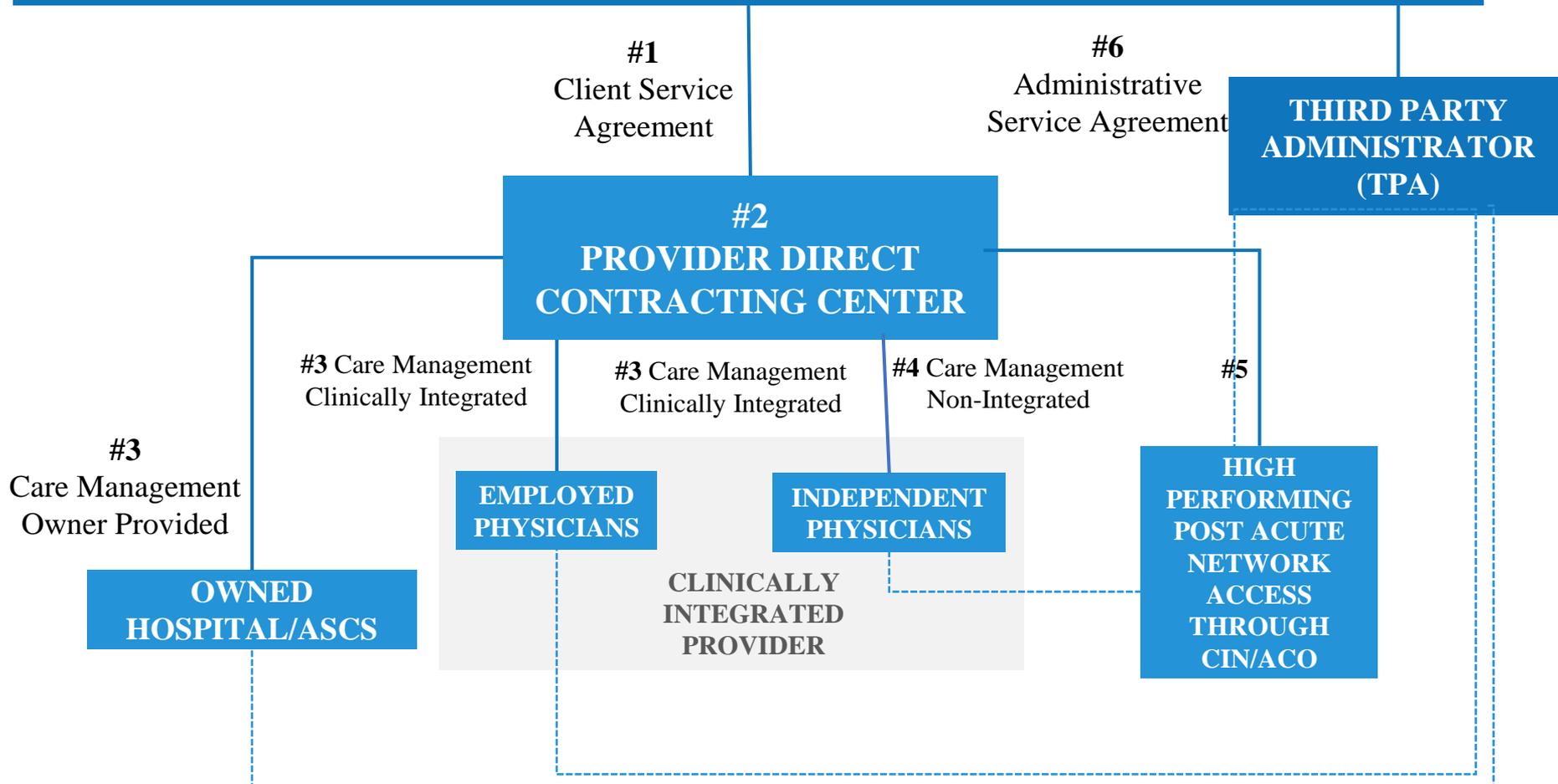


Developing a compelling value proposition to shift independent providers, particularly PCP's, to a clinically integrated network hinges on the value of potential contracting opportunities coupled with system provided infrastructure support.

	Participation	Contractual Opportunities	Incentives
	Tier 4 – Fully Aligned <ul style="list-style-type: none"> Primary Care Employed Medical Group 	<ul style="list-style-type: none"> Capitated Contracts Narrow Network Commercial / DTE 	<i>Risk-sharing Value-based Incentives</i>
	Tier 3 - Advanced <ul style="list-style-type: none"> Specialty Groups 	<ul style="list-style-type: none"> Narrow Network Commercial / DTE In-network Provider 	<i>In-network Access to Lives JV Participation Other Alignment Models</i>
	Tier 2 - Moderate <ul style="list-style-type: none"> Hospital Contracted Groups 	<ul style="list-style-type: none"> In-network Provider 	<i>Contract + Subsidy Performance Goals</i>
	Tier 1 - Basic <ul style="list-style-type: none"> All Other Network Participants 	<ul style="list-style-type: none"> Messenger Model Contracting 	<i>Claims Analytics Care Management Resources</i>

Overview of Direct Contracting Arrangements

EMPLOYER PLAN



Bundled Payment Financial Model

- **Employer benefit = lower cost; Provider benefit = volume + risk-share**

DRG Inpatient and PACS Fee for Service Model

$$\$3,200 + \$12,400 + \$9,200 + \$1,200 = \$26,000$$



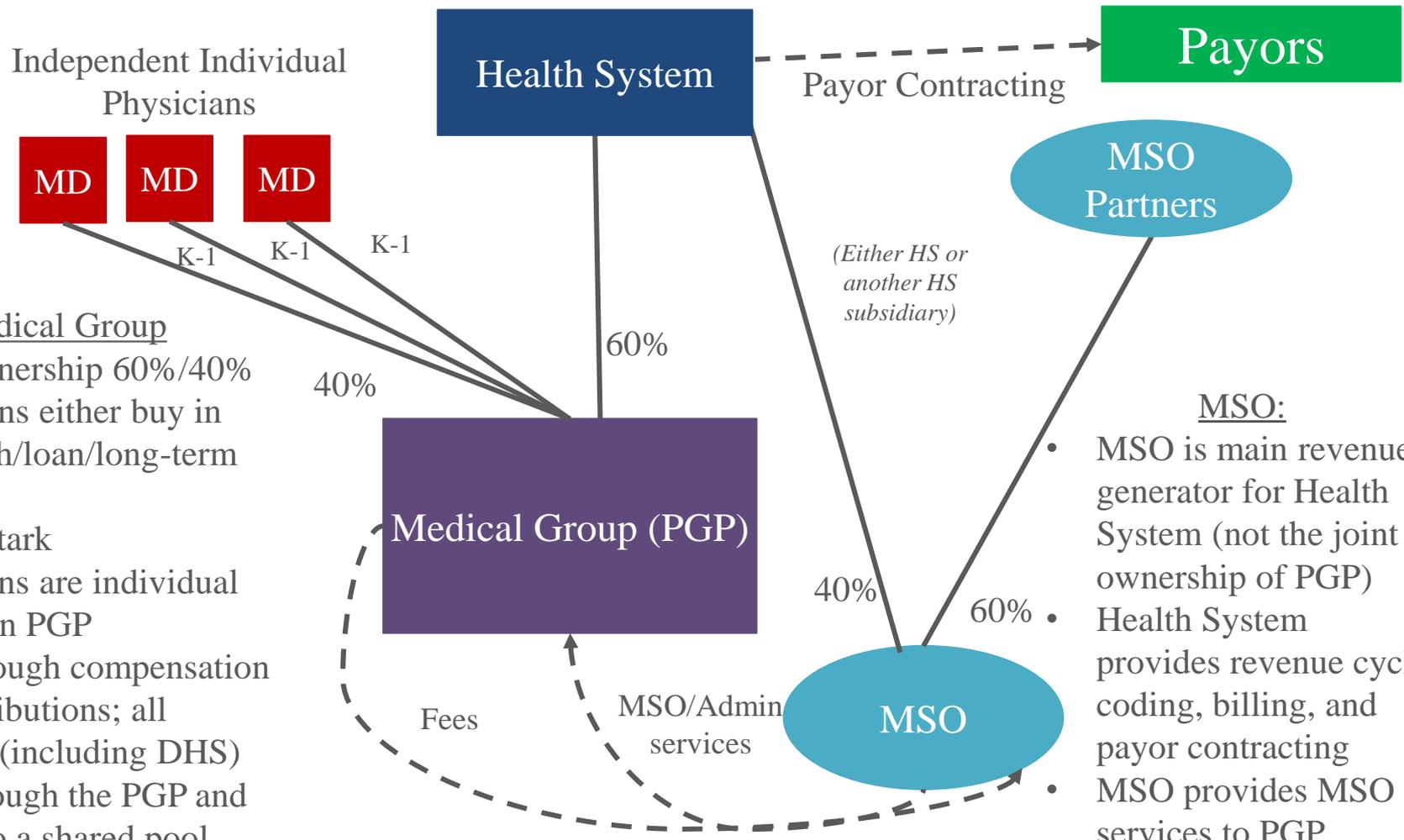
Bundled Price = \$24,000

	Fee-for-Service (On Average)	Bundled Payment
Volume to Partnered Provider	125	250
Total Payment for Services	\$26,000	\$24,000
Price of Care Delivery	\$26,000	\$23,000
Savings from Efficiency & Partnerships	\$0	\$3,000 ¹
Bundled Margin	--	\$1,000
Net Impact to Employer	\$500,000²	
Net Impact to Provider	\$870,000³	

1) Represents FFS payment of services less price of care delivery in bundle model

2) Assumes a \$2,000 savings to the employer across 250 encounters

3) Bundle Margin * volume + additional hospital volume margin estimated as \$12,400 * 40% * additional volume



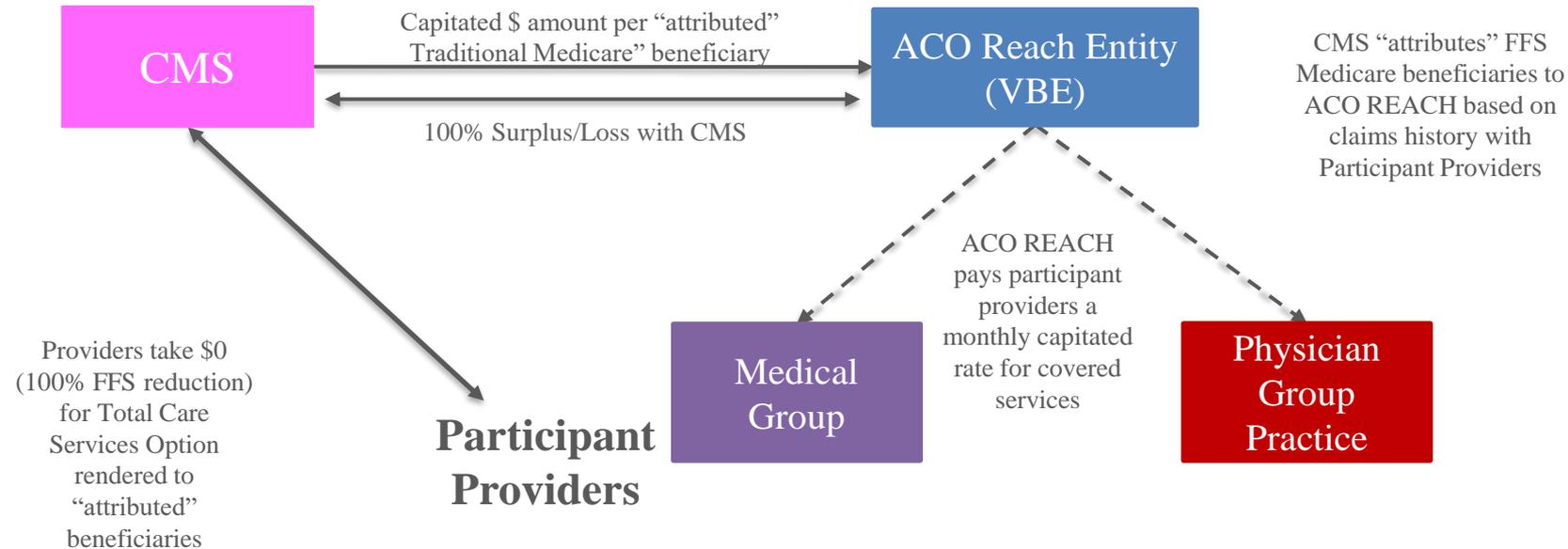
Medical Group

- Split ownership 60%/40%
- Physicians either buy in with cash/loan/long-term contract
- PGP – Stark
- Physicians are individual owners in PGP
- Paid through compensation not distributions; all revenue (including DHS) runs through the PGP and goes into a shared pool
- Health System doesn't take any from the shared pool
- PGP is mainly primary care

MSO:

- MSO is main revenue generator for Health System (not the joint ownership of PGP)
- Health System provides revenue cycle, coding, billing, and payor contracting
- MSO provides MSO services to PGP
- PGP pays FMV fees to MSO

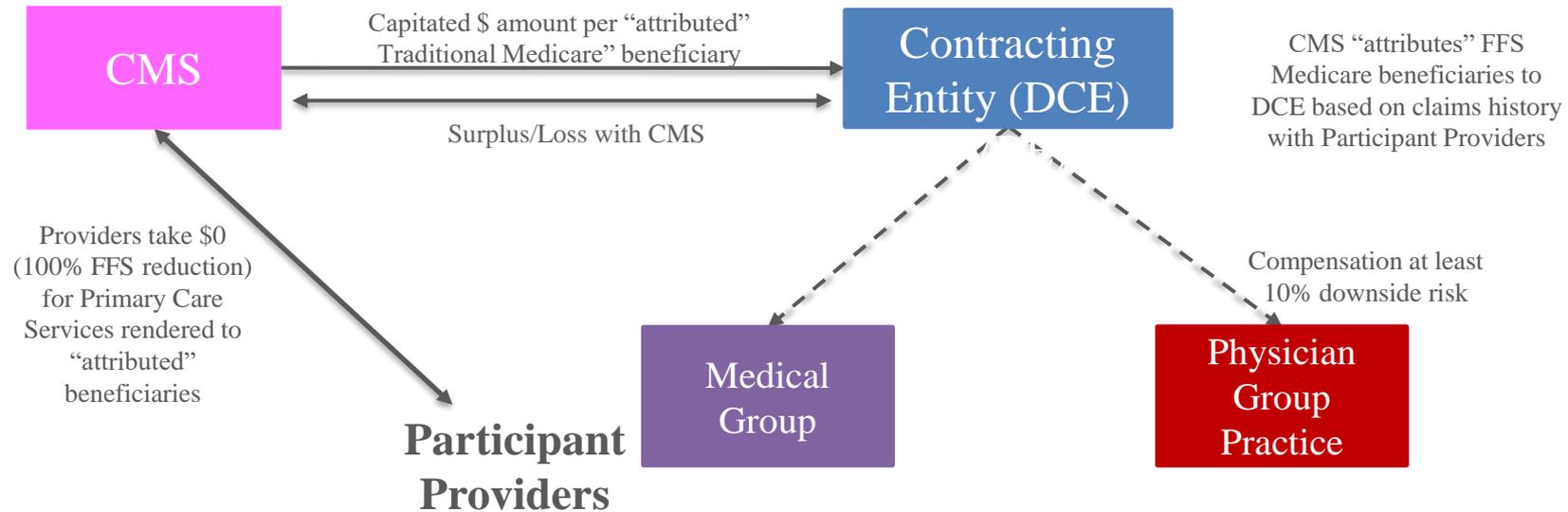
ACO Reach – Global Option Total Care Capitation Payment - Full Financial Risk



- Target Patient Population = Attributed Medicare Beneficiaries
- ACO at full financial risk during the entire duration of the arrangement.
 - ACO is financially responsible on a prospective basis for cost of all patient care items and services for each patient in the TPP
- Remuneration (surplus payments) results from value-based activities undertaken by ACO
- ACO Board = Accountable body responsible for financial & operational oversight of the VBE

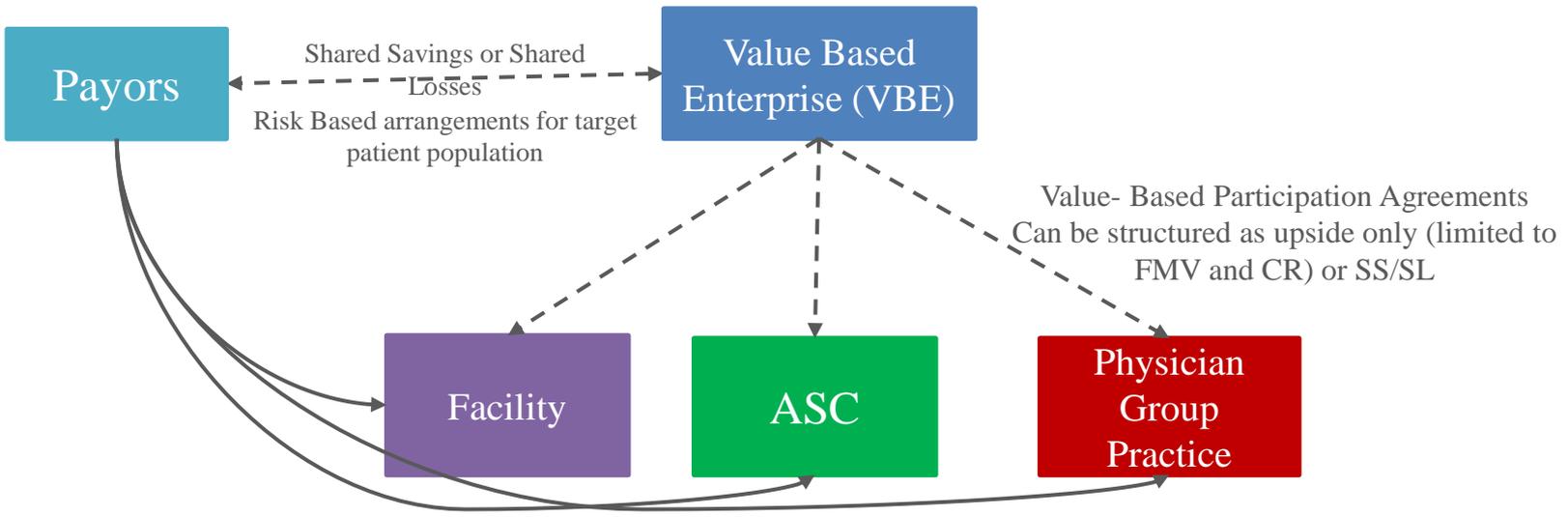
Direct Contracting Overview

Meaningful Downside Risk



- Target Patient Population = Attributed Medicare Beneficiaries
- PCP Global would not fall under the full financial risk model.
- DCE participant physicians sharing in the surplus/loss would be required to meet the meaningful downside financial risk to the physician.
 - Physician responsible for repaying or forgoing no less than 10% of the total value of remuneration the physician receives under the value-based arrangement.
- Methodology for shared savings/shared loss set out in writing set in advance

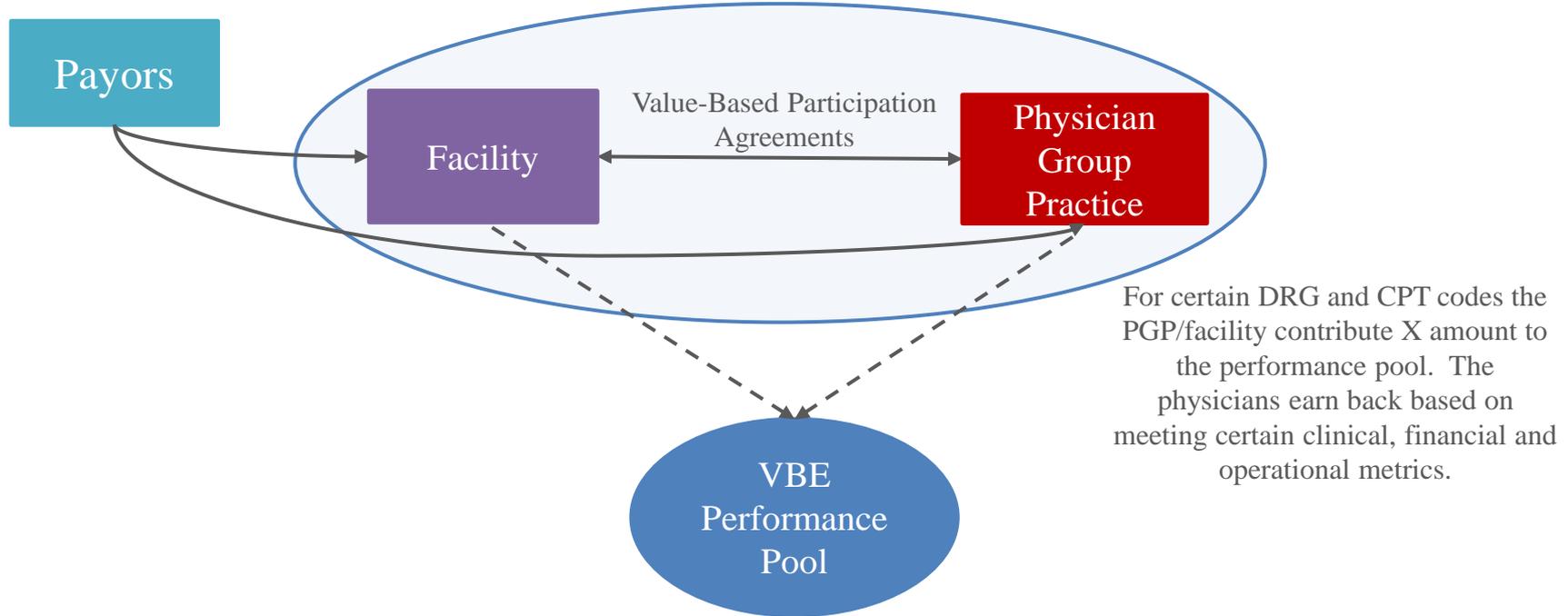
Meaningful Downside Risk



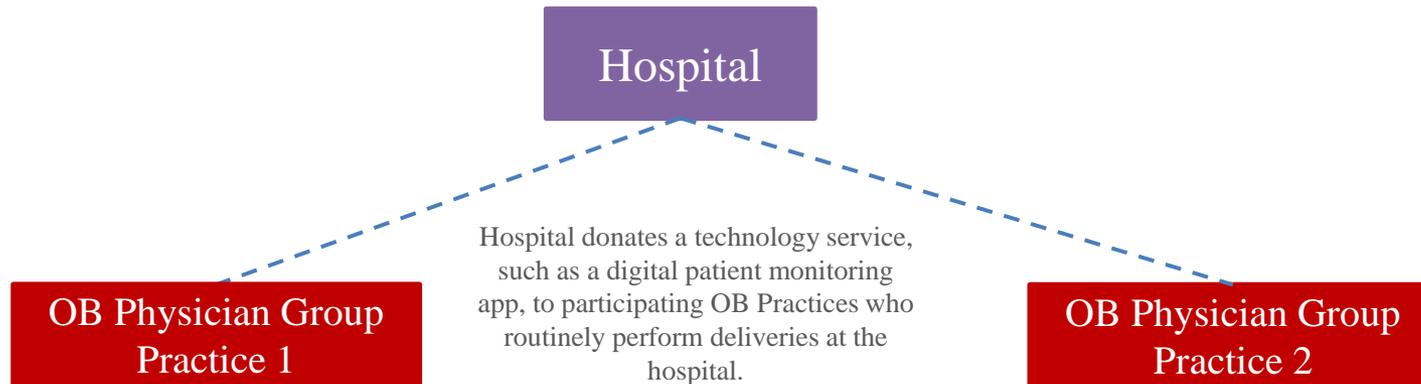
- TPP = Payor insured patients with certain conditioned.
- Arrangement set forth in writing and signed by the parties.
 - Specifies value-based activities and how activities will further the value-based purpose.
- Remuneration = shared saving/shared loss distributions to physicians
- Identify committee comprised of physicians and hospital representatives to serve as accountable body responsible for financial and operational oversight.
- Potential earnings are limited depending on whether the organization is “upside only” or whether the organization is at meaningful downside financial risk.

Bundled Payment Example – No VBE Intermediary

Meaningful Downside Risk



- TPP = Patients served by VBE with certain condition
- Arrangement set forth in writing and signed by the parties.
 - Specifies value-based activities and how activities will further the value-based purpose.
- Remuneration = performance pool distributions
- Identify committee comprised of physicians and hospital representatives to serve as accountable body responsible for financial and operational oversight.



- Target Patient Population = Patients scheduled to have deliveries performed at the Hospital
- Arrangement set forth in writing and signed by the parties.
 - Specifies value-based activities and how activities will further the value-based purpose.
- Remuneration = donation of technology service
- Identify committee comprised of physicians and hospital representatives to serve as accountable body responsible for financial and operational oversight.
- Set outcome measures against which physicians will be assessed (for example, utilization of app, participating in hospital initiatives to better coordinate care for OB patients).



Questions?



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