Coker GROUP

Business Advisors for the Healthcare Industry

Frost Brown Todd LLC

ATTORNEYS

Five Cutting Edge Orthopedic Affiliation Strategies

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LEARNING OBJECTIVES

Examine	Identify	Review	Consider	Understand
Examine specific orthopedic practice affiliation models that will be most prominent in 2022 and beyond with a practical understanding of how to structure the alignment models going forward	Identify issues within orthopedic practices that drive possible alignment transactions, considering ancillary services' values toward affiliation, especially ASCs	Review the role of private equity in orthopedics and explore the legal and regulatory ramifications of cutting-edge models (Are they doable? What are the risks versus the rewards?)	Consider cutting-edge models such as the "PE-Like" model for health systems and succession planning for the typical orthopedic practice	Understand the economics of such cutting-edge models (is one more financially beneficial than another?) including the benefits of varying forms of leverage of orthopedic groups in affiliation strategies

I. INTRODUCTION

INTRODUCTION

- As the healthcare industry evolves, affiliations between orthopedic physicians and hospitals/investors will continue to increase
- While some of the affiliation structures of today have become increasingly complicated, they offer much greater options to physicians that historically avoided alignment
- Implementing strategies that improve alignment between orthopedic groups and their affiliates is essential as the focus on value-based care continues
- Properly structured affiliations can increase clinical and financial performance, and increase operational efficiency
- This is particularly important in Texas, where the Corporate Practice of Medicine ("CPOM") is prohibited and can create even further compliance considerations for advanced arrangements
- Compliance continues to be a key consideration, especially with the prevalence of consolidation and encroachment on commercial arenas

AFFILIATION STRUCTURES

Limited Integration

Managed Care Networks (Independent Practice Associations, Physician Hospital Organizations): Loose alliances for contracting purposes

Recruitment/EPPM/PSM: Economic assistance for new physicians

Group (Legal-Only) Merger: Unites parties under common legal entity without an operational merger

Call Coverage Stipends: Pay for unassigned ED call

Medical Directorships: Specific clinical oversight duties

Moderate Integration

Service Line Management: Management of all specialty services within the hospital

MSO/ISO: Ties hospitals to physician's business

Clinical Co-Management: Physicians become actively engaged in clinical operations and oversight of applicable service line at the hospital

Joint Ventures: Unites parties under common enterprise; difficult to structure; legal hurdles

Full Integration

ACO/CIN/QC: 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

Employment "Lite": Professional services agreements (PSAs) and other similar models (such as the practice management arrangement) through which hospital engages physicians as contractors

Employment*: Strongest alignment; minimizes economic risk for physicians; includes a "PE-Like" model

Group (Legal and Operational) Merger: Unites parties under common legal entity with full integration of operations

Private Equity Affiliation: Ties entities via legal agreement; sale to private investor/ operator

PE Like Models: Ties practices to health system in a PE "look-alike" structure

Typically Physician-to-Physician

Typically Physician-to-Hospital

Either Physician-Physician or Physician-Hospital

Physician to Private Investor

* *Includes the Physician Enterprise Model (PEM) and the Group Practice Subsidiary (GPS) model both of which allow the practice entity to remain intact even after employment of the physicians by the hospital*

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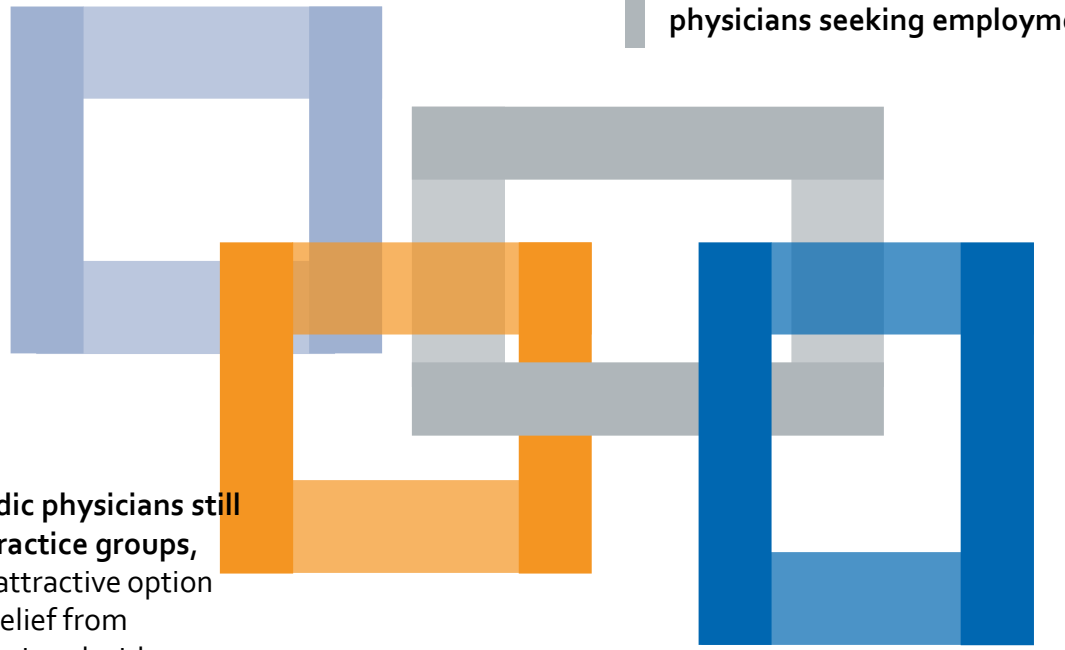
II. STANDARD AFFILIATION STRATEGIES

EMPLOYMENT

Employed physicians outnumber those who are self-employed for the first time in United States history (50.2% of patient care physicians).

According to a 2019 survey published by Merritt Hawkins, orthopedic physicians generate an average of $3.2 million in net revenue for their affiliated hospitals each year – motivating hospitals to extend **competitive compensation offers for physicians seeking employment**



Progressive technology, fee-for-value payment structures, and healthier work/life balance has driven the increase in physician employment

The majority of orthopedic physicians still operate within private practice groups, employment remains an attractive option for physicians who want relief from administrative duties associated with running a private practice

Employment is increasingly becoming more popular with all specialties, including historically independent orthopedic practices due to shifts in the industry and the ability for hospitals to provide a more stable, competitive income.

PROFESSIONAL SERVICES AGREEMENTS ("PSAs")

Traditional PSA

- Hospital contracts with physicians for professional services
- Hospital employs staff and "owns" administrative structure

Global Payment PSA

- Hospital contracts with practice for Global Payment
- Practice retains all management responsibilities

Practice Management Arrangement

- Practice entity retained and contracts with hospital
- Administrative management and staff not employed by hospital, but physicians are employed

Hybrid Model

- Hospital employs/contracts with physicians
- Practice entity spun-off into a jointly-owned MSO/ISO

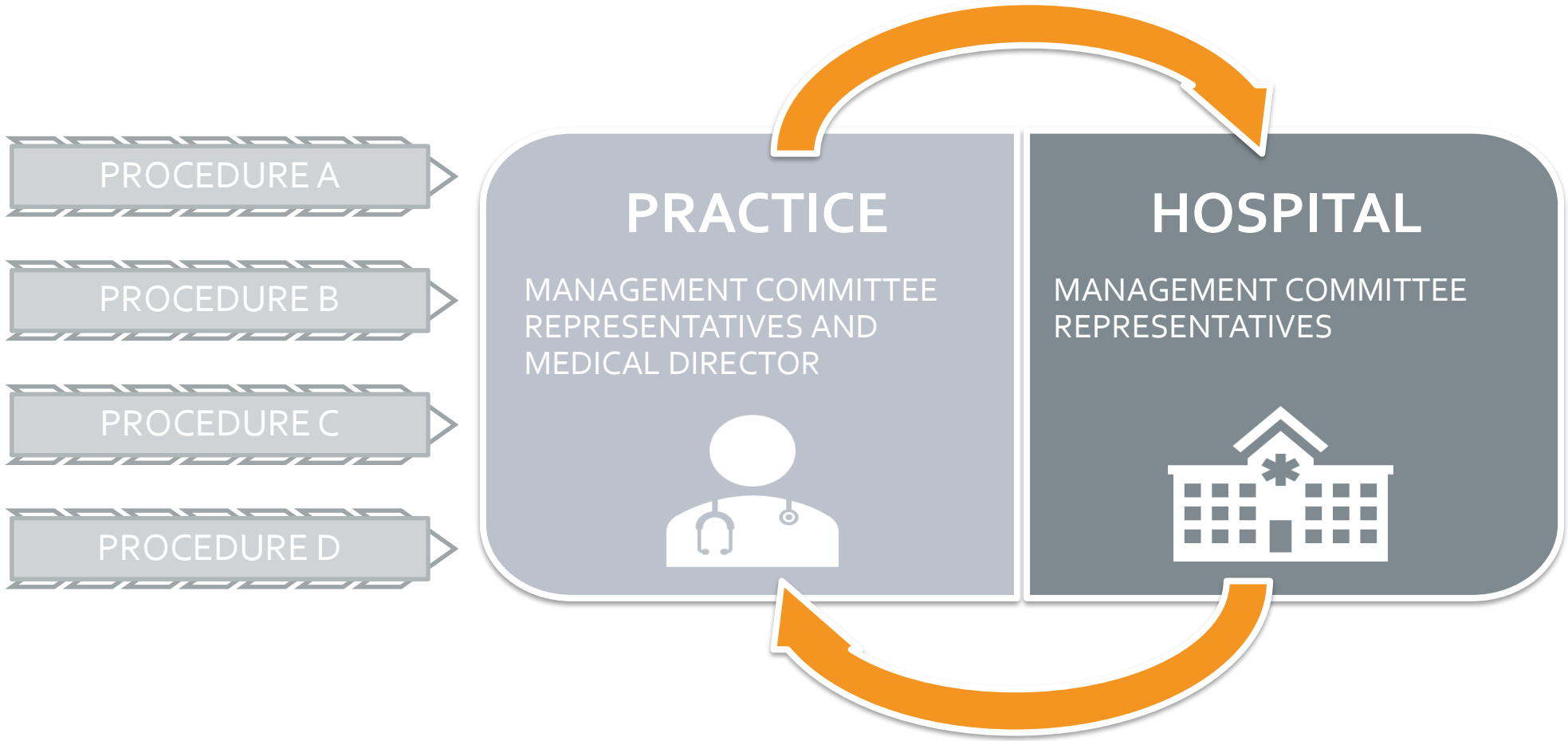
Carve-Out PSA

- Specific physicians, locations, specialties, etc. are "carved out" and contract with hospital via PSA

- **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**

CLINICAL CO-MANAGEMENT AGREEMENT

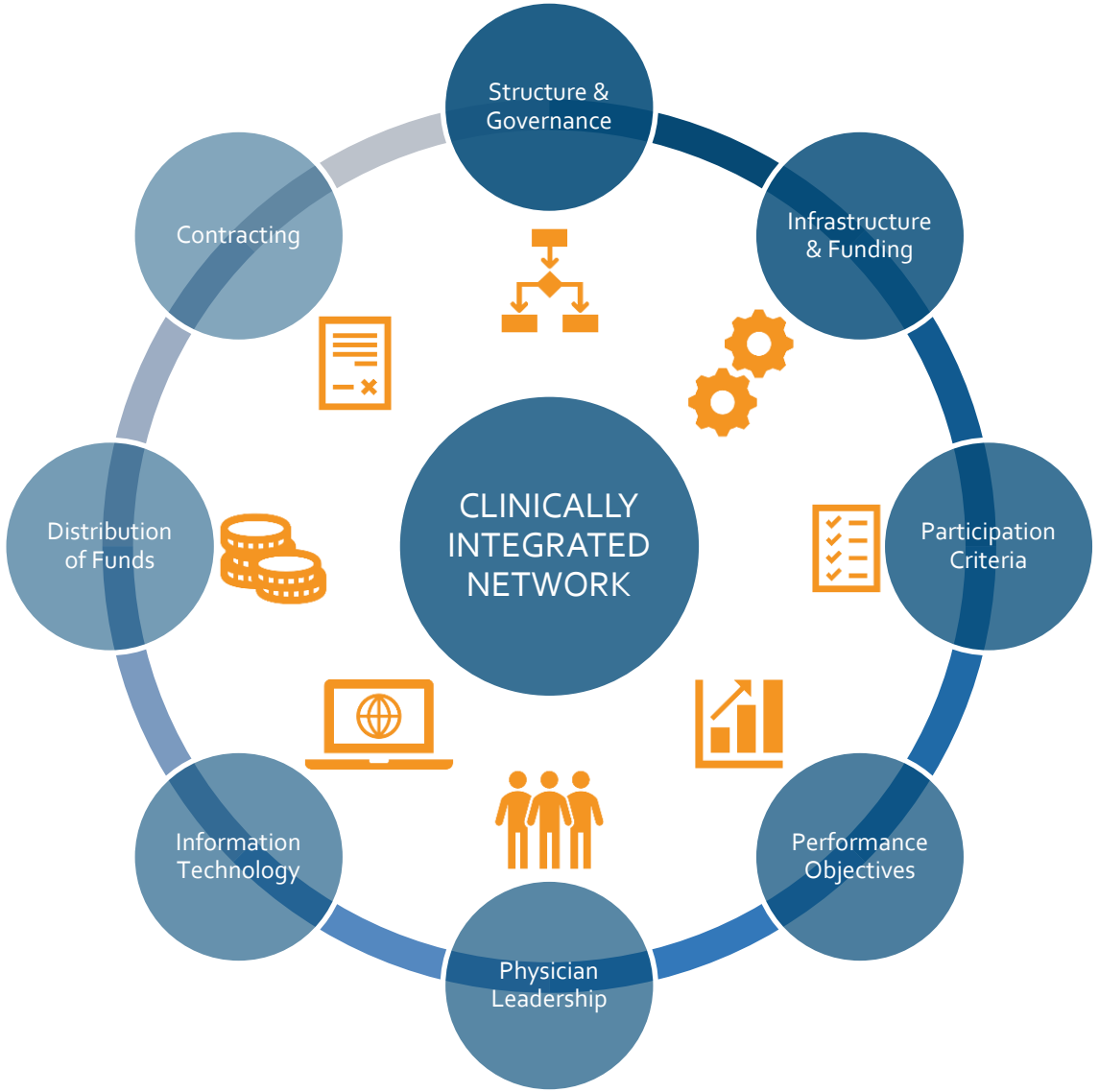
Clinical Co-Management Agreement for Oversight of Service Line



**Each service line/specialty can have its own CCMA, which can be included as a singular alignment strategy or as a "wraparound" (i.e., add-on) to another, major alignment strategy*

Fixed Fee
Contingent Fee

CIN/ACO


Structure & Governance
Infrastructure & Funding
Participation Criteria
Performance Objectives
Physician Leadership
Information Technology
Distribution of Funds
Contracting
CLINICALLY INTEGRATED NETWORK

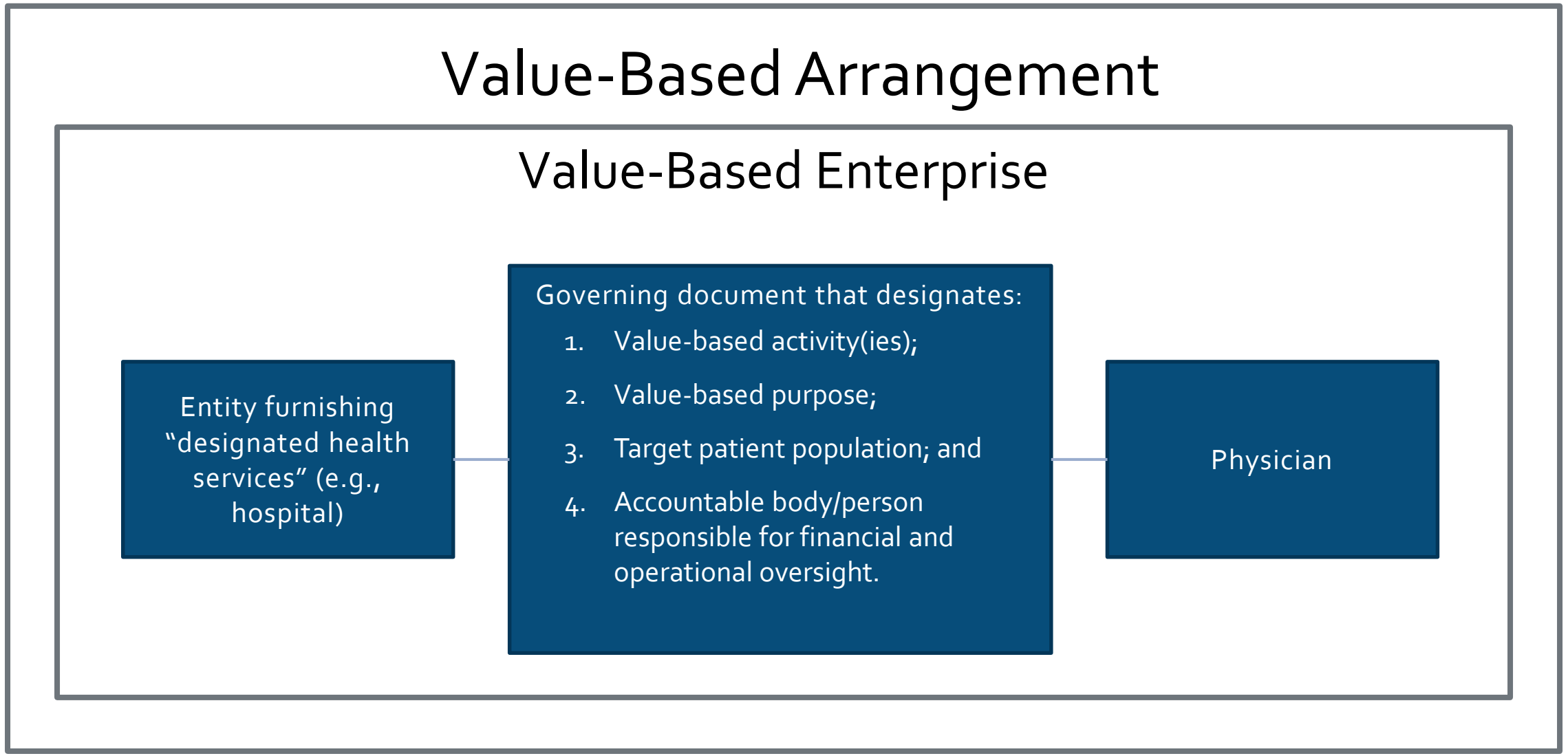
III. CUTTING-EDGE AFFILIATION STRATEGIES

1. VALUE-BASED ENTERPRISES

VALUE-BASED ENTERPRISE

- Stark Law ("Stark") and the Anti-Kickback Statute ("AKS") have previously placed limitations on compensation to physicians that created challenges for developing value-based arrangements
- As of January 19, 2021, the Centers for Medicare & Medicaid Services ("CMS") implemented changes, value-based exceptions and safe harbors, to allow for more flexibility related to value-based enterprises ("VBEs")
- VBE is a term used to describe arrangements with two or more VBE participants:
  - Working to achieve at least one value-based purpose
  - Each of which is a party to a value-based arrangement with the other or at least one other VBE participant in the VBE
  - An accountable body or person responsible for financial and operational oversight of the VBD
  - Have a governing document that describes the VBE and how the VBE participants intend to achieve its value-based purpose
- Thus, organizations that fit this purpose now have greater ability to incentivize providers to meet the mutual value-based goals
  - One such program that has received renewed interest under these expanded guidelines is gainsharing arrangements (see following slides)

VALUE-BASED ARRANGEMENT



STARK LAW VALUE-BASED CARE EXCEPTIONS

VBE AT FULL RISK EXCEPTION FOR ALL PATIENT CARE (42 CFR 411.357(aa)(1))

- The **VBE** must assume **full** financial risk for all patient care items and services covered by a payor for each patient in the target patient population.
- **Example:** Capitation payments (pre-determined payments per patient per month or other period of time) or global budget payment from payor that compensates for all care items and service for patients in the target patient population.

PHYSICIAN AT MEANINGFUL DOWNSIDE RISK EXCEPTION (42 CFR 411.357(aa)(2))

- The **physician** must assume the responsibility to repay or forgo **at least 10%** of the remuneration the physician receives under the VBE for failing to achieve the VBP of the VBE.
- **Example** – DHS-entity and physician part of a VBE where total remuneration potentially due to physician is $100,000 but $20,000 is withheld and payable only upon successfully completing the value-based activities called for under the arrangement.

VALUE-BASED ARRANGEMENT WITH NO RISK EXCEPTION (42 CFR 411.357(aa)(3))

- Arrangement must be in writing and describe the value-based activities and how such activities will further the VBP of the VBE; the target patient population; the type or nature of the remuneration; the methodology used to determine the remuneration; and the outcome measures against which the recipient of the remuneration is assessed, if any.
- **Example** – Hospital pays physicians $10 each time they order a certain test pursuant to a value-based arrangement.

As risk decreases, regulatory burdens increase

GAINSHARING

- No fixed definition of a "gainsharing" arrangement – typically refers to an arrangement in which a **hospital provides participating physicians a percentage share of any reduction in the hospital's costs for patient care attributable in part to the physicians' efforts**
- In order to receive payment, the clinical care should not be adversely affected as measured by selected quality and performance measures
- In addition, many plans require a determination by an independent consultant that the payment represents fair market value ("FMV") for the collective physician efforts
- Medicare Part B and Medicaid payments to physicians generally are unaffected by a gainsharing arrangement (meaning their payor reimbursement for professional fees continue)
- Gainshare arrangements are sometimes referred to by hospitals as hospital efficiency agreements ("HEAs")
- Gainsharing arrangements are now permissible and feature genuine cost savings opportunities to the hospital along with adherence to quality metrics

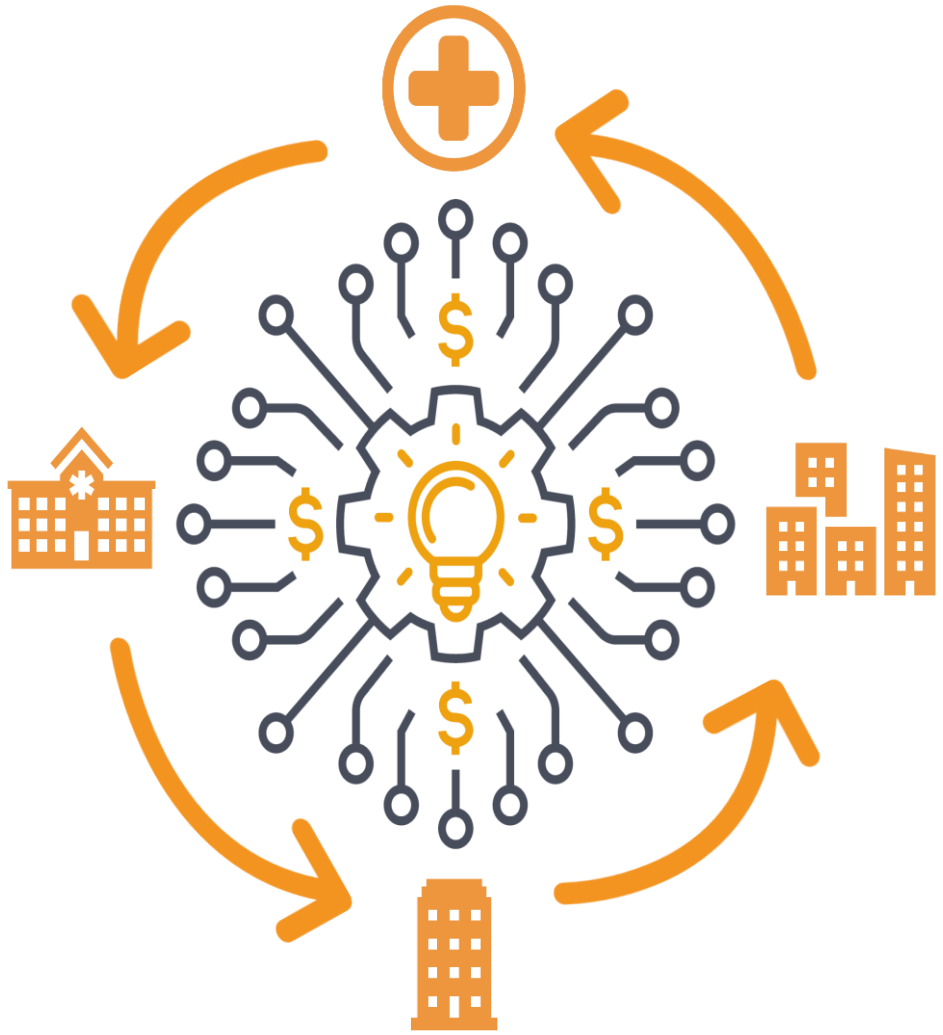
RECENT UPDATES

- Advisory Opinion ("AO") 17-09 was notable in that it creates new opportunities for gainshare arrangements and for them to be within more assured compliance boundaries
  - Prior to this (and MACRA) the OIG took the position that the gainsharing CMP laws prohibited any physician incentive plan that included the reduction of services, even if those services were medical unnecessary (1999 Special Advisory Opinion on Gainsharing Agreements)
- MACRA narrowed the gainsharing CMP prohibition to arrangements that would limit *medically necessary* services
- While AO 17-09 addresses AKS; however, it does not address Stark Law
  - Thus, compensation must still take into consideration Stark implications

2. PRIVATE EQUITY

PRIVATE EQUITY ACQUISITION/INVESTMENT

- Private equity ("PE") 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**
- Value is returned to investors primarily through liquidity events (i.e., sale of entities, initial public offerings, other transactions)
- Investments in healthcare entities may be directly from PE firm or more likely through PE-sponsored platform companies
- Platform companies are the initial entity purchased by a PE sponsor, which then entails add-on acquisitions
- Most deals involving PE buyers are actually led by a platform company, as opposed to the actual PE firm
- **PE is quite interested in most surgical proceduralist entities, including orthopedics**



PRIVATE EQUITY AFFILIATIONS

Typical deal characteristics of PE acquisitions of orthopedic practices…

- 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
- In addition, most orthopedic practices own/operate single-specialty ASCs
- These ASCs are always of great interest to PE and usually, their buy-in is a requirement
- ASC values will usually result in a market-driven multiple of their (independent of the practice) EBITDA.

** Fundamentally, most orthopedic practices distribute all their excess earnings each year to their partners; hence, no retained earnings or "book" equity exists*

PRIVATE EQUITY ECONOMICS

Hypothetical Example of Acquisition by PE Firm

Acquisition by PE Firm		
Practice Revenue (Collected)		*$13,000,000
Total Physician Compensation (Pre-Haircut)		*$6,900,000
Total Number of Physicians		10
Haircut	10%	$690,000
Reduced Comp per Physician		$69,000
Multiple on Haircut		7.0
Transaction Value	(7x$690.000)	$4,830,000
Proceeds of Transaction per Physician		$483,000

**Practice revenue and physician compensation based on MGMA data for orthopedics*

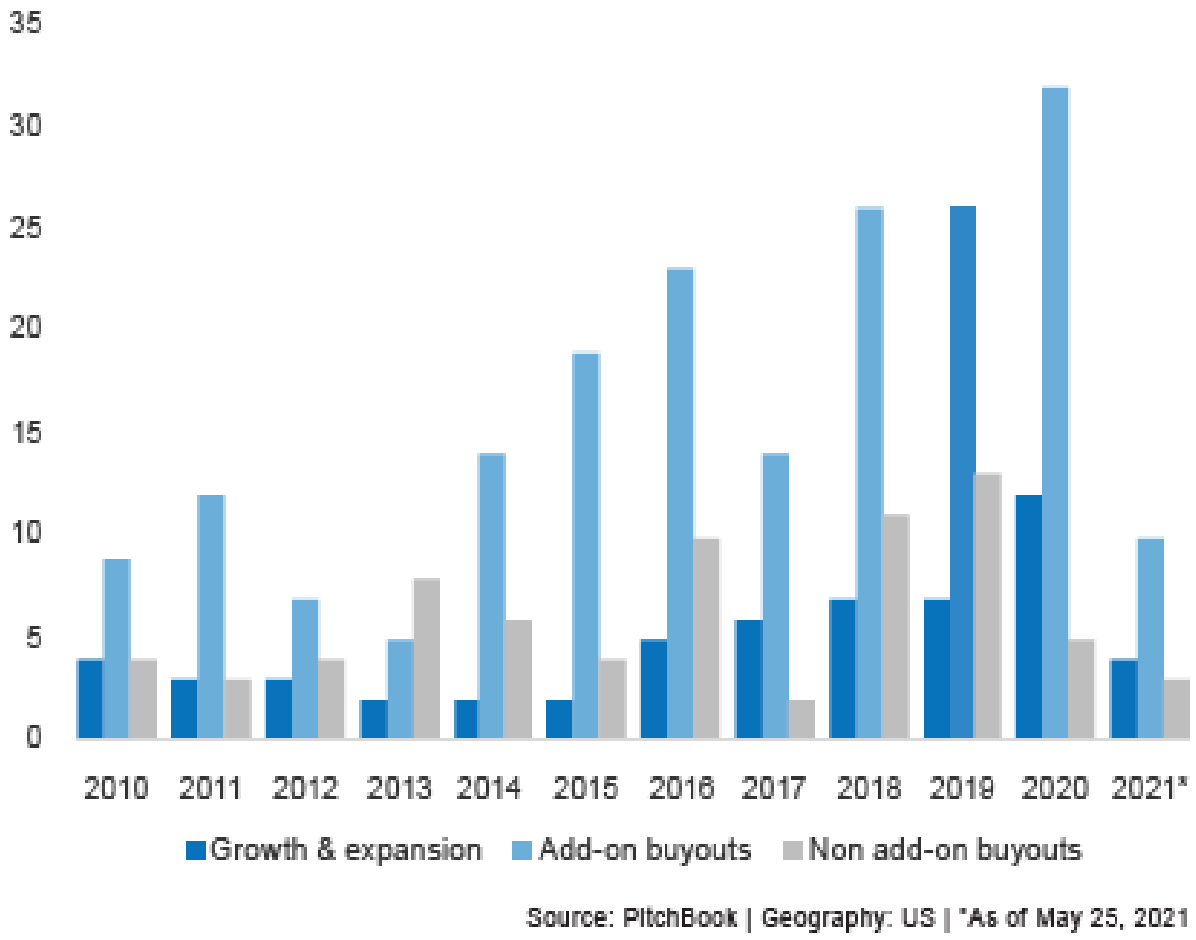
PRIVATE EQUITY CONSIDERATIONS

- If the consensus among the physicians selling their practice is to maximize the valuation paid at the time of the transaction and ultimately forego their independence to an outside organization (hospital or PE firm), then the PE model may likely be the best option
  - Consider the ability to reach a consensus among all voting parties
- This may be even more so if the practice is primary care or a group with few ancillaries
- This model is likely the only *real* option for maximizing upfront value for that type of entity
- Even with ancillaries are involved, if the hospital is willing to purchase them, that will only increase the upfront value
- Thus, this structure becomes even more appealing for specialties such as orthopedics
- Realistically, health systems may not budget to pay (or even have available) the upfront funds
- Larger specialty practices like orthopedics are likely the only interested entities in PE and PE-Like transactions (and vice versa)*
- Sellers must answer **"Why are we doing this?"** and **"What is our greatest priority to achieve in doing a deal?"**
- These transactions are even more challenging in Texas under the CPOM and interested parties should seek legal counsel before pursuing to ensure it is structured appropriately

** Unless smaller groups can be aggregated into a larger consortium*

PRIVATE EQUITY TRENDS

Private Equity Trends: US PE Activity (#) In Orthopedics by Deal Type



Source: PitchBook | Geography: US | *As of May 25, 2021

- Increased PE activity in orthopedics is largely attributed to the wide variety of ancillary service opportunities that can serve as additional profit centers. Common services include:
  - ASCs
  - PT/OT/hand therapy
  - Multiple imaging modalities (MRI, CT, Ultrasound, X-ray, bone densitometry
  - Durable medical equipment
  - Prosthetics/orthotics
  - Injections
  - Pain management
  - Urgent care/walk-in clinics
  - Occupational health centers

PRIVATE EQUITY PROS/CONS

Pros

- Practice is often paid larger upfront value
- Physicians may maintain ability to participate in ancillary services
- Practice operations and risk assumed by new owner/operator (possible MSO)
- Practice may retain more impactful control over day-to-day operations
- Compensation potentially lifted if higher rates are achieved in the future and new owner allows physicians to benefit from those rates
- Compensation haircut mitigated via growth initiative
- Spin-off MSO might be established and exist going forward (may also be sold separately)
- Rollover equity to the Seller (future sales value)

Cons

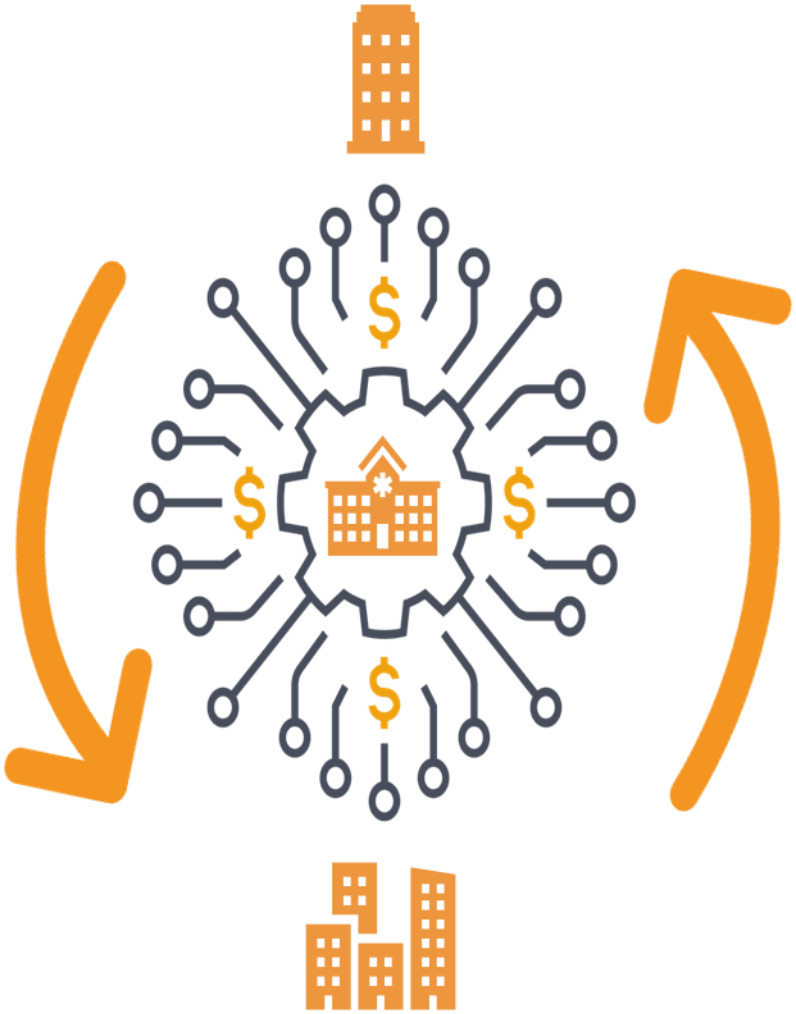
❿New, unknown relationships

- Some PE groups have more clinical management/operations experience, than others
- May / may not be the lead portfolio company
- Compensation haircut is permanent
- Limited participation in significant governance or management decisions (i.e., acquisitions, future sales, etc.)
- May significantly impact Practice culture, recruiting, staffing, etc.
- Material holdbacks usually exist
- Conditions to closing could impact the speed to closing
- Perception of less stability
- Minority interest retained

3. PRIVATE EQUITY-LIKE (HOSPITAL) MODELS

PRIVATE EQUITY-LIKE ACQUISITION/INVESTMENT

- 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 PE firm
- Hospitals are more beholden to specific regulatory frameworks, etc.
- However, if considering the "haircut" over time, hospital transactions can actually be a more profitable long-term solution
- Thus, consideration must be given to the timing of the transaction and the specific nuances of the practice and its physicians



PRIVATE EQUITY-LIKE ECONOMICS

Hypothetical Example of Acquisition by PE Firm

Acquisition by Hospital using PE Model		
Practice Revenue		*$13,000,000
Total Physician Compensation		*$6,900,000
Total Number of Physicians		10
Haircut	10%	$690,000
Reduced Comp per Physician		$69,000
Term of Haircut		3 years
Total Reduced Comp per Physician (3 years)		$207,000
Multiple on Haircut		N/A
Transaction Value (under DCF Approach)**		$2,760,000
Proceeds of Transaction per Physician		$276,000

**Practice revenue and physician compensation based on MGMA data for orthopedics*

*** Assuming typical discount rates and related valuation tenets*

PRIVATE EQUITY-LIKE PROS/CONS

Pros

- Hospital has been / will be in the business of delivering quality healthcare
- Practice perception of greater stability
- Known, current relationships
- Still receives upfront value (though likely less than with PE buyer)
- Compensation haircut may be temporary and may be restored with appropriate FMV adjustments
- Compensation model may more accurately reflect work effort
- Upfront value received for ancillaries, as applicable
- Maintain positive dynamics of local healthcare services
- Practice operations and risk may be assumed by the hospital
- Spin-off MSO might be established and exist going forward (may also be sold separately)
- Experience with clinical integration

Cons

- Minority interest may be retained
- Greater loss of control and autonomy of practice operations and leadership
- Lack of pathway to leadership for new physician employees in the group
- Less ability to participate in ancillaries due to regulatory constraints
- Potentially have less ability to increase future compensation, due to comp model likely tied to production (growth may mitigate)
- Limited future participation in the growth or profitability of the group
- Minority interest may have little future value

4. JOINT VENTURES

JOINT EQUITY VENTURES

- In most instances, joint ventures are considered when the necessary capital for a venture is too much for a single practice to take on – such as the development of an ASC or imaging center, plus are synergistic to create such collaborative models
- Key opportunities that typically require a joint venture include:
  - ASCs
  - Imaging centers
  - Pain management centers
  - Real estate partnerships
    - Jointly owned medical office buildings
    - Surgery centers
    - Imaging facilities
  - Management Services/Business Services Organizations ("MSOs"/"BSOs")
- Two of the most common joint equity venture structures are the equity model group assimilation structure, and the physician equity structure

JV STRUCTURES

Equity Model Group Assimilation

- A more advanced version of a merger that results in a jointly owned physician practice
- All of the practice's assets and work initiatives are merged into an equally owned entity between the practice and the hospital/investor
- Often includes the actual professional component of the practice and is not limited to joint ancillary investment
- Because physicians' incomes are based on the performance of the jointly owned entity, all investors share interest in profitability and ROI
- Initial investment capital is a significant consideration – often the practice will be valued, and its value will be a part of the capital that is contributed to the newly owned and established entity

Physician Equity Approach

- Joint ventures often are nonclinical investments such as MSOs/BSOs and real estate developments
- Although the physicians and hospitals/investors are not necessarily adjoined relative to the clinical delivery of services, they are truly integrated with such joint initiatives/investments
- Service provider joint ventures such as ASCs, imaging clinics, and others require equity and capital participation with the opportunity for profit, but also the risk of loss
- Goals of such joint ventures include:
  - Direct ownership and influence over service delivery
  - Predictable alignment of interests
  - Access to capital and ROI

5. MANAGEMENT/BUSINESS SERVICE ORGANIZATIONS

MANAGEMENT/BUSINESS SERVICE ORGANIZATIONS

- Joint ventures can include the formation of MSO's/BSO's among separate orthopedic and related specialty groups
- An MSO is an organization that provides operational management and administrative support services to individual physicians, private practices, and medical groups
  - Historically, this entity most likely was wholly owned by physicians (at least initially), with relatively minor oversight, and focused on alleviating the management pressures independent providers faced.
  - MSOs typically provide business services for a fee at FMV
  - In other cases, MSOs purchase the tangible assets (i.e., buildings, equipment, and supplies) of their client physicians
  - MSO may also lease the assets to the physicians
  - MSOs can develop group purchasing, malpractice discounts, discounted equipment leasing, shared staffing and benefits, and common EHR and billing systems
- More recently, MSOs have begun rebranding as BSOs to imply service offerings beyond the traditional operations management, HR, revenue cycle, and support services
- Because MSOs/BSOs are structurally flexible (i.e., they are not limited to providing only practice management services), there is a significant opportunity to achieve higher value for both the BSO and the entities served in today's healthcare environment
- BSOs can offer tangible affiliation incentives that fall into various opportunistic channels, such as shared ancillaries, diagnostic services, etc.
  - Such initiatives require joint investments, but risks are mitigated via the hospital's involvement and investment

MANAGEMENT/BUSINESS SERVICE ORGANIZATIONS

- MSOs can be a bridge to organizations seeking to clinically integrate but that lack the necessary infrastructure
- MSOs can show physicians the administrative side of how a health system functions
- Provide the necessary IT infrastructure such as having providers use the same EHR system
- Allows providers to share in common goals
- Introduces different providers to the collaborative process
- MSOs have the ability to support IPAs, PHOs, and ACOs
- MSOs may provide certain opportunities to providers seeking additional opportunity in the healthcare space but limited by the Prohibition on CPOM in Texas

CONCLUSION

CONCLUSION

- Despite ongoing reimbursement changes, increasing practice expenses, and additional focus on value-based arrangements, the landscape surrounding orthopedic practices continues to offer financial stability to physicians choosing to remain in private, independent practice
- Regardless, this does not mean that providers seeking ongoing levels of independence/autonomy do not have affiliation options available to them
- Rather, hospitals and investors alike are becoming savvier and more innovative to develop models that meet physician desires, while still offering increased levels of partnership
- Thus, organizations should consider some of these newer models, which may offer more opportunities than ever before

Q&A

Thank you and Questions

ABOUT THE PRESENTERS

ABOUT CHAD ECKHARDT, ESQUIRE

Chad's focus on the health care industry provides him an opportunity to advise businesses and health care entities in corporate matters, formation and structuring, contract negotiation, and regulatory compliance. He works with publicly traded and privately owned health care entities, including a wide range of not-for-profit organizations. He has assisted numerous hospitals, physician practices, ancillary service providers and related entities on mergers, acquisitions and clinical integrations and issues pertaining to Stark, Anti-Kickback, billing compliance, Recovery Auditor programs, HIPAA, licensing, Health Care reform and other regulatory and transactional aspects of the industry. Chad also leads the Health Care Innovation industry team.

Chad also advises not-for-profit organizations on governance and policy issues, IRS compliance, and Form 990 issues. Prior to graduating from Salmon P. Chase College of Law, Chad taught English at the secondary and collegiate levels.

Chad is the team leader of the firm's Health Care Innovation team.

ABOUT STEPHEN ROSS, MHA, FHFMA, CMPE

Stephen Ross, a vice president with Coker Group, has over 20 years of industry experience successfully leading health system strategy and key business development. His work encompasses mergers and acquisitions, physician practice/health system integration, medical staff planning and related assistance, physician compensation plan development, and organization revenue performance/enhancements.

Stephen specializes in assisting healthcare organizations in hospital-physician alignment transaction due diligence and negotiations, medical staff development planning, fair market value(FMV)/commercial reasonableness (CR) assessments and consulting services. He has experience with physician network development, Stark, Anti-kickback, operations/revenue enhancement, managed care, and strategy advisement.

Stephen's expertise has been beneficial for numerous organization across the country.

He is a Fellow of the Healthcare Financial Management Association (FHFMA) and is a Certified Medical Practice Executive (CMPE). He is also certified as a Black Belt in Lean Six Sigma methodologies.

He earned a Bachelor of Science in Business Administration from Thomas Edison State College and a Master of Healthcare Administration from Ohio University.

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THANK YOU

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