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Resource Guide





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Guide to Financial Arrangements of Health Care Management Services Organizations

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Introduction

Management Services Organizations (MSOs) in the health care services industry play critical roles in the delivery of patient care in the United States. Although their roles vary greatly across the industry landscape, the most common intentions are to align provider services and business services to create value by improving quality, access, efficiencies, and cost. Moreover, MSOs have gained significant popularity in recent years and are expected to continue on a growth trend. This guide will provide a deeper understanding of financial arrangements of MSOs as a pillar for success for all parties involved.

First, this guide introduces the provider MSO structure from an organizational and financial perspective, followed by five steps to sound financial management of MSO arrangements. Next, the discussion examines on a deeper level various arrangements between certain providers (e.g. hospitals, physicians, and care innovators) and unique MSOs. Recognizing the start-up nature of many MSOs in today's market, this guide will then shift to effective financial management of newly established arrangements. Given the high transaction volume and robust regulatory environment in which MSO arrangements operate, the final topics will be centered on fair market value (FMV) payments and compliance maintenance. Through the framework of this guide, providers, managers, and key stakeholders will strengthen their knowledge of MSO financial arrangements to be better prepared for successful launch and growth endeavors.

Overview of MSOs

The general structure of a health care MSO arrangement involves two main parties: a provider organization and a management services

organization (also referred to as a manager). The term “provider” in this context can be broadly applied to professionals and/or facilities providing direct health care services to patients. Patient service revenues are generated and billed through the providers using their contracted rates. Providers include, but are not limited to, hospitals, physician groups, and independent freestanding specialty clinics. As such, the landscape is comprised of a wide variety of provider organizations party to MSOs, which requires the managers to tailor specific management services and expertise to each unique arrangement. For example, a manager for an interventional radiology provider may be more focused on equipment and facility operations for a small group of direct physician users, while a manager for a physical therapy provider may be more focused on strategic planning of clinic locations and therapist staffing models for a broad network of referring physicians.

The business case for MSOs can be thought of in terms of goodwill¹ value. Without the MSO, the provider performs all operational services and retains all excess earnings that drive goodwill value. Under a MSO arrangement, some of the services (and profits associated with providing those services) are shifted to the manager. Hence, some of the goodwill value is also shifted to the manager under the MSO. It is expected that the combination of the provider and manager strengths through the MSO arrangement will enhance the value and quality of the entire service and business activity. Overall, goodwill value increases to the benefit of both parties. Table 1 on page 32 is a hypothetical example of this concept assuming the same service line with and without a MSO. Note, it is assumed without a MSO, business management of the service line is internal within the provider organization. Therefore, the provider is more heavily involved in nonprofessional business management.

Table 1. Goodwill Value for the Provider and MSO

	Without MSO		With MSO	
Enterprise Attributes	Management (Internal)	Professional Provider	Manager (MSO)	Professional Provider
Contact with Patients		X		
Contact with Suppliers	X		X	
Barriers to Entry	X		X	
Innovation	X		X	
Quality	X		X	
Specialized Licenses/Expertise		X	X	
Source of New Patients		X		X
Referrals Made To		X		X
Advertising & Professional Relations		X	X	
Number of Locations	X		X	
Owner Presence		X		
Reputation	X		X	
Billing Method	X		X	
Trained Workforce	X		X	
Competitive Advantage		X	X	
Compliance	X		X	
Management Depth	X		X	
Professional Provider Goodwill Allocation	60%		40%	
Management/Manager Goodwill Allocation	40%		60%	
Enterprise Goodwill Value	\$1,000,000		\$2,000,000	
Professional Provider Goodwill Allocation	\$600,000		\$800,000	
Management/Manager Goodwill Allocation	\$400,000		\$1,200,000	

Increase

2.0x

The list of enterprise attributes without a MSO are weighted more toward the provider, but shifts to the manager with a MSO. Assuming the parties perform, the shift in attributes increases the overall goodwill and allocated goodwill value for both.

The dynamics of this model depend greatly on the type of arrangement. For example, physicians in a practice with a MSO likely experience an overall decrease in provider goodwill value. However, if they also hold ownership in the MSO, they should participate from an increase in manager goodwill value. In order to better understand the value creation, the discussion will shift to more specifics as relates to the structure and financial mechanisms of MSO arrangements.

While a great deal of variety exists among health care MSO arrangements, one thing they generally have in common is a contract often

referred to as the Management Services Agreement (MSA). MSAs define the roles of the parties, terms of the contract, and the specific management services being provided. From a financial management perspective, the most important aspects of MSAs are the compensation terms and the scope of management services because each of these will translate directly to income statement line items impacting both parties. A simple MSO structure is illustrated in Figure 1.

In addition to the basic structure illustrated in Figure 1 below, it is common to see arrangements with additional compensation outside of the MSA. For example, the MSO can often be a lessor of real property and equipment to the provider, which would fall under a separate leasing agreement. A simple illustration building on the previous structure is shown in Figure 2 on page 33.

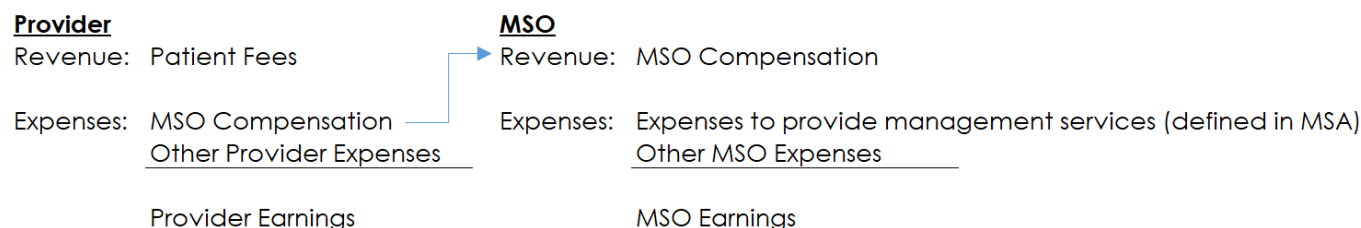
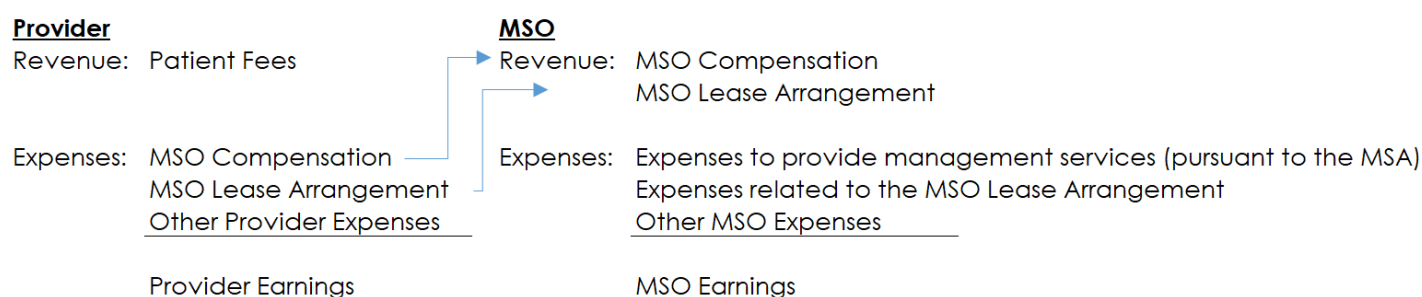
Figure 1. Basic MSO Structure


Figure 2. Compensation Outside the Basic MSO Structure

Five Steps for MSO Financial Management

Now equipped with a basic understanding of the provider and manager roles and the financial framework, this section will provide five steps to sound financial management of MSO arrangements.

1. As previously mentioned, focusing on patient fee revenue at the provider level is the first step of MSO financial management. Both parties need to understand the variables of patient revenue such as revenue concentration (dependent on few or many services, providers, or patients), payer mix and contracts, collectability, and accounts receivable turnover. A billing and coding audit may also be performed for further revenue assurance. Recognizing that this revenue belongs to the provider, the manager plays an important role in the patient revenue cycle based on effectiveness of the management services.
2. Because it is such a material part of the arrangement, parties often jump to focusing on the MSO compensation amount. However, a better approach in managing the financial structure of the arrangement is to next focus on the expenses incurred by the manager in providing the management services pursuant to the MSA because the MSO compensation is often derived directly from these expenses, as discussed later. Expanding on the expenses attributable to providing management services, a typical menu of services is as follows:
 - » Financial, cost, and operational reporting and budgeting
 - » Billing and collecting on behalf of the provider
 - » Accounting, business office, revenue cycle, and decision support functions
 - » Scheduling, pre-authorizations, and patient follow-up
 - » Internal controls design and risk assessment
 - » Establishing non-clinical policies and procedures
 - » Establishing, measuring, and achieving quality goals
 - » Facility space and equipment planning, procurement and maintenance
 - » Vendor contracting including medical supplies and device procurement
 - » Information technology hardware, software, and network management, including electronic health record systems

- » Third-party contracting for professional, consulting, or other outside services
- » Payer contracting
- » Human resources functions including payroll, benefits, hiring, terminating, and training
- » Advertising, public and provider relations
- » Regulatory compliance with Centers for Medicare & Medicaid Services (CMS), The Joint Commission, or other state and federal authorities
- » Other managerial decision making and corporate governance

Management services could include some, all, or more from this menu, which is one main reason there is no one-size-fits-all MSO or MSA. Moreover, the scale of these manager functions in terms of time, manpower, capital requirements, and expertise also vary greatly among arrangements. Once the scope and scale of services are well understood from a financial perspective, providers and managers are in much better position to execute strategies. Scalability is a critical, proven key to success for the stakeholders endeavoring to improve the value equation—this will be discussed in subsequent sections.

3. At this point, it is likely intuitive that managers will require a certain level of compensation to achieve their financial goals, much like any other business. However, an important distinction in the health care MSO industry is that in order to have a legally compliant arrangement, compensation must be at fair market value and be commercially reasonable in order to meet exceptions and safe harbors pursuant to Stark Law, Anti-Kickback statutes, and certain state laws. Some exceptions exist, but for the purposes of this guide, it is assumed compensation must be compliant. As such, FMV and commercial reasonableness will be discussed in further detail later.

Several variations of compensation models exist in the market with some of the most common being fixed or flat fee, percentage of provider revenue, manager costs plus a defined mark-up, and other bonus and risk-based models. Many MSAs also have a mix of these models. Whichever models are used, they must make sense from the financial perspective of both parties. When negotiating MSAs, collaborative and transparent analyses are always encouraged so that both parties understand each other's goals and strategies, and so that the arrangement as a whole is reasonable.

4. Alongside the manager, the provider must also identify its other expenses apart from MSO compensation. For example, hospitals will likely have certain clinical and overhead expenses, and medical practices will have physician professional compensation expenses. Similarly, the manager must consider any incremental costs outside of the MSA such as corporate or capital requirements.
5. Once each of the components of the financial statements are established, it is critical to perform a reasonableness check of the arrangement as a whole. In other words, ignoring payments between the parties, create an enterprise income statement using patient service revenue and total expenses of the provider and manager. One should consider whether the implied total earnings from an enterprise perspective reasonably allocated to each parties' implied profit splits through the arrangement. The parties' margins and splits may also be analyzed in total dollars, with financial ratios and rates of return. The key qualitative factors to consider during this analysis are: (1) whether the financial arrangement makes sense for both parties relative to their risks; and (2) whether the arrangement provides a reasonable framework to provide quality patient care and/or meet certain health care needs. This step in the financial analysis will ultimately tell the story of these qualitative factors.

In summary, the general steps toward sound financial management of MSAs are: (1) establishing provider-based patient revenue; (2) establishing manager expenses pursuant to the scope and scale of the MSA; (3) establishing a reasonable MSO compensation model relative to both parties; (4) considering other expenses outside of the MSA; and (5) holistically analyzing the arrangement. Whether focusing on quality improvement, cost efficiencies, or return on invested capital, the provider and manager should now be aligned to achieve individual and collective goals through an MSA arrangement. From this framework, the discussion will move to more specific types of arrangements common in the industry.

Hospital–MSO Arrangements

Hospital–MSO arrangements continue to be a major part of the health care delivery system spanning a wide variety of inpatient and outpatient services. Hospitals generally leverage clinical expertise, brand name, reputation, payer contracts, and market presence. MSOs generally leverage expertise in administration and operations, physical site and equipment development, access to capital, and professional relationships. Moreover, scalability is one of the most important factors of these MSO arrangements. As platform managers are able to efficiently serve multiple service lines or multiple hospitals, the economics improve for both parties by way of cost management and fair management fees. These arrangements also provide an important competitive advantage as a faster vehicle for speed to market.

As hospitals continue to face capital constraints, they look for ways to meet the health care needs of the community to keep up with growth, demographics, and technology. For example, if high demand exists for a growing service line such as outpatient spine procedures, a hospital will partner with a MSO that has the right expertise and access to capital to design and build out the physical and managerial functions. For the more capital-intensive arrangements, particularly in off-campus

outpatient services, the manager will often take on the primary risk of purchasing or leasing the physical assets, including real property and equipment. Physical assets add another layer to the arrangement outside of the MSA.

Generally for real estate leases—whether the manager is primary landlord or sub-landlord, the rent and facility expenses are a direct pass through to the hospital. Two important areas to examine are: (1) any potential mark-ups to the lease for FMV compliance; and (2) from a risk perspective, each of the parties' terms, such as effective dates and termination rights. An example of increased risk for the manager that is related to real estate may be one in which the manager has a long-term lease or owns the space, but the sublease to the hospital has a one year term and either party can terminate without cause with 30 day notice. Assuming no mark-up on the FMV sub-lease, it would be reasonable for the manager to analyze the aggregate compensation of the arrangement to account for overall risk and required return.

The expenses for high cost equipment and leasehold improvements for services such as diagnostic imaging and radiation therapy are often borne by the manager and leased to the hospital. The same financial considerations apply from the real estate discussion above with the added challenge of monitoring capital expenditure requirements along the depreciation horizon. In light of the overall arrangement, considerations should be made for whether the return on invested capital and internal rate of return make sense and whether there is sufficient cash flow for future capital expenditures. When financials do not align as expected, adjusting MSA compensation (within FMV) may be the best way to re-align required outcomes. An example of an adjustment could be a bonus based on collections thresholds.

Other forms of hospital–MSO arrangements do not involve capital assets and consist only of the MSA. These are common for on-campus hospital services such as surgery departments. In this context, more complex MSAs include a compensation component based on quality and performance measures. Generally speaking, this component starts at full compensation for meeting 100% of the measures, and then decreases on a scale relative to the measures. In other words, there is more downside than upside for the manager. This type of arrangement poses an analytical challenge whereby, at a single point in time, the hospital could benefit financially by way of lower quality which lowers MSA compensation expense. However, it stands to reason that due to lower quality, hospital reimbursement and utilization would also be negatively impacted. Recognizing a lag between the impacts of low quality to the manager and the hospital, the best way to address this challenge is forecasting to a future period until both manager and hospital have normalized average financial statements for comparison.

One final highlight for these types of arrangements is the importance of managing complex systems including electronic medical records (EMR), IT, coding, and billing. As previously discussed, solidifying the patient revenue cycle is step one for sound financial management in any MSO arrangement. Therefore, when the manager is responsible for mastering these systems and functions, the success of the arrangement is heavily dependent on its investment, training, and collaboration with the hospital. Likewise, the hospital is responsible for providing the tools and resources for their systems to the manager.

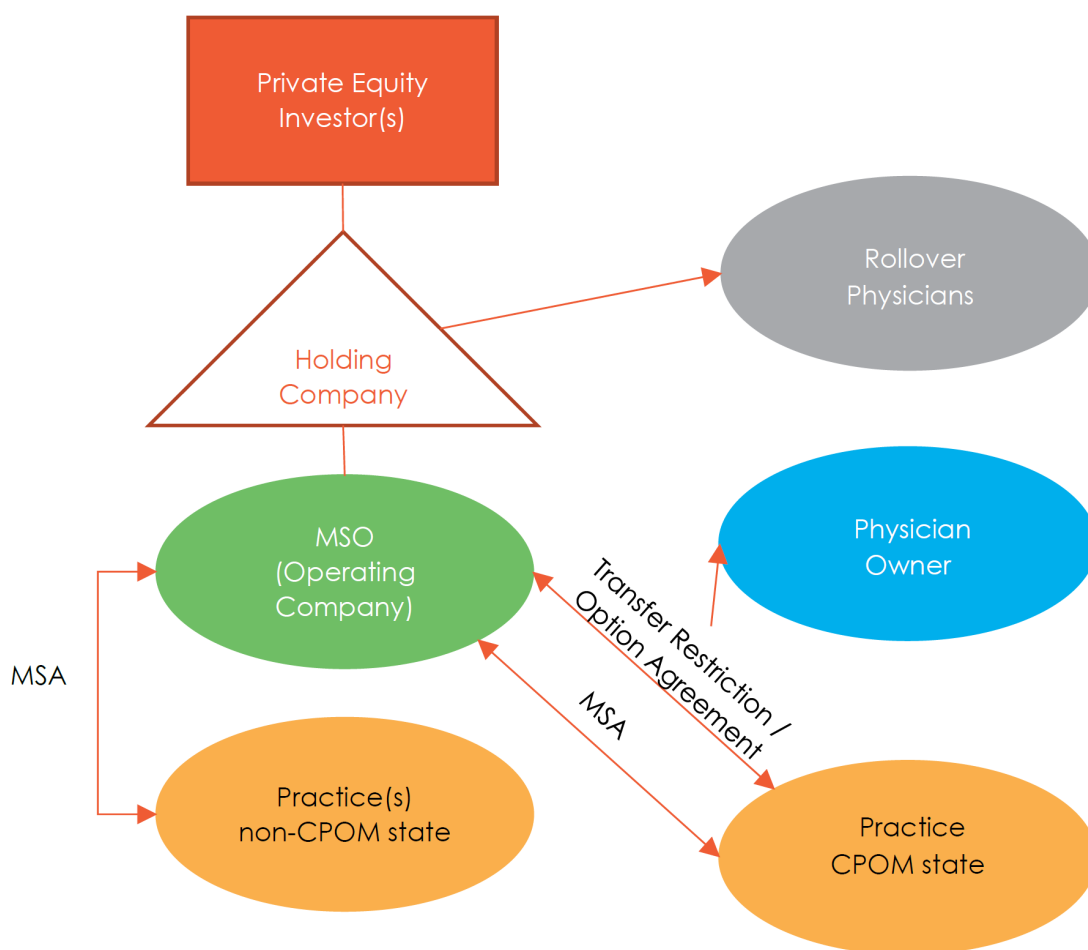
Private Equity Perspective: Physician Practice–MSO Arrangements

Over the last decade, marked initially by the passage of the Affordable Care Act, physician practice merger and acquisition transactions have been a major force in the health care industry. In particular, as a horizontal integration strategy, private equity funds have been major players in acquisitions of practices through MSO models in an otherwise fragmented market. Earlier in the decade, private equity investments in retail specialties such as dermatology and ophthalmology proved successful, and has since expanded into other hospital-based and office-based areas such as anesthesia, surgical specialties, and even primary care. Again, scalability is a leading value driver (1) as MSOs concentrate administrative costs so that physicians can focus on high quality patient care; (2) with size, MSOs can leverage a better negotiating position with payers; and (3) in new capital, which can fuel growth in patient services.

Arrangements involving private equity, physician practices, and MSOs have very unique structures in terms of ownership and how the funds flow. A basic organization chart and flow are illustrated in Figure 3 below. Note, because certain states with Corporate Practice of Medicine (CPOM) laws restrict non-hospital corporations from employing physicians, clinical services and assets must be completely separate from management services and assets. This nuance creates additional due diligence requirements to understand the potential value transferred to the MSO to attract investors. Additionally, compensation to the MSO by the physician-owned professional entity must be compliant with fair market value.

Beyond the structure presented, ancillary services are often included as high-value drivers in the MSO arrangement. When referral relationships exist with physician-owners in the arrangements, compensation to the MSO must also be compliant with fair market value.

Figure 3. Arrangements Involving Private Equity Investors²



The basic mechanisms of these types of arrangements often begins with a compelling offer and business valuation from the private equity firm for the practice acquisition. In these arrangements, terms generally drive valuation post-transaction, and the physicians continue to generate enterprise revenue and earn professional compensation through provider entities. Physicians, however, take a reduction in professional compensation in return for upfront proceeds, paid via cash or rollover stock consideration. If the physicians rollover stock, they will participate in equity returns through the MSO alongside the private equity investors and other physician rollover owners.

From a financial perspective, each party will ultimately measure success to some degree through return on equity throughout the private equity investment cycles, and while the physicians ultimately generate top line revenue, the heart of these arrangements is the MSO and its ability to execute on compliant value propositions.

MSOs for Health Care Innovators

At the time of this guide, the global COVID-19 pandemic has significantly impacted the health care services industry. Due to quarantining and social distancing, CMS quickly realized that health care delivery had to shift to remote options. Telemedicine boomed as CMS and commercial payers removed many of the historical compliance and reimbursement roadblocks. Care innovators—those who have adapted and created new ways to provide patient care—are at the forefront of adopting MSO models to grow.

Information technology is the major force behind many of the innovating companies, which has brought into the health care services industry new players such as Silicon Valley investors and software developers. Because MSO models have proven success through size and scale, these new players are able to very quickly bring to market innovative provider-based solutions.

The managers' value in these arrangements is heavily weighted on IT expertise, which requires a different way of thinking about the cost-risk-return relationship. In other words, the financial arrangement may reflect the MSOs providing something quite different than a typical basket of management services or commonly used equipment and technology. Many of these innovators are start-ups in nature, which leads to a discussion of how to financially manage a brand new MSO in the market.

Financial Management for MSO Start-Ups

In addition to the innovators, many traditional start-up MSOs enter the health care services industry every year. This section will provide insight and considerations for newly established MSOs.

Creating a pro forma is an important first step in deciding whether or not to utilize an MSO. The MSO should determine what functions it will provide for the operating entity(s). However, this can take many forms; activities performed by the start-up MSO may be simpler in nature and include accounting, human resources, marketing, billing and collections, or other administrative-type functions.

It can be helpful when determining actual costs for an organization to assign expense line items for the different functions that they are providing to an operating entity. This will likely include both direct and indirect expenses. Payroll costs for individuals that are providing the accounting function can usually be identified easily as a direct cost. This can become a little more challenging when the MSO is providing services for several operating entities. However, in this case, the manager may find it useful to allocate costs by number of hours spent performing the accounting function for each specific operating entity. Examples of indirect costs may be rent expense related to lease space for manager employees, software costs, utilities, and salaries and wages for management personnel. Indirect cost allocations are often based upon a relevant measure assigned to a function. It is important to utilize a measure that is easily trackable and designated to a specific activity. This measure should be consistent from period to period.

A manager may take advantage of a broad approach to determine a reasonable mark up to actual costs for management services and risks incurred by the MSO. "Reasonable" can be a rather vague term; therefore, comparing costs and risks to industry benchmarks can provide a helpful gauge. In addition, the manager should review the financial operations of the operating entity to determine if the cost being charged makes sense in proportion to the operating entity's revenue and expenses. If this is out of line, the manager should adjust accordingly. Mark-ups determined through a broad approach should not be considered in any legal contracts, but can serve for modeling and budgeting purposes.

Understanding the revenue cycle of the operating entity(s) will be important to the MSO. If the MSO is not providing the revenue cycle services, it is still important that they are acutely aware of how the revenue cycle of an operating entity is performing. Patient revenue cycles have extremely complex rules and regulations that, if not actively managed and monitored, can have detrimental effects on both the manager and operating entity.

It is also prudent of the MSO to determine appropriate key performance indicators (KPI) for the operating entity. These KPIs should be measured against industry benchmarks for the operating entity's location and practice specialty. Important KPIs to measure may be the labor to revenue, drugs to revenue, supplies to revenue, labor turnover, overtime usage, accounts receivable aging, and patient volume. Having both financial and non-financial KPIs will provide a more holistic view of the health of an organization.

In whatever manner a new MSO chooses to structure the services they provide, these should be documented in a legal contract, such as the MSA. This reduces the risk of potential blurred relationship lines between the MSO and the operating entity. This can also be beneficial in defending against potential Stark law violations or kickback accusations. To that end, the next section expands upon regulatory compliance matters.

FMV and Commercial Reasonableness

As previously mentioned, in order to be legally compliant, health care MSO arrangements are more often than not required to meet certain exceptions under the Stark Law and safe harbors under the Anti-Kickback Statute (AKS). Arrangements can be compliant in accordance with the professional services arrangement exception criteria for Stark³ and the similar personal services and management contracts safe harbor criteria for AKS⁴.

From a financial perspective, the most critical criteria for compliance lies with fair market value compensation and commercial reasonableness. Stark states that compensation must be set in advance, does not exceed FMV, and does not take into account volume or value of referrals. Stark also expands on FMV of compensation stating it must be commercially reasonable and furthers the legitimate business purposes of the parties. Similarly, AKS states that aggregate compensation is set in advance, does not exceed FMV, and does not take into account the volume or value of referrals.

At the time of this article, final changes to Stark and AKS related to FMV and commercial reasonableness are under consideration. One notable change that was proposed is that parties would not necessarily have to demonstrate profitability to be compliant. This is an interesting area to monitor because a hurdle could be removed for arrangements intending to meet certain health care needs, albeit without all parties recognizing profit.

For FMV compliance, a third-party valuation of the compensation arrangement is required. This includes all aspects of management fees pursuant to the MSA and lease payments for all physical assets. To provide insight into the valuation process of MSA compensation, professional standards set forth three approaches to value: the Cost, Market, and Income Approaches. In general, the Cost Approach takes into account the direct and indirect costs of the MSO for providing its services and applies a supportable mark-up for a value indication. The Market Approach applies metrics from comparable arrangements in the market when applicable. An Income Approach is traditionally a discounted cash flow analysis (however, that rarely applies to MSA compensation). Therefore, better alternative methods include sensitivity analyses tailored to the specific economics of both parties. Prudent valuations take into account the financial arrangements holistically and specific to the parties.

For established MSOs, the analysis is often based on historical financial information. Alternatively, for start-ups, the analysis is based on pro forma financials. So not only is the pro forma integral for financial planning a new arrangement, it serves as a critical basis for compliance.

It is very important to periodically review existing or new fee arrangements in light of FMV, at least on an annual basis. With time, actual performance can be materially different than previous assumptions or historical performance. It is not uncommon for MSO fee arrangements to move outside fair market value due to a host of factors. For this reason, many MSAs explicitly call for annual FMV reviews as part of the parties' compliance plan.

The FMV review should include a qualitative assessment of the arrangement such as any material changes in operations. A quantitative review focuses more on actual and prospective financial results relative to the contractual compensation terms in order to determine if FMV still applies or if adjustments are required. In summary, establishing and monitoring FMV compliance will keep all parties on a path to success.

Conclusion

MSOs continue to propel health care services in the U.S. among a wide variety of providers and stakeholders. This guide set out to provide an overview of MSO arrangements, steps to take for solid financial management, provided a deeper dive into specific types of arrangements, and brought attention to compliance matters. In the end, hopefully these topics bring light to an exciting, growing area in the health care industry.

Endnotes

- 1 Goodwill—that intangible asset arising as a result of name, reputation, customer loyalty, location, products, and similar factors not separately identified. *Statement on Standards for Valuation Services No. 1: Appendix B – International Glossary of Business Valuation Terms*.
- 2 Figure 3. adapted from a presentation at the Healthcare MSO Conference, a DealFlow Event in New York N.Y.: Michele A. Masucci & Michael I. Schnipper, *Corporate and Regulatory Issues in Structuring Healthcare MSO Transactions*, NIXON PEABODY, LLP (Sept. 27, 2019).
- 3 42 C.F.R. § 411.357(d).
- 4 42 C.F.R. § 1001.952(d).

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