FAIR MARKET VALUE PRIMER

Value-Based Care Distribution Models

For value-based care organizations such as multi-provider networks (MPNs), assessing the fair market value of payments to participating providers for their contribution to shared savings and other performance and quality -based bonus income from payers can be a challenge.

GENERAL OVERVIEW

MULTI-PROVIDER NETWORKS

Multi-provider network ("MPN") is a generic term for a variety of provider/payer contracting entities that include accountable care organizations ("ACOs"), clinically integrated networks ("CINs"), independent physician associations ("IPAs"), management services organizations ("MSOs"), and physician-hospital organizations ("PHOs"). MPNs consist of a network of physicians and other providers that group together to contract with third-party payers, and often participate in contracts that include the potential for care management, shared savings, and other performance and quality -based bonuses that can generate revenue for the MPN. These bonuses are separate from the contracted rates participating providers receive for their professional services.

SHARED SAVINGS DISTRIBUTION MODELS

Most MPNs receive the majority of their revenue through these shared savings and other quality and performance -based bonuses earned through effective care management over the course of a performance period. Some MPNs also charge their participating providers a membership or administration fee, while others have additional revenue streams such as health information exchange ("HIE") access fees. The MPN usually distributes a portion of the bonus income received from payers to participating healthcare providers based on a pre-determined distribution formula outlined in the provider participation agreement or similar document, regardless of ownership (a "provider distribution model" for simplicity). The remainder of the bonus income is retained to cover operating costs and generate a return for the MPN's owners.

As with most financial arrangements between healthcare providers, especially those in position to refer patients to each other, it is prudent for MPNs to make efforts to ensure that payments from their provider distribution models meet the fair market value standard.[1]

FMV CHALLENGES

Developing a provider distribution model that will result in FMV payments for these types of arrangements is particularly challenging for several reasons:

1. **Payments Are Not Tied Directly to Services with Measurable Effort:** Unlike other forms of physician compensation, shared savings distributions are not tied to services that can be quantified through wRVUs, hours worked, or other productivity-based metric. The value-based nature of these arrangements offers considerably greater flexibility than other physician compensation arrangements, but also less clarity.
2. **Wide Variety of Organizational and Operational Structures**: Drawing comparisons between different MPNs is difficult, as organizational structures differ widely, with ownership ranges from 100% physicians to 100% health system to 100% corporate, and everything in between. Further, MPN's may generate revenue from a variety of sources beyond these risk-based bonus payments, such as care management fees (typically PMPM), HIE access fees, and participant dues, each of which may or may not be shared with the provider network. Finally, provider distribution models vary in structure, as some are based on shared savings revenue, some on profits, and others based on a more complicated formula, which can include different payment structures for different classes of providers (primary care vs. specialists vs. facilities, etc.).
3. **Revenue Uncertainty**: Shared savings and other quality and performance -based bonus payments, which are usually the primary source of revenue for an MPN, are highly uncertain. Many contracts, such as the Medicare Shared Savings Program ("MSSP"), are binary: no payments are made (or even losses are incurred) if cost-based goals are not achieved by the MPN. As has been widely reported, only around 30% of MSSP ACOs have historically earned shared savings bonuses in any given year. MPN operating expenses, on the other hand, are mostly fixed.

TESTING FOR FMV

There is no single formula or rule of thumb that ensures that a provider distribution model will result in FMV payments. Instead, the model should be reviewed from several perspectives, each of which is based on economic concepts drawn from the three traditional approaches to valuation: market, income, and cost.

- **Test #1 (Market)**: Do the payments make sense relative to publicly-available market data for similar arrangements?
- **Test #2 (Income)**: Is the anticipated split of future overall entity profits reasonable relative to the contributions of each stakeholder group?

[1] It is worth noting that this isn't always the case due to several waivers published by the OIG related to the Stark Law and the Anti-Kickback Statute for specified financial arrangements involving Medicare Shared Savings Program ("MSSP") ACOs.

- **Test #3 (Cost)**: Over the long-term, can the MPN be expected to cover operating costs, and even generate a reasonable return for its owners after provider distributions have been made?

Test #1 (Market): Do the payments make sense relative to publicly-available market data for similar arrangements?

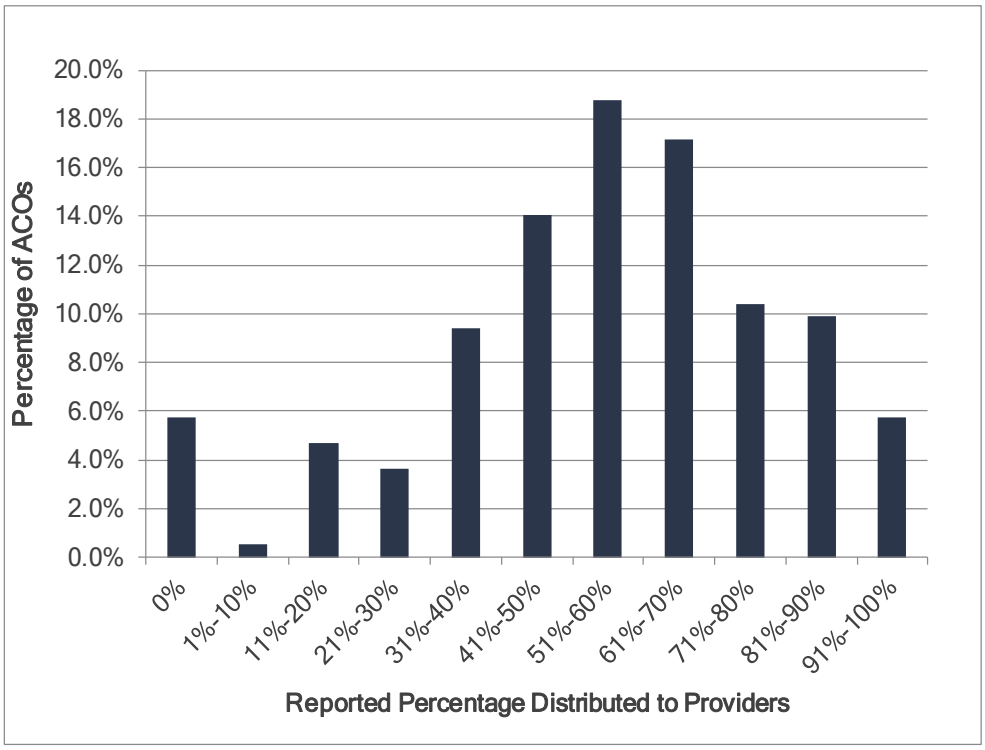
As private arrangements, most MPN participation agreements and the related provider distribution models are not disclosed publicly. The one exception is ACOs, where participation in the MSSP requires the disclosure of the intended split of shared savings income between providers and the ACO. We performed a study that involved researching the publicly reported distribution split for 192 ACOs who achieved savings in PY 2019, and found that the reported distribution models ranged from 0% to 100% of shared savings distributed to providers, which is not terribly helpful. The range at the 25th and 75th percentiles was 45% to 75% distributed to providers, respectively, while the median reported provider distribution was 60% of shared savings.

ACO Provider Distribution Benchmarks				
	25th Percentile	Median	Average	75th Percentile
Provider Distributions	45.0%	60.0%	58.0%	75.0%
Retained by ACO	55.0%	40.0%	42.0%	25.0%

Source: Study of 192 ACOs that publicly reported their PY 2019 shared savings distributions.

Separating the study results into increments of 10% reveals that the most common provider distribution percentage was in the 51% to 60% range, while the 61% to 70% range was the second most common.

Value-Based Care Distribution Models



Source: PY 2019 study of 192 ACOs that achieved shared savings.

While the study generally reflects our experience performing provider distribution model FMV reviews and entity valuations, there are several important limitations that contribute to the wide variation of reported policies that should be noted when relying on this data:

- Ownership percentages are not disclosed: An ACO that is 100% physician-owned may not have a provider distribution model at all and may choose to divide 100% of the profits pro rata based on ownership.
- Participation fees and other income, if any, are not disclosed: An ACO that collects membership fee revenue from participants, particularly when it is equal to or in excess of budgeted operating expenses, may feel comfortable allocating 100% to providers.
- Revenue vs. profit: While most ACOs report provider distributions as a percentage of shared savings revenue, others may report as a percentage of profits (after operating expenses) - most do not specify which.
- Facilities may be included as participants: "Providers" can include both physicians and hospitals/health systems or even ambulatory surgery centers ("ASCs"), and the split between the two is often not reported.
- Reporting as a simple percentage: Some distribution models are more complicated than applying a simple percentage, and may differ from the reported split in practice.

Other market-based approaches may include a review of the distributions on a per member per month ("PMPM") basis relative to other value-based programs.

Test #2 (Income): Is the anticipated split of future overall entity profits reasonable relative to the contributions of each stakeholder group?

Another important test is to review the overall expected MPN profits prior to provider distributions (total revenue less operating costs excluding physician distributions), and determine whether or not the overall profit split among stakeholders is reasonable. While this is a fundamentally subjective assessment of reasonableness, there is empirical evidence indicating that the provider network is critically important to value of an MPN (it's in the name after all), and that providers should therefore receive a substantial portion of the overall profits generated by the MPN. According to the *Scope Research Intangible Asset Database*, an MPN's provider network is the most valuable intangible asset in the healthcare services industry relative to the overall enterprise value of the entity itself, representing 61.4% of the overall value at the median. The category of intangible assets that comes the closest to having as much relative value are the facility contracts that hospital-based physicians rely on for substantially all of their revenue. This analysis supports the notion that the provider network represents the majority of the value of an MPN, and the split of overall profits should reflect this reality.

Top 10 Most Valuable Healthcare Intangible Assets

			As a % of Enterprise Value		
Segment	Intangible Asset	Count	25th Percentile	50th Percentile	75th Percentile
ACO/CIN/IPA/PHO	**Provider Network**	**9**	**27.0%**	**61.4%**	**82.0%**
Hospital-Based Physicians	Facility Contracts	21	25.3%	43.0%	54.4%
Radiation Oncology	Certificate of Need	3	14.7%	39.9%	48.1%
Cardiac Monitoring	Proprietary Technology	4	10.7%	16.6%	21.2%
Physical Therapy	Trade Name	6	11.1%	15.4%	19.1%
Rehabilitation Hospitals	Certificate of Need	6	9.5%	13.1%	33.0%
Healthcare Staffing	Proprietary Databases	10	5.2%	12.2%	14.1%
Home Health	Medicare License	20	7.2%	11.7%	14.4%
OccMed/Urgent Care	Trade Name	4	3.0%	10.1%	25.0%
Healthcare Staffing	Trade Name	10	7.4%	9.6%	15.3%

Source: Scope Research Intangible Asset Database

Test #3 (Cost): Over the long-term, can the MPN be expected to cover its operating costs, and even generate a reasonable return for its owners after provider distributions have been made?

The third test is similar to the second, but focuses on the MPN's ability to cover its operating costs and earn a reasonable return for its owners, rather than the relative profit split between stakeholders. Many MPNs fail to generate a profit each year. While acknowledging that operating at a loss in some years is normal, and it may be commercially reasonable to do so, it's also important to assess whether the MPN can be expected to cover its operating costs in the long-term, and compare its normalized profit margins to appropriate benchmarks.

One of the better benchmarks for this analysis is the margin earned by outsourced administrative service providers to the healthcare industry. This comparison is appropriate because the primary purpose of an MPN is to provide information technology infrastructure, data analytics, and administrative personnel to its provider network, much like an outsourced administrative services organization. The *Scope Research Valuation Database*, which publishes information related to merger and acquisition transactions involving healthcare companies, can be utilized for selecting a reasonable margin or markup cost. One important note is that these benchmarks are most comparable to a situation where the MPN is at full risk for its operating costs, e.g. its expenses are not subsidized by participant dues.

Value-Based Care Distribution Models

Outsourced Services Margin Benchmarks			
Segment	Count	Average EBITDA Margin	Average Markup on Cost
Outsourcing: Billing	8	25.0%	33.4%
Outsourcing: Care Management	**6**	**16.0%**	**19.0%**
Outsourcing: Communications	5	20.6%	25.9%
Outsourcing: Consulting	3	22.7%	29.3%
Outsourcing: GPO	2	45.8%	84.5%
Outsourcing: Staffing	13	12.9%	14.8%
Outsourcing: Technology Services	3	25.5%	34.3%
Outsourcing: Transcription	2	23.7%	31.0%
Outsourcing: Workers Comp/Payer Services	6	26.0%	35.1%
Outsourcing: Other	5	28.8%	40.4%
Total	53	24.7%	34.8%

Source: Scope Research Valuation Database

ABOUT BUCKHEADFMV

BuckheadFMV specializes in the valuation of healthcare businesses, services, and assets of all kinds. Our focus is on providing well-supported FMV opinions for even the most complex arrangements and organizations, deep proprietary research on healthcare valuation issues, and a nimble approach to client service.

FMV OPINIONS

Our valuation experts provide fair market value (FMV) and commercial reasonableness opinions for a wide range of financial arrangements entered into by physicians, hospitals, and other healthcare entities.

BUSINESS VALUATION

We have extensive experience in the valuation of healthcare organizations. Our singular focus on the healthcare industry enables our deep understanding and knowledge of healthcare valuation issues and

PHYSICIAN COMPENSATION CONSULTING

In addition to valuation services, we provide a variety of compensation-related consulting services, including physician compensation design and modeling.

ASSET APPRAISALS

Our valuation experts also provide appraisals of furniture, medical and office equipment, medical records, and other selected assets in healthcare facilities. Our reports are specifically tailored to healthcare acquisitions and include documentation of compliance with the Stark Law and other healthcare regulations.

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HEALTHCARE VALUATION SERVICES

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EXPERIENCE AND EXPERTISE

FMV Opinions and Physician Compensation Consulting

- Block Leasing
- Call Coverage Arrangements
- Clinical Co-Management
- Consulting Services
- Employment Agreements
- Hospital-Based Specialties
- Lithotripsy Services
- Management Services Arrangements
- Marketing Services
- Medical Directorships
- Meeting Attendance
- Midlevel Supervision
- Non-Monetary Compensation
- Part A Pathology
- Patient Centered Medical Homes
- Perfusion
- Physician Recruitment Incentives
- Professional Interpretations/Reads
- Quality Incentives
- Shared Savings Distribution
- Space, Equipment, & Staff Leasing

Business Valuation and Asset Appraisals

- ACOs, CINs, IPAs, and PHOs
- Ambulance and EMS
- Ambulatory Surgery Centers
- Behavioral Health
- Cancer Centers
- Clinical Laboratories
- Diagnostic Imaging
- Dialysis
- Endoscopy Centers
- Home Health
- Hospices
- Hospitals
- Infusion Centers
- Physical Therapy
- Physician Practices
- Rehabilitation Hospitals
- Surgical Hospitals
- Urgent Care