GOING HOSPITAL BASED: GETTING THE DEAL DONE – TRANSACTIONAL ISSUES

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Trends in Hospital-Physician Collaboration

• Employment
• Practice acquisitions and charitable contributions
• Community oncologists moving on-campus or into hospital-affiliated groups
• Integration and alignment for quality and efficiency improvement and for multi-disciplinary care
• Legal developments narrow somewhat options for collaboration
Hospital Employment of Oncologists

Currently Employ

Plan to Employ in Next 2-3 Years

No Plan to Employ

\[ n = 126 \]

Source: The Advisory Board Company, 2010 Oncology Roundtable
Physician Employment

• Increase in employment by hospitals
• Shortage of oncologists by 2012
• Change in attitude of younger physicians toward employment
• Financial distress of community medical oncologists
• Integrate, align and control destiny
• Less legal risk
  – Joint pricing without violating antitrust
  – Refer and share ancillaries without violating fraud and abuse laws
  – Hire for competitive purposes
Continued Interest in Collaborative Arrangements

Percentage of Hospitals Having Implemented or Considering Alignment Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Implemented</th>
<th>Considering in Next 2 Years</th>
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<tbody>
<tr>
<td>Co-management Contract</td>
<td>22%</td>
<td>27%</td>
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<tr>
<td>Equipment Lease</td>
<td>15%</td>
<td>24%</td>
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<tr>
<td>Joint Venture</td>
<td>21%</td>
<td>37%</td>
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<td>Under Arrangement</td>
<td>18%</td>
<td>10%</td>
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n = 107

Source: The Advisory Board Company, 2010 Oncology Roundtable
Professional Services Agreements
PSAs: Introduction

• **Professional Services Agreements**
  – Powerful tool
    • To staff existing Hospital cancer center or develop new hospital facility
    • To convert existing group sites to Hospital-licensed facilities paid at hospital outpatient payment rates
    • Integrate and align Hospital and Group to improve quality, efficiency and operations of Hospital’s oncology service line
PSAs: Introduction (cont.)

• Potential economic win-win
• Group paid fair market value compensation on an aggregate fixed fee or wRVU basis
  – Eliminates risk of reimbursement reductions and collection risk (free care/bad debt)
  – Other: purchase of equipment, management services, employee lease?
• Hospital establishes new satellite sites or facility and new book of oncology business
  – Good contribution margin due to combination of hospital rates and physician office cost structure
  – Potential 340B pricing opportunity
• Potential economic losers
  – Payors—higher rates for “same” services
  – Higher patient co-pays
Hospital provides:
- License
- Provider-based status
- 340B pricing

Oncology Group provides:
- Physician/NP/PA staffing

$/wRVU

Professional Services Agreement
PSA Transaction

• Avoid U/A transaction—Group cannot “perform the service”
  – Hospital could take assignment of Group leases from landlords
  – Hospital could purchase Group’s FFE and inventory at fair market value
  – Hospital would need to employ nurses/techs at off-campus locations (to meet Medicare provider-based status rules)

• Group can provide all other staff
  – Physicians/NPs/PAs
  – Non-clinical staff at all sites
  – Nurses and techs at on-campus sites
Professional Services Agreement

Hospital provides:
• License
• Provider-based status
• 340B pricing
• Space/equipment
• Nurses/techs (off-campus)

Group provides:
• Physicians/NPs/PAs
• Non-clinical staff
• Nurses/techs (on-campus)
• Administrative services?

Notes:
• PSA on fair market wRVU basis
• Asset/inventory purchase at FMV
• Employee lease /management agreement on a FMV (i) fixed fee, (ii) cost plus, or (iii) percentage of collections or NOI with a FMV floor and cap
• Billing services at fair market percentage of collections or fixed fee per claim?
Principal PSA Legal Issues

• Provider Based Status Regulations
  – Within 35 miles of main Hospital campuses
  – Hospital license requirements/Physical space standards
  – CON issues
  – Clinically, financially and administratively integrated
  – Hospital reporting lines
  – Hospital must directly employ mid-levels/techs at off-campus sites (other than NPs/PAs)
  – Oncology group can lease non-clinical staff and NPs/PAs to Hospital
  – No off-campus joint venture with oncology group
Principal PSA Legal Issues

- **340B Drug Pricing**
  - Discount from average manufacturer price generally based on manufacturer’s best price
  - Applies only to outpatient drugs
  - Available to DSH hospitals, free-standing cancer hospitals, children’s hospitals, CAHs, RRCs, sole community hospitals, FQHCs, and certain special federal grantee programs
  - 8% DSH for RRCs and SCHs; 11.75% for others
  - No applicable to for-profits
  - Must be within 35 miles of main hospital/meet provider-based status standards
  - Effective after first cost report filed with CMS and enrollment (quarterly) with HRSA/OPA—up to 16 months process
  - Supply and extend by contract to retail pharmacies for hospital patients
Principal PSA Legal Issues

• Stark Law

  – Under arrangements prohibition: cannot have investment interest in entity (including own medical group) that “performs” the DHS service
  – ”Stand in the shoes”
  – Personal services, fair market value or indirect comp exception: fair market value requirement/independent appraisal advisable
Principal PSA Legal Issues

• Anti-Kickback Statute
  – Approximate personal services and management contracts and/or space or equipment rental safe harbor
    • Fair market value/independent appraisal strongly advised
  – Some irreducible AKS risk: aggregate compensation not set in advance if wRVU based
Principal PSA Legal Issues

• **Tax Exemption Considerations**
  
  – No inurement/private benefit
  
  – No excess benefit transaction
  
  – Rebuttable presumption of reasonable compensation process
  
  – Rev. Proc. 97-13 and private use of bond financed space or equipment/duration limitations (3 years/2 year out)
Principal PSA Legal Issues

• Can hospital purchase practice or service line(s) as on-going business in connection with PSA?
• Valuation challenges—commercially reasonable, FMV, and can’t vary with anticipated referrals
  – Inherent AKS tension between on-going business value and anticipated referrals from selling physicians
  – Tension between Stark law and sale of ancillaries
  – Trade-off of compensation/price?
  – Value on a “re-start” basis?
  – Carve-out governmental business (but, some state all-payor statutes)?
  – No earn-out if sellers in position to refer
• Tax structuring to maximize net payment
Other Key PSA Issues

• Payor pushback
• Role in governance of service line
• wRVU valuation issues
  – Relation to existing physician compensation/ margins on drugs, imaging, labs, etc.
  – Benefits/other continuing expenses
  – New physicians/NPs/PAs
  – Anti-dilution protection
  – Harmonizing with alternative payment arrangements
• No overlap of duties/double payment
Other Key PSA Issues

• **USP 797 standards/State pharmacy issues**

• **Staffing Issues**
  – Split staff (off-campus) and salary/benefit differentials
  – Union issues

• **Unwind rights**
  – Asset repurchase
  – Lease assignment/real estate repurchase
  – Solicitation of employees
  – Data/records access/transfer
  – Systems issues
  – Non-compete exception
Hybrid PSA/Service Line Co-Management Arrangements
What is a Service Line Co-Management Arrangement?

• Independent contract relationship
• Focused on a Hospital’s oncology service line
  – Scope?
• To engage physicians as a business and clinical partner in managing, overseeing and improving service line quality and efficiency
Service Line Co-Management Direct Contract Model

- Payors
- Hospital
- Operating Committee
- Designees

- Onc Service Line
- Hospital-licensed services

- Co-Management Agreement:
  - Two, or multi-party contract
  - Specifically enumerated services
  - Allocates effort and reward between groups

- Oncology Group I
- Oncology Group II
- Other Group(s)
Service Line Co-Management Joint Venture Model

- Payors
- Onc Service Line
- Hospital
- Oncologists/Groups
- JV Management Company

- Capital Contributions
- Management Infrastructure
**Service Line Co-Management Arrangements**

- **Typically two levels of payment to physician managers:**
  - **Base fee** – a fixed annual base fee that is consistent with the fair market value of the time and effort participating physicians dedicate to service line development, management, and oversight
  - **Bonus fee** – a series of pre-determined payment amounts, each of which is contingent on achievement of specified, mutually agreed, objectively measurable, program development, quality improvement and efficiency goals
  - Aggregate payment generally approximates 2-4% of service line revenues expressed as fixed FMV fee; independent appraisal advisable.
Sample Medical Oncology Performance Standards

- Comply with NCCN/QOPI guidelines
- Increase in patient satisfaction
- Increase in staff satisfaction
- Decrease in infusion site infections
- Substitution of lower cost drugs/items for drugs/items of equivalent efficacy and quality
- Increase in patient accruals for hospital clinical trials
Sample Medical Oncology Performance Standards

• Increase in percentage of patients with written treatment plans at start of infusion

• Increase in percentage of written treatment plans with indication of:
  – Staging
  – Intention of therapy
  – Approved treatment regimen for tumor site/staging

• Increase in percentage of written treatment summaries at completion of course of treatment
Notes:
- Same as PSA arrangement, plus
- Service Line Co-Management Agreement
  - PSA component – wRVU rate equal to aggregate current physician comp/benefits
  - Asset/inventory purchase
  - Employee Lease/Administrative Contract – Fixed fee, cost plus or percent of collections with FMV floor and cap
  - Co-management base component – fixed fair market value fee
  - Incentive component contingent on meeting specified quality and efficiency improvement standards – fixed FMV fee per standard
Regulatory Considerations

- There are legal constraints on Service Line Co-Management Agreements (i.e., Stark, CMP, and AKS):
  - No stinting
  - No steering
  - No cherry-picking
  - No gaming
  - No payment for changes in volume/referrals
  - No payment for quicker-sicker discharge
  - No reward for changes in payor mix, case mix
  - Must be FMV; independent appraisal required
Key Service Line Co-Management Issues

• Additional work for already busy physicians

• Scope of service line under management
  – Service line co-management services
  – No overlap with, *e.g.*, PSA, employee lease, Medical Director agreement or other agreements

• Performance standards and targets
  – Validation
  – Achievability
  – Reset
Key Service Line Co-Management Issues

• Operating Committee composition and authority

• Term/durability
  – Rev. Proc. 97-13 (5/3 years if 50%+ fixed)

• Dilutive effect of adding physicians due to fixed FMV fee for services rendered

• Cost of independent monitor, valuation, security offering (for JV)

• Some irreducible legal risk
Key Deal Maker/Breaker Issues

• Governance
• Financial Terms
• Term/Duration
• Termination
• Restrictive Covenants
• Unwind Rights
• Addition of New Physicians
• Buy-In/Buy-Out Rights (if applicable)
• Break-Up Fees?
• Arbitration/Dispute Resolution
Valuation Considerations
Presentation Overview

• Healthcare FMV 101
• Current Healthcare Transaction Trends
• Business Valuation Considerations
• Compensation Valuation Considerations
FMV 101: Healthcare Arrangements & Transactions

• 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 sometimes counter-intuitive to the lay person.

• Strategic value (or investment value) is often confused with FMV.
FMV 101: Healthcare Arrangements & Transactions

• Generally, any transaction between potential referral sources must be:
  – Consistent with FMV; and
  – Commercially reasonable.

• A transaction can be “FMV,” but not commercially reasonable, and vice versa.

• Healthcare regulations impose specific guidance that directly impacts FMV analysis:
  – Avoid tainted market values.
  – Avoid improper valuation methodologies.
FMV 101: Healthcare Arrangements & Transactions

- **Business Valuation (BV) guidance is well established.**
  - Healthcare valuation experts follow extensive body of knowledge and standards.
  - Consideration of healthcare regulatory definition of FMV.

- **Compensation Valuation (CV) guidance – no formal guidance or standards**
  - Stark allows for “any method that is commercially reasonable.”
  - Absence of formal guidance facilitates greater valuator judgment regarding approaches and methodologies considered and applied (and related outcomes).
  - FMV outcomes must be defensible.
Current Healthcare Transaction Trends

- Physician Practice Acquisitions
- Physician Employment
- PSAs/Quasi-Employment Agreements
- Co-Management/Pay-for-Performance Arrangements
- On-Call Arrangements
- Medical Directorships
Physician Practices Acquisitions: Overview

• To establish FMV, you must understand and incorporate the proposed terms of the deal.
• Appraisers are polarized with respect to the appropriateness of certain valuation approaches.
• Relationship between purchase price and post-acquisition compensation
• Some transaction consultants can establish unreasonable expectations.
Physician Practices Acquisitions: Valuation Approaches (BV)

• 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, etc.).

• An **Income** Approach discounts (or capitalizes) expected future cash flows to the buyer.
Physician Practice Acquisitions: Divergent Valuator Opinions

• 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: Post-Acquisition Compensation

• If physician compensation is subject to an increase upon acquisition, the increased compensation is generally treated as an offset to any intangible value.

• The valuation community is largely, but not entirely, in agreement in this regard.
Physician Practice Acquisitions: Pre-Planning the Valuation Focus

• If a practice acquisition consists only of tangible assets, most valuators 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.
Physician Practice Acquisitions: Other Issues (Medical Oncology)

• Can a physician ancillary service (e.g., chemo infusion) be carved out and sold?
  – Healthcare regulations may prohibit valuing in-office ancillaries based upon future cash flows if such cash flows are dependent upon future referrals of the selling physician(s).
  – An infusion business is not capital intensive, and there are minimal barriers to entry. Therefore, is there any value in an infusion business apart from the expected future referrals?

• 340B Drug Savings/Higher Provider-based Reimbursement Rates
  – Hospitals can’t pay for values they create.
Valuation Alternatives

• Potential increase to physician compensation either through PSA or employment with Hospital (subject to FMV constraints)
• Hospital Oncology Service Line Co-Management Arrangements
• Medical Directorships
• Other Administrative Services
Employment Agreements: Overview

• Physician employment is still very active.
• 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 and typically unique.
• Benefit plans are becoming more robust.
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” RVUs
• Failure to consider CPT modifiers and impact on wRVUs
  – Assistant at surgery
  – Multiple procedures
  – Bilateral procedures
  – Reduced procedure
• Physician vs. Mid-level providers
• CMS changes in wRVUs
• New or discontinued CPT codes
Employment Agreements: Other Considerations

- **Personally Performed Services vs. Incident-To Services vs. Direct Services** rendered by a physician or midlevel provider

- Understand “Normalized” compensation levels by provider as compared to “Reported” compensation (Form W-2, Schedule K-1, Schedule C, 1099, etc)

- Accurate wRVU production levels by physician
Employment Agreements: Other Considerations

• Impact of transaction structure on prospective wRVUs.
  – Considerations for “lost” infusion wRVUs when infusion center becomes hospital-based post-affiliation

• The prospective physician compensation model structure must preserve FMV throughout the full range of likely production outcomes.

• Structure physician compensation model to mitigate unintended consequences.
  – Tiered comp per wRVU model required?
  – Excess compensation tests?
Employment Agreements: Other Considerations

Common physician compensation normalization adjustments:

• Non-clinical compensation
  – External administrative contracts
  – Atypical ancillaries running through practice
• FMV rent; practice owned office/building
• FMV staff benefits
• FMV physician benefits
Employment Agreements: Other Considerations

Common physician compensation normalization adjustments (cont.):

- Non-recurring income and expenses
- Non-operating income and expenses
- Depreciation and inactive asset considerations
- Excess/deficient support staffing levels
- FMV staff compensation considerations
Employment Agreements: Other Considerations

• Can physicians be “made whole” for ancillary profits?
• Defining “normal” ancillaries
  – Oncology – chemotherapy infusion
• 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
- Should certain payments be pass-through or fixed rather than as a component of a wRVU rate?
Co-Management Agreements: Overview

• **Purpose:** Recognize and appropriately reward participants for developing, managing and improving the quality and efficiency of a particular hospital service line.

• **Scope:** May cover inpatient, outpatient, ancillary and/or multi-site services.

• **Participants:** May include one or more physicians, medical groups or faculty practice plans, or a joint-venture entity owned in part or entirely by participating physicians or medical groups.
Co-Management Agreements: Overview

• Typically two levels of payment under the Co-Management Arrangement:

  • **Base Fee:** A fixed annual base fee that is consistent with the FMV of the time and efforts of the participating physicians
    – Includes compensation for service line development, management and oversight

  • **Bonus Fee:** A series of predetermined payments that are contingent on the achievement of specified, mutually agreed upon targets
    – Targets must be objectively measurable and based on program development, quality improvement and efficiency.

• Fees must be fixed and commensurate with FMV.
Co-Management Agreements: Overview

Examples of Co-Management Services:

• Clinical improvements
• Work flow process improvement
• Physician and patient scheduling
• Nurse and non-physician clinician oversight
• Patient case management activities
• Credentialing activities
• Materials management
• Medical staff committee service and leadership
Co-Management Agreements: What Drives Value?

- The total fee payable under a co-management arrangement typically ranges from 2% to 4.5% (on a calculated basis) as % of service line net revenue
- The fee is fixed as a flat dollar amount, including both base and incentive components, for a period of at least one year.
- Commonly, the base fee equals 50-70% of the total fee.
- The extent and nature of the services drive their value. Thus, the valuation assessment is the same whether the manager consists of only physicians or physicians and hospital management.
Co-Management Agreements: What Drives Value?

Determinants of value include:

• What is the scope of the hospital service line being managed?

• How complex is the service line?

• How extensive are the duties being provided under the co-management arrangement?

• How many physical locations are being managed?
Co-Management Agreements: What Drives Value?

• Size adjustments based on service line revenue:
  – Large programs may be subject to an “economies of scale” discount.
  – Small programs may be subject to a “minimum fee” premium.

• Consider the appropriateness of the selected incentive metrics:
  – Is the establishment of the incentive compensation reasonably objective?
  – What is the “delta” between projected performance and incentive thresholds?
Co-Management Agreements: What Drives Value?

• Consider the appropriateness of the selected incentive metrics (cont.):
  – Are there a sufficient number of metrics given the size of the program?
  – Consider the split of base compensation and incentive compensation.

• Occasionally, certain other services (e.g., call coverage) may be included among the co-management duties. (Some hospitals prefer to embed call coverage in the co-management fee to avoid a separate compensation arrangement with the physicians.)
Co-Management Arrangements: Possible Pitfalls

• Overstated service line/revenue stream

• Redundancy of provided management services (third-party manager involved?)

• Care must be taken to ensure that employed physicians who are part of co-management arrangements are not double paid for their time.
  – Employment compensation based solely on wRVUs is self-normalizing.
Co-Management Arrangements: Possible Pitfalls

• Medical director agreements related to the managed service line must be compensated through the base management fee.

• Existing hospital committees need to be accurately accounted for; may require an adjustment to the Market Approach

• There can be no passive participants. Co-management duties are substantial and require significant time and effort of all participants.

• Lack of an effective compliance program that tracks and monitors the performance and achievement of the base management tasks
Medical Director Agreements

• Is the arrangement commercially reasonable? Are the services needed, and to what extent?

• Is “opportunity cost” an appropriate valuation consideration? Do physician compensation rates differ for clinical vs. administrative services?

• Hourly compensation arrangements may be comforting, but there is much opportunity for abuse.
Summary

• Numerous issues and challenges might arise when exploring hospital-physician employment and/or contractual affiliations.

• Various compliant hospital-physician affiliation structures exist, along with related opportunity for BV and/or CV value recognition.

• All such options need to be carefully assessed and scrutinized for both legal and FMV compliance.
Summary

• There is disagreement in the valuation community regarding the appropriateness of certain valuation approaches. Involving multiple valuation firms in different aspects of the same overall transaction can be risky.

• The health care regulatory and compliance environment is dynamic. Continue to monitor your arrangements for ongoing legal and FMV compliance.
Questions?