

# Healthcare FMV Issues

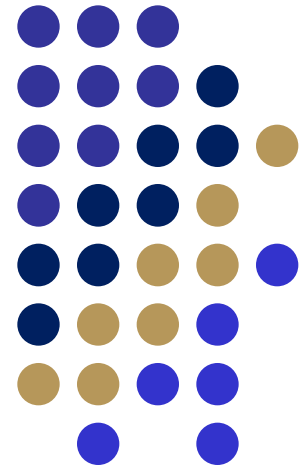
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*Practical Health Retreat*  
*Hall Render Killian Heath & Lyman, P.C.*

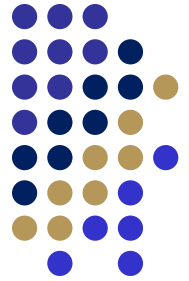
Presented by:  
Daryl P. Johnson, MAcc, AVA, Managing Partner

February 25, 2011

  
HealthCare Appraisers  
INCORPORATED



# Presentation Overview

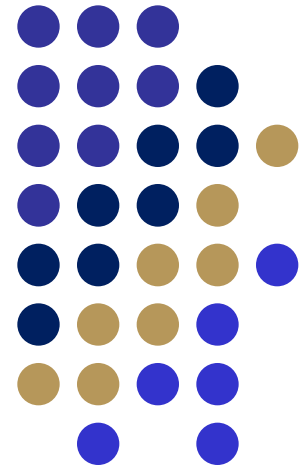


1. Current Transaction Trends and FMV Issues
2. FMV Pitfalls
3. Observations from Recent Legal Cases

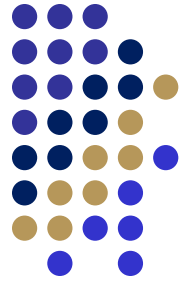
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*Current Transaction Trends and FMV Issues*



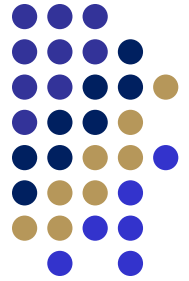
# Current Healthcare Transaction Trends



- Physician Practice Acquisitions
- Physician Employment
- Quasi-Employment Agreements
- Co-Management/Pay-for-Performance Arrangements
- Other Compensation Arrangements

# Physician Practice Acquisitions

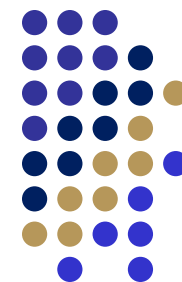
## Overview



- A very significant number of acquisition transactions are taking place.
- In particular, cardiology and oncology practices are active targets.
- Valuators are polarized with respect to certain valuation approaches.
- Relationship between purchase price and post-acquisition compensation.
- Consultants can establish unreasonable expectations among physicians.

# Physician Practice Acquisitions

## Divergent Valuator Opinions

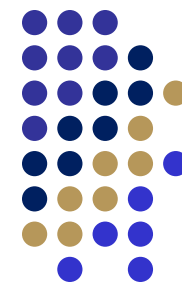


- Approaches to valuing physician practices (or any business entity) include Market, Cost and Income.
- A Market Approach is generally of little value due to lack of comparability and reliable data.
- A Cost Approach restates the entity's balance sheet, including specifically identified intangible assets (e.g., workforce in place, trade name, favorable 3<sup>rd</sup> party payor contracts, etc.)
- An Income Approach discounts (or capitalizes) expected future cash flows to the buyer.



# Physician Practice Acquisitions

## Divergent Valuator Opinions (cont.)

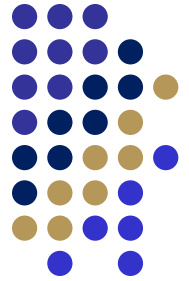


- Certain respected appraisers espouse “Cash is king... a DCF is the sole determinate of physician practice value.”
- Other appraisers identify and value specific intangible assets (*e.g.*, workforce in place), and such approach generally results in a higher value than a DCF analysis.
- Relative pros and cons of this difference in opinions?
  - “DCF only” is safer, more conservative?
  - “DCF only” may not foster many (or any?) transactions.



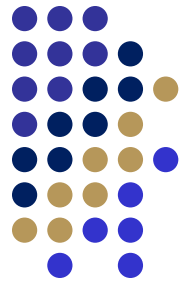
# Physician Practice Acquisitions

## Divergent Valuator Opinions (cont.)



- What if the DCF shows no value? Will physicians sell their practices for the value of tangible assets?
- Does the valuation/payment for intangibles cause higher regulatory concern? Does traditional valuation theory govern healthcare transactions, or is the healthcare sector truly unique?

# Physician Practice Acquisitions Post-Acquisition Compensation

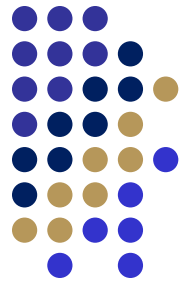


- What if the physicians' compensation is *higher* post-transaction?
- In cases where purchase price includes intangible value, the purchase price and post-acquisition compensation are inextricably linked.
- The valuation community seems to be in agreement in this regard.



# Physician Practice Acquisitions

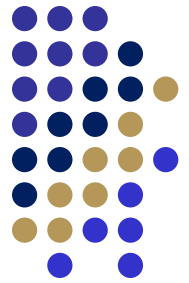
## Post-Acquisition Compensation (cont.)



- In other words, increased future compensation is a form of purchase price to offset intangible purchase price.
- Determining the “compensation offset”
  - Increased compensation is a form of purchase price consideration.
  - In a DCF, the cash flow can be adjusted to reflect the higher compensation – or – a direct purchase price offset can be computed.
  - If the practice value is based upon a Cost Approach, the compensation offset is trickier (*e.g.*, Do you tax affect? Do you discount to PV?).

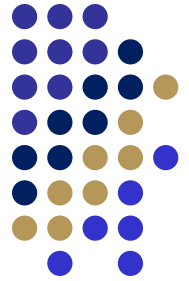
# Physician Practice Acquisitions

## Pre-Planning the Valuation Focus



- If a practice acquisition consists only of tangible assets, most valuers tend to agree that post-acquisition compensation is unencumbered by the purchase transaction.
- If the goal is to maximize future compensation, there may be no benefit in conducting a business valuation (*i.e.*, a DCF or valuation of specific intangibles).
- A “tangible asset acquisition” coupled with FMV future compensation seems to be a readily defensible approach. This approach may also accommodate “C” corp taxation issues.
- On another note – “Large” purchase prices driven by physician pay reductions are seeing a revival.

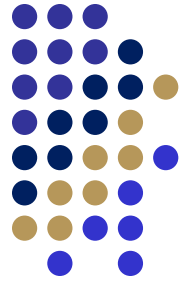
# Physician Practice Acquisitions Consultants' Advice



- “Physician practices are worth a multiple of revenues.”
- You can have your cake and eat it, too...  
*”There is no relationship between purchase price and post-acquisition compensation.”*
- “The selected valuation firm is too conservative. Other firms yield much higher values.”

# Physician Practice Acquisitions

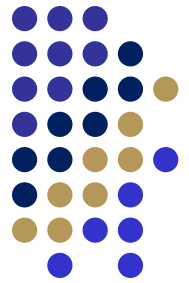
## Other Issues



- Valuing ancillaries that depend upon the future referrals of the selling physicians?
- Services that will be discontinued (*e.g.*, duplicative services or CON assets)
- Differentiating “equity value” and “transaction value”

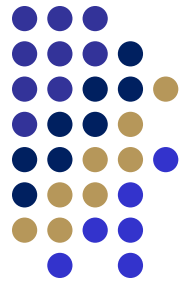


# Employment Agreements Overview



- Employment activity has seen a significant uptick in past 12 months.
- Productivity-based models are in vogue; *median compensation per wRVU* is a widely viewed metric.
- Employment agreements have many moving parts... the “terms and features” are critically important.
- Can in-market physicians be paid at higher rates?
- Can/should “downstream referrals” be considered?
- Benefit plans are becoming more robust.

# Employment Agreements Using Survey Data

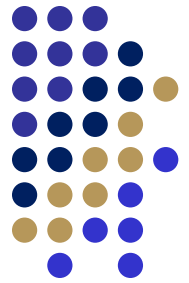


- Confucius Statistician say...”If you torture the data long enough, it will confess to the crime it did not commit.”
- MGMA data can be misused in a variety of ways, including:
  - Cherry picking from among different tables (e.g., regional data vs. state data)
  - Failure to consider ownership/ancillary profits that may be inherent in 90<sup>th</sup> percentile compensation
  - Do regional compensation differences exist? The grass is always greener...



# Employment Agreements

## Compensation per wRVU



### Example of misuse of MGMA data:

- For Orthopedic Surgery: General
- 90<sup>th</sup> percentile cash compensation - \$799,883
- 90<sup>th</sup> percentile wRVUs – 13,147
- 90<sup>th</sup> percentile compensation per wRVU - \$97.97

### *Where is this going?*

- 90<sup>th</sup> percentile wRVUs x 90<sup>th</sup> percentile compensation per wRVU = \$1,288,000
- MGMA states that there is an inverse relationship between physician compensation and compensation per wRVU
- *Median compensation per wRVU* is dramatically different than median compensation.

# Employment Agreements

## “Stacking”



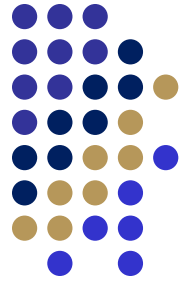
**If you label compensation layers by different names, you can stack them higher and higher!**

- Sign-on bonus
- Productivity bonus
- Medical directorship
- Co-management agreement
- Quality bonus
- Retention bonus
- Call pay
- Tail insurance
- Excess vacation
- Relocation costs
- Excess benefits



# Employment Agreements

## Perils of wRVU Models



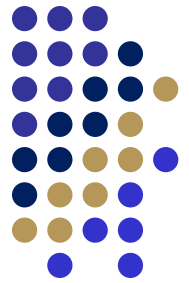
**Hospitals implementing wRVU models have been observed to make errors related to:**

- “Total” vs. “work”
- GPCI adjustments
- Assistant at surgery
- Multiple procedures
- Mid-level providers
- Site-of-service differences
- CMS changes in wRVUs
- New or discontinued CPT codes



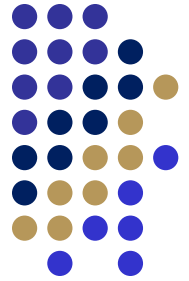
# Employment Agreements

## Other Issues



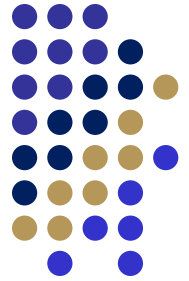
- Can physicians be “made whole” for ancillary profits?
  - Defining “normal” ancillaries
    - Oncology – chemotherapy infusion
    - OB/GYN – Ultrasound tests?
    - Cardiology – Stress tests, Echo?
    - Orthopedic surgery – MRI?
- Part-time arrangements (*e.g.*, for procedures only)
- Perils of overly complicated compensation structures
- Valuing clinical vs. administrative duties

# Quasi-Employment Agreements



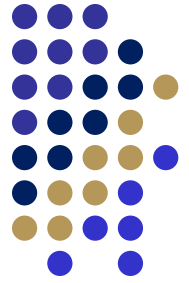
- Gaining in prevalence
- Entails a PSA, with the physicians compensated as independent contractors on a wRVU basis; additional payments are made for taxes/benefits and retained practice expenses.
- Payment may also be made for “leasing” of non-clinical employees and fixed assets.
- FMV considerations – generally the same as employment arrangements
- **Note:** Should certain payments be pass-through or fixed rather than as a component of a wRVU rate?

# Current Issues in Clinical Co-Management Arrangements



- Virtually any type of P4P arrangement may be termed a co-management agreement now.
- Co-management arrangements are still “untested” (*i.e.*, no Advisory Opinions or government actions specific to co-management arrangements).
- Some hospitals and health lawyers are skeptical of the arrangements.
  - Some are only comfortable with hourly physician compensation arrangements.
- Compensation for call coverage is oftentimes included and valued among the duties.
- Defining the service line revenues
  - Avoid double-counting revenues.
- Establish the scope of services; the arrangement may cover inpatient, outpatient, ancillary and/or multi-site services, and may encompass many specific duties.

# Current Issues in Clinical Co-Management Arrangements



## FMV Issues:

- Subjective aspects of establishing the management fee, and applicable valuation approaches
- Identifying base tasks and tracking the achievement of these day-to-day management tasks
- Applicable valuation methods
- Ensuring no third-party managers or management by hospital
- Must be integrated with medical director payments
- Consider the possible *effective* hourly rate

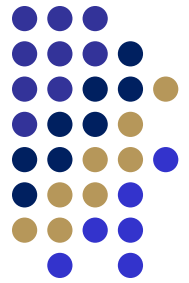
# Current Issues in Clinical Co-Management Arrangements



- Who monitors the metrics?
- Are the monitors subject to re-basing?
- Can a retrospective fact pattern cast an arrangement in a bad light? What if there is no evidence of the physicians incurring time, attending meetings, etc.?



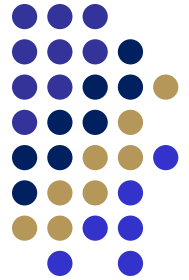
# Lithotripsy (the poster child for potential regulatory abuse)



## From CMS Q&A:

- Q – “Where a physician-owned lithotripsy partnership contracts with a hospital to provide a lithotripter and skilled technical “under arrangements,” may the hospital pay for such services using a per-use or percentage-based compensation formula without violating the physician self-referral law?”
- A – “In Phase II, we recognized the common practice of many contractors to provide the tools of their trade in connection with service contracts (69 FR 16091). There we did not require the use of the exception in 411.357(b) for the lease of equipment whenever equipment was provided as part of a service contract. “
- Non-DHS
- Industry is running with the concept of a “service” (for lithotripsy, but not for other similar “services”)

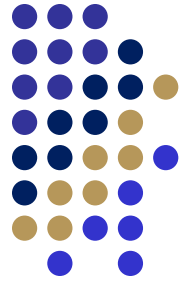
# Lithotripsy



## From commentary to 2009 IPPS [emphasis added]

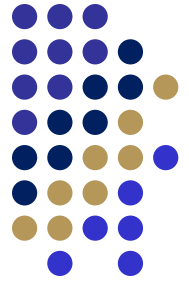
- “...As a further example, we would also have a serious question as to whether an agreement is commercially reasonable if the lessee is performing a sufficiently high volume of procedures, such that it would be economically feasible to purchase the equipment rather than continuing to lease it from a physician or physician entity that refers patients to the lessee for DHS. Such agreements raise the questions of whether the lessee is paying the lessor more than what it would have to pay another lessor, or is leasing equipment rather than purchasing it, because the lessee wishes to reward the lessor for referrals and/or because it is concerned that, absent such a leasing arrangement, referrals from the lessor would cease. In some cases, depending on the circumstances, such arrangements may also implicate the anti-kickback statute.

# Lithotripsy



- Virtually no “untainted” market values exist.
- Even once “independent” litho providers found they needed to JV with physicians to survive.
- A Cost Approach can demonstrate that lithotripsy margins can be inordinately high.
- 2009 IPPS commentary issue – when to apply the make vs. buy analysis
- Consequences to a hospital based on physician expectations
  - Include loss of lithotripsy procedures...and loss of all other procedures performed by urologists.

# On-Call Arrangements

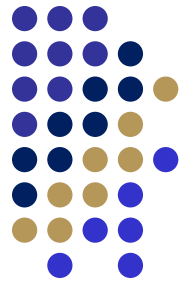


- SullivanCotter indicates that only 9% of hospitals establish on-call payment rates through FMV analysis.
  - 57% use a consensus process involving management and physician leadership.
  - 41% negotiate individually with each physician/practice.
- Virtually all compensated on-call arrangements exist between physicians and hospitals to which they refer.



# On-Call Arrangements

## Relevant Factors (cont.)



- Frequency and nature of call events
  - Telephone consults
  - Required presence at the ED
  - Required response time
  - Integrity/availability of data
  - Call frequency surveys
- Nature of the specialty
  - OB (typically unfunded patients with no prenatal care)
  - Surgeons (a surgical procedure is likely required, including follow-up care)
- Compensation earned by such specialists for clinical work
- Number of physicians available to participate in call rotation

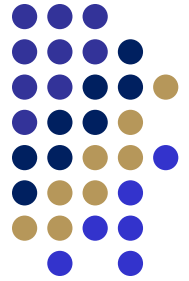
# On-Call Arrangements

## Relevant Factors (cont.)



- Exposure to unfunded care
  - Unfunded patients
  - Low-pay patients (*e.g.*, Medicaid)
- Additional considerations
  - “Restricted” vs. “unrestricted” call
  - Required rapid response (*e.g.*, TPA administration)
  - Professional liability exposure
  - Required coverage by medical staff bylaws
  - Call compensation to employed physicians

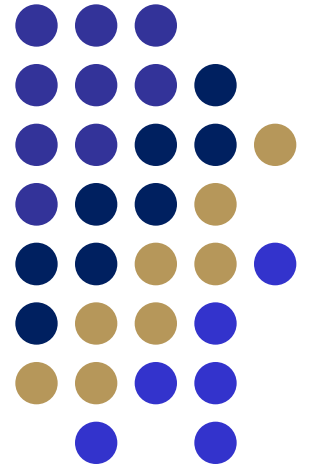
# Part-time Turnkey Lease Evaluations



- Even with a real estate appraisal in hand, FMV of a space lease arrangement may not be assured.
  - Rentable vs. usable square footage
  - CAM...gross...net...full service...modified gross...utilities, etc.
  - Are any services or equipment provided by the hospital?
  - Must the FMV assessment consider proximity value when a hospital is the lessor?
  - How to deal with build-out allowances, varying lease terms and other special provisions that may be in physician space leases.

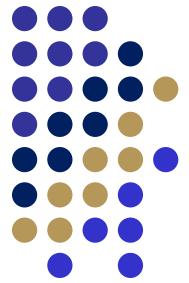
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*FMV Pitfalls*



# FMV Pitfalls

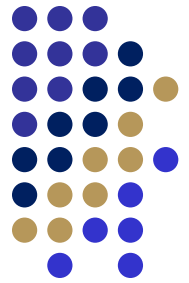
## Use of an Incorrect Standard of Value



- Healthcare regulations stipulate **fair market value** as the applicable standard of value
- The definition of **fair market value** (*i.e.*, the concept of a hypothetical willing buyer/willing seller) is counter-intuitive to the lay person.
- **Strategic value (or investment value)** is often confused with FMV.

# FMV Pitfalls

## Use of Tainted Market Data

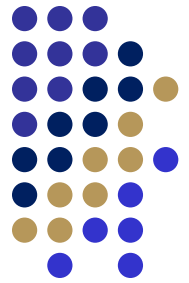


- Generally, any market data used to establish FMV must be “arm’s-length”. Healthcare transactions are frequently suspect.
- A market approach is the preferred valuation approach for many types of compensation arrangements.
- For certain types of arrangements, virtually no “non-tainted” data is available.
- The valuator must consider alternate approaches.
  - Consider whether the arrangement can be “cross-walked” to a non-healthcare setting. If the arrangement would make sense in a non-healthcare setting, it may make sense in healthcare (provided that referrals are never considered/valued).



# FMV Pitfalls

## Misapplication of a FMV Opinion

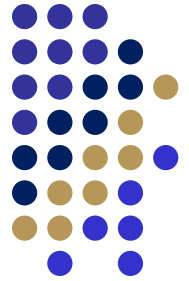


### Examples :

- Opinion was valid only over a specified range of outcomes.
- Misapplied “units”
  - Surgical cases vs. procedures; patients vs. “fractions”
  - Unrestricted vs. restricted call
  - 24-hour on-call rate applied to a 14-hour call period
- FMV opinion is ambiguous or conditional.
- FMV opinion included critical governing assumptions that were not considered in its application.

# FMV Pitfalls

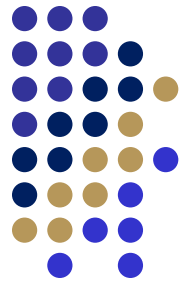
## An Unreliable FMV Opinion



- Even with a fair market value assessment, many things can still go wrong:
  - The terms and provisions assumed by the appraiser may not match the agreement.
  - The valuator may have lacked sufficient knowledge of the subject matters.
  - Consider the “shelf life” of the appraisal, and whether there are any post-closing obligations (such as a true-up).
  - Is the appraisal compelling? Does it appear to meet the standard that regulators may require?

# FMV Pitfalls

## The “No Risk” Risk Premium

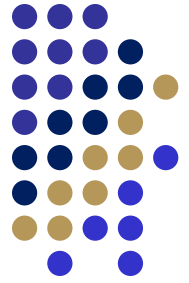


- FMV should not be influenced by the inclusion of gratuitous contract provisions that add “false” risk.
- Examples:
  - Early termination provisions that are not likely to be exercised
  - The perpetual renewal of a one-year lease
  - Leaseback arrangements for space or personnel



# FMV Pitfalls

## Medical Directorships

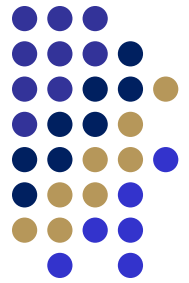


- Use of clinical versus administrative benchmarks
- Role or number of hours are not reasonably needed or required (*i.e., medical directorships are still sometimes handed out as a pure form of compensation*)
- Hours worked are not documented (or did not occur)



# FMV Pitfalls

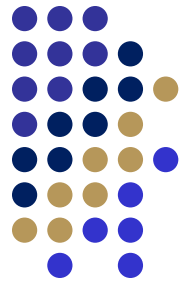
## Commercially *Unreasonable*



- Advertising on physician practice websites by recipients of referrals (*e.g.*, pathology labs)
- Payment to physicians to coordinate their own on-call schedules
- Restricted call arrangements involving low patient encounter frequency
- Lease arrangements for equipment that should be purchased
- Hospital transaction costs that exceed the value of the underlying transaction

# FMV Pitfalls

## The “Behind the Scenes” Management Company



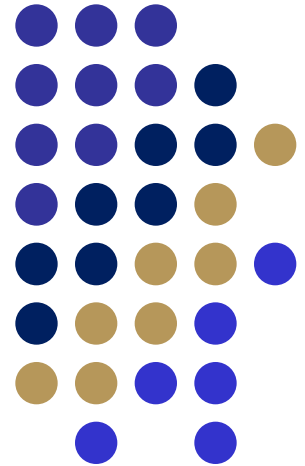
**A physician practice (the “Manager”) that engages a third-party management company to fulfill the Manager’s obligations to a hospital may undermine the arrangement.**

- Both the Manager and the third-party management company may seek a “full profit” for their efforts.
- The Manager may appear to be profiting from arbitrage, or the overall arrangement may appear to be a sham.

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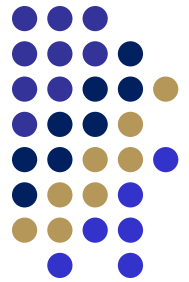
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*Perspectives on Recent Legal Cases*



# Kosenske Case (January 21, 2009)

*United States ex rel. Kosenske v. Carlisle HMA, Inc. and Health Management Associates, Inc.*, 554 F.3d 88 (3d Cir. 2009)



- Stark Law Case – exclusive anesthesiology agreement with first opportunity to provide pain management services in new outpatient clinic
- No written contract and no money changed hands – group bills professional component and hospital bills facility/technical component
- Possible FMV lessons
  - Arm’s length negotiations between parties in a position to refer to each other inherently lack independence and are suspect.
  - Seemingly innocuous arrangements may fall under FMV scrutiny.

# Covenant Settlement (August 25, 2009)

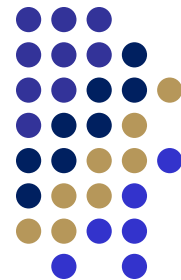
*Covenant Medical Center and Wheaton Franciscan Healthcare – Iowa, Inc., Waterloo, IA*



- \$4.5 million settlement involving five employed specialist physicians allegedly paid salaries in excess of FMV and not commercially reasonable
- Covenant claims the physicians were exceptionally productive, and were paid a percentage of practice earnings from personally performed services after deducting practice expenses.
- Possible FMV lessons
  - Government may have used one or more national compensation surveys in its case. Not clear how FMV was determined.
  - Prior to this settlement, many felt employment arrangements were a lower risk alignment strategy.
  - Underscores importance of proper legal review and independent FMV determination.
  - Accounting properly for practice expenses is critical in a “net-earnings” deal.

# Tuomey Case

*United States of America, ex rel. Michael K. Drakeford, M.D. v. Tuomey Healthcare System, Inc.*, CA No.: 3:05-CV-02858-MJP,  
U.S. District Court for the District of South Carolina



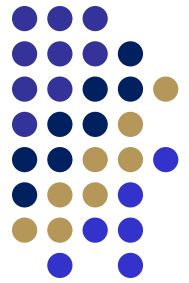
(First trial ended in split verdict in March 2010 indicating Stark violation but no **False Claims Act** violation – later thrown out.)

## Possible lessons to be learned?

- The existence of an “independent” FMV report may not be persuasive.
  - Valuator lack of independence and/or lack of experience
  - Counsel and their clients should consider whether a valuation analysis/conclusion is compelling (whether prepared internally or by an independent firm).

# Bradford Case

United States ex rel. Singh v. Bradford Regional Medical Center,  
F. Supp.2d , 2010 WL 4687739 (W.D. Pa.)



- Another less than stellar valuation report – Half page of analysis devoted to supporting a payment for a non-compete in the amount of \$284,000 per year.
- Components of the analysis included consideration of CT/MRI revenues/expenses. However, the physicians were only *thinking about* adding CT/MRI.
- Does *consideration* of referrals run afoul of Federal regulations, even if the resulting compensation is consistent with FMV?

# Healthcare FMV Issues

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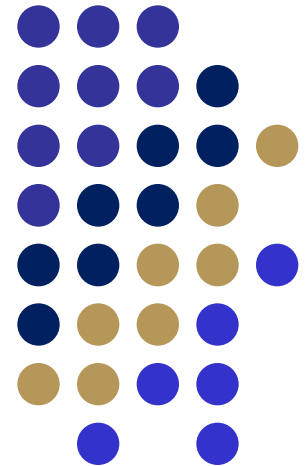
*Presentation for  
Hall Render Killian Heath & Lyman, P.C.*

Presented by:

Daryl P. Johnson, MAcc, AVA, Principal

February 25, 2011

  
HealthCare Appraisers  
INCORPORATED



# Questions?

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