BAKER & DANIELS

HealthCare Appraisers INCORPORATED

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Avoiding Fair Market Value Pitfalls

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"What do you mean by FMV?"

- In the healthcare context, there are essentially 3 basic views on the meaning of FMV:
  - "Person on the street" perspective
  - Professional appraisal perspective
  - Legal/regulatory perspective
- Unfortunately, these 3 basic views frequently conflict.
- Parties can get "dazed and confused" when these 3 competing views meet to complete a transaction.

"The Street" View of FMV

- "What everyone is getting paid in the market"
- "What the hospital down the street is paying"
- "Incremental cost plus a profit margin"
- "What's in a survey book"
- "What it's worth to one party to the transaction"

Professional Appraisal View of FMV

- "The price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arm's length in an open and unrestricted market, when neither is under a compulsion to buy or sell and when both have reasonable knowledge of the relevant facts."

  (International Glossary of Business Valuation Terms)

Professional Appraisal View of FMV

- Based on the “hypothetical-typical” buyer concept
- FMV contrasts with investment value or strategic value
- Determination of FMV is based on 3 approaches to value:
  - Cost
  - Income
  - Market
- Formal body of knowledge and professional standards governing the appraisal practice for real estate and business valuation (“BV”)
- No current body of knowledge or standards for compensation valuation (“CV”)

Legal/Regulatory View of FMV

- Stark Definition:
- FMV is defined as the value in arm's-length transactions, consistent with the general market value. General market value means the compensation that would be included in a service agreement as the result of bona fide bargaining between well informed parties to the agreement who are not otherwise in a position to generate business for the other party.

Legal/Regulatory View of FMV

- Stark regulations state that the definition of FMV "is qualified in ways that do not necessarily comport with the usage of the term in standard valuation techniques and methodologies."
- Stark example:
  Exclusion of market comparables between parties in position to refer
- Stark example:
  FMV can be established by "any method that is commercially reasonable."
- OIG Anti-kickback statute example:
  Footnote 5 to Advisory Opinion 09-09 cautioning the use of the DCF method for an ASC valuation

Avoid the FMV Definition Pitfall

- The “Street” perspective of FMV is generally not reliable for healthcare regulatory purposes but may provide useful information.
- Regulatory definition of FMV may limit or qualify FMV methods used in professional appraisal practice.
- FMV as determined under professional appraisal standards may be more rigorous than the regulatory requirements.

Avoid the FMV Definition Pitfall

- Learn to identify and navigate through the different views of FMV as they arise in negotiating transactions and compliance reviews.
- Recognize that appraisal professionals do not give regulatory advice, but only their opinion as to the determination of FMV, which may or may not take into account regulatory considerations.
- Strive for an efficient relationship between the parties who determine FMV.

Loss of Control Of Payment Allocation

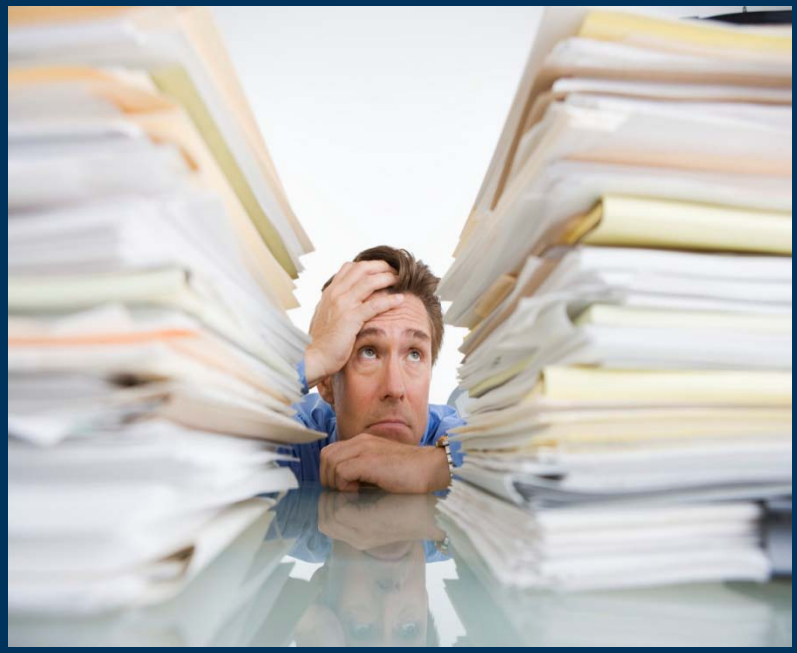
Memorial Health University Medical Center Settlement. Government alleged that Memorial paid above market for administrative services and compensation was ***pooled*** permitting top referral source to obtain disproportionate share of compensation. Memorial Health paid $5,080,000 to settle the case.

Compensation Stacking

Provider entering into multiple compensation arrangements that would be:

i) above a full-time equivalent (1.0 FTE); and

ii) highly unlikely that a physician could perform all duties either because of the number of hours required or for quality reasons.



On-Call Compensation "Stacking" with Employed Physicians

- Case Study: Neurosurgeon in private practice seeks employment based on a wRVU model.
  - Physician currently receives $2,000 per shift for on-call pay.
  - Should the physician continue to receive the full $2,000 per shift in addition to his compensation per wRVU model?

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

Independent Contractors/Medical Directorships

- Use of clinical v. administrative benchmarks.
- Role or number of hours are not reasonably needed or required (i.e., developing arrangement only to "retain" physician in service area).
- Hours worked not documented.

See Exhibit A (Time Card) and
Exhibit B (Monthly Tracking Tool).

[ORGANIZATION NAME]

EXHIBIT A

PHYSICIAN: «FirstName» «LastName», «Title» MEDICAL DIRECTOR OF: «JobTitle»

PAY PERIOD

For a complete listing of duties please reference the Medical Director Agreement.

Please indicate time in half hour increments.

DUTIES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
A. Provide program assistance, guidance, and recommendations.																															
B. Provide medical guidance and direction.																															
C. Provide educational inservices and/or conferences.																															
D. Administrative duties.																															
E. Be available to discuss and review treatment.																															
F. Be a physician liaison.																															
G. Meet regularly with Clinic staff. Attend meetings as requested.																															
H. Other																															

GRAND TOTAL:_____

_____ _____ Approved by:_____

«FirstName» «LastName», «Title» Date

* In addition to the above, please generally describe the services performed this month.

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EXHIBIT "B"

MEDICAL DIRECTOR
Tracking Tool

Last Name	Current Hrly Pay	Contract Hrly Pay	Contract Weeks	Actual Total Hrs. Wrk	Prorated Hrs.	Contracted Annual Hrs.	Contract Start Date	Contract Expire Date	Total Annual Compensation
Dr. Kilroy	$102.42	$114.00	17	65.5	59	180	09/01/05	08/31/06	$20,520.00
Dr. Bombay	$117.65	$102.56	26	68	78	156	07/01/05	06/30/06	$16,000.00
Dr. Doctor	$142.12	$111.00	43	201.5	258	312	08/01/05	07/31/06	$34,632.00
Dr. I.M. III	$139.54	$137.80	4	79	80	1040	08/01/05	07/31/06	$143,310.40
Dr. Feelgood	$134.77	$97.87	26	321	442	884	07/01/05	06/30/06	$86,520.00

Current Hourly Pay: Current hourly rate based upon total hours documents
(Total Annual Compensation/52 X Contract Weeks)/(Actual Total Hours Worked)
Contracted Hourly Pay: (Total Annual Compensation)/(Contracted Annually Hours)
Contract Weeks: Number of weeks into current annual contract cycle
Total Hours Worked: Number of hours of services documented by physician during current term based upon time sheets approved
Prorated Hours: Average hours physician would have worked if hours evenly distributed throughout contract term:

Contracted Annual Hours: Number of hours required by contract on annual basis
Contract Start: Effective Date of current annual term
Contract Expiration: Expiration date of current annual term
Total Annual Compensation: Total amount of annual compensation per contract

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Commercial Unreasonableness

- While most conceivable compensation arrangements can be valued, when does an arrangement lack commercial reasonableness?
  - Advertising on physician practice websites by recipients of referrals (*e.g.*, pathology labs)
  - Payment to physicians to coordinate their own on-call schedules
  - Lease arrangements for equipment that should be purchased
  - Hospital transaction costs that exceed the value of the underlying transaction

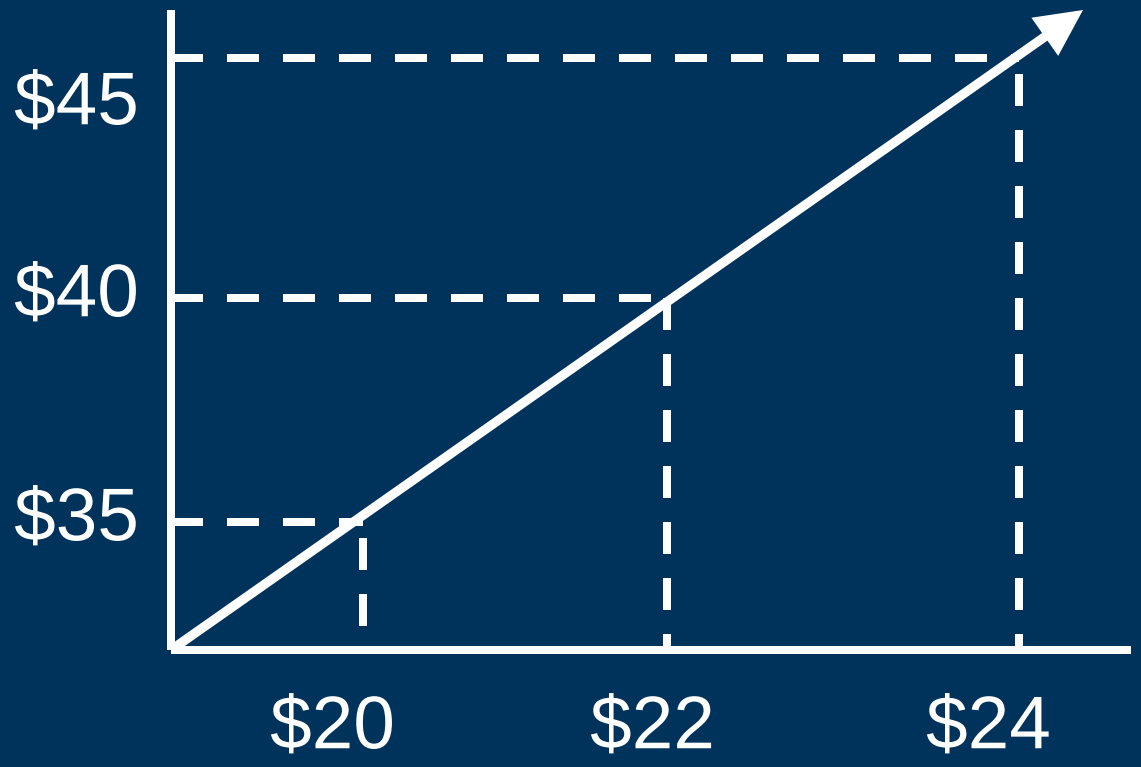
Real Estate: High Risk

- Gross v. triple net lease documentation to support lease amount
- Incorrect square footage for leased space
- Hospital/lessor losing money on real estate holdings when most real estate leasing companies in market are generating profit/margin
- Not charging for increases in maintenance or annual increases when lease contemplated such increases
- Enhanced tenant improvements not factored into lease rate

Real Estate: High Risk

- Time share arrangements
  - Not accounting for “vacancy” in time share arrangements
  - Time share “creep” (i.e., using staff, supplies, or specialized equipment not factored into time share compensation arrangement)

Tenant Improvements Allocations



Real Estate - Shared Space

- Must allocate all costs
- Rental of space (Half or Full Day Slots)
- Vacancy Rate (Project 20% vacancy?)
- Supplies
- Utilities
- Staff (Registration, Nursing, etc.)
- Equipment

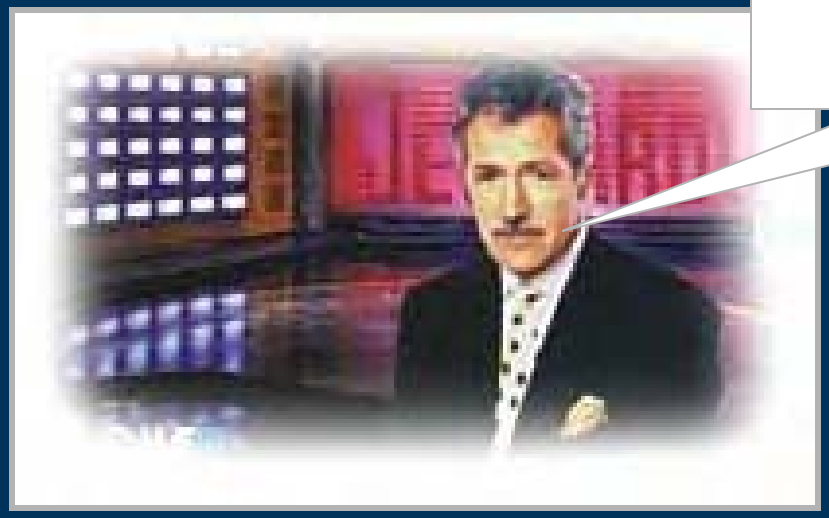
Real Estate
Shared Space - Example

- Assume the following:
- $18 gross per square foot rental (exclusive use)
- 30% projected vacancy
- 1,000 square feet in suite
- Building has 6,000 square feet, with 1,000 square feet for common area (5,000 square feet usable space)
- Suite capable of being leased in half day increments (8:00 A.M. – Noon; 1:00 P.M. – 5:00 P.M.)

Real Estate
Shared Space - Example

- Furniture and equipment in suite determined to be leaseable at $2,000 per year using independent third party leasing company.
- Miscellaneous medical/office supplies projected to be used in suite is approximately $5,000 annually if suite leased 70% of the time

Real Estate
Shared Space - Example



Real Estate
Shared Space - Example

- $18 (exclusive use rate) + 30% (vacancy) = $25.71 per square foot ($18 .7 = $25.71)
- 1,000 square feet (suite) 5,000 square feet (building not including common area) = 20% (percentage of suite's usable space in building's usable space)
- 1,000 square feet (common area) x 20% (suite to building)
- = 200 square feet (common area allocated to suite)

Real Estate
Shared Space - Example

- 1,200 square feet (suite plus allocated common area) x $25.71 = $30,852
- $30,852 + $2,000 (furniture and equipment) + $5,000 (medical/office supplies) = $37,852
- $37,852 52 (weeks) = $728 (weekly rate)
- $728 5 (business days in week) = $146 (daily rate)
- $146 2 = $73 (half day rate)

Real Estate
Shared Space - Example

Real Estate
Shared Space - Example

Example becomes more complicated if:

- Part of suite is leased (as opposed to full suite)
- Staff is provided by landlord/hospital
- Specialized equipment is used
- Non-standardized supplies are used by a tenant

Ancillary Revenue

Compensation in an ***employment arrangement*** is based, in part, on ancillary revenue generated by the employed physician's referrals to employer/hospital.

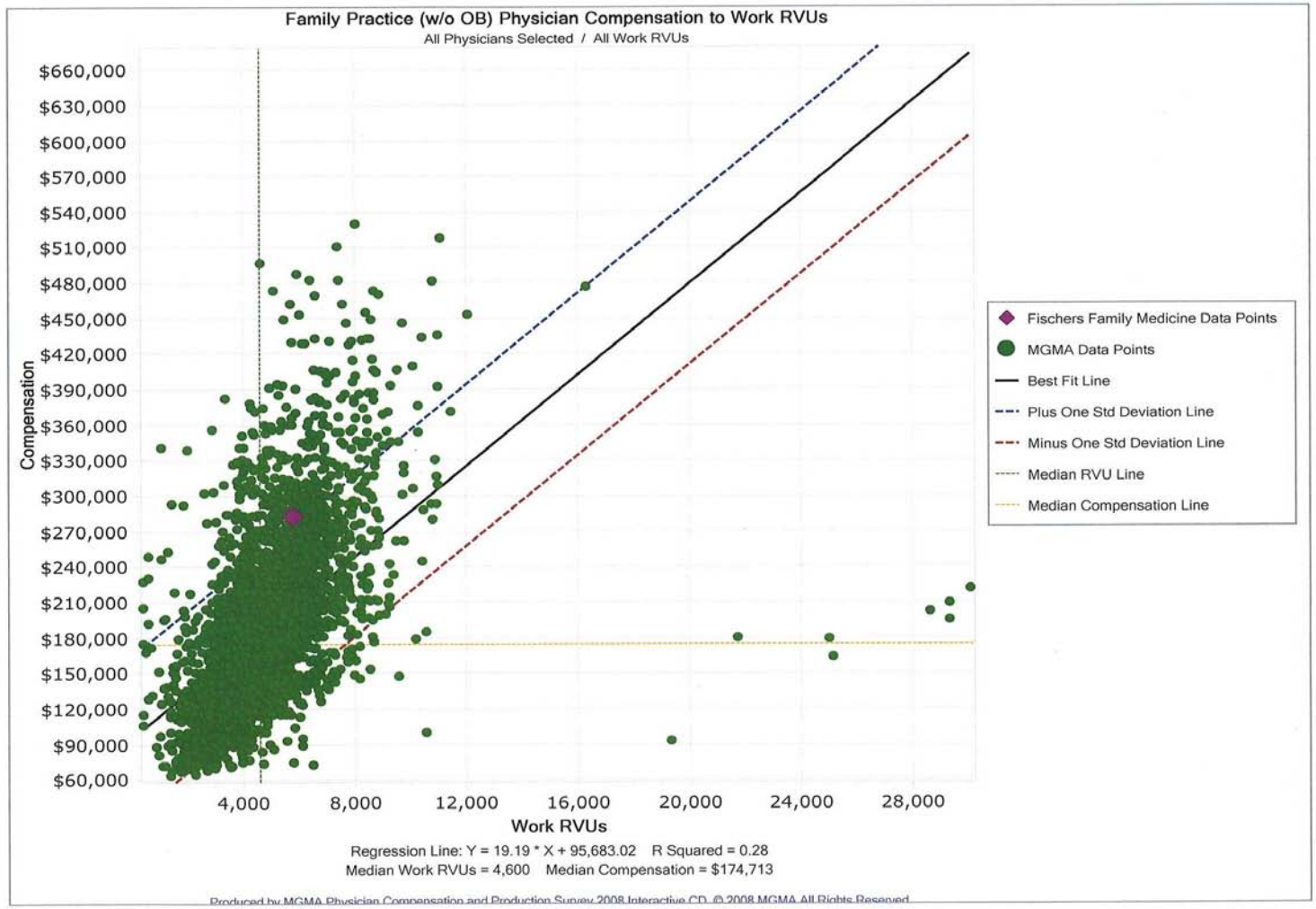
Example: The specialty of oncology generates substantial revenue from ancillary services.

Misuse of RVUs

- Overview of relative value units (or RVUs)
- Key difference between *total* RVUs and *work* RVUs
  - *Total* RVUs include *work*, *practice expense* and *malpractice*.
- Possible over-counting due to:
  - Assistant at surgery
  - Multiple procedures
  - Midlevel providers
  - Site of service differences

National Benchmark Data Mistakes

- Poor alignment of compensation v. productivity
- Use of worked RVUs v. total RVUs
- Employment v. shareholder data – most benchmarks combine, but some benchmark sources separate the data. This is most notable in specialties that generate substantial income from ancillary services. For the specialty of oncology, as reported in the 2008 MGMA Report, the 90th percentile for shareholders is $966,135 and for employees is $515,705.


Family Practice (w/o OB) Physician Compensation to Work RVUs
All Physicians Selected / All Work RVUs
$660,000
$630,000
$600,000
$570,000
$540,000
$510,000
$480,000
$450,000
$420,000
$390,000
$360,000
$330,000
$300,000
$270,000
$240,000
$210,000
$180,000
$150,000
$120,000
$90,000
$60,000
Compensation
4,000
8,000
12,000
16,000
20,000
24,000
28,000
Work RVUs
Fischers Family Medicine Data Points
MGMA Data Points
Best Fit Line
Plus One Std Deviation Line
Minus One Std Deviation Line
Median RVU Line
Median Compensation Line
Regression Line: Y = 19.19 * X + 95,683.02 R Squared = 0.28
Median Work RVUs = 4,600 Median Compensation = $174,713
Produced by MGMA Physician Compensation and Production Survey 2008 Interactive CD. © 2008 MGMA All Rights Reserved.

Matching Compensation to Services Provided

Case Study: Internist in private practice seeks employment under a base salary and incentive bonus model commensurate with her current level of compensation.

- She currently makes $400,000 per year from her practice that includes several MLPs who generate twice their salary and benefit cost in collections.
- What should her compensation level be under employment?

Misconceptions of the Survey Data

#1 – *The surveys are the definitive snapshot of physician compensation in the marketplace.*

- Participants are not selected using statistical sampling methods.
- Each survey tends to represent a different segment of the marketplace.
  - MGMA and AMGA: Larger multispecialty groups
  - SCA: Health system-affiliated physicians

Misconceptions of the Survey Data

#2 – The surveys present compensation for clinical physician services.

- Most surveys report compensation from all sources, including:
  - Compensation for clinical services
  - Owner compensation
  - Ancillary compensation
  - Medical directorships and call coverage

Misconceptions of the Survey Data

#3 – *Regional or state data better reflect my local marketplace*.

- Regional data may be concentrated from respondents in a small number of states or even a single state.
- State data may reflect participants in a few locales with varying market dynamics.
- State data often has a limited number of respondents.

Misconceptions of the Survey Data

#4 – *Compensation and productivity always correlate in the survey data*.

- Regression line analysis on the MGMA data indicates the correlation between compensation and wRVUs or pro collections may be limited in various specialties.
- Correlation between pro collections and comp tends to be higher than wRVU correlation.
- Correlation can vary significantly from year to year.

Misconceptions of the Survey Data

#5 – *Compensation per wRVU rate should correlate with a physician's wRVU productivity level.*

- According to MGMA, there is an inverse relationship in its survey data between productivity and the comp/wRVU rate.
  - Highest wRVU producers have the lowest comp/wRVU rate.
  - Lowest wRVUs producers have the highest comp/wRVU rate.

Proper Use of the Survey Data

- Avoid uncritical use of the surveys, i.e. simply "pulling numbers out of a book"
  - Compare subject physicians to survey respondent profiles and to multiple productivity measures
- Avoid assumptions about the data
- Use multiple surveys and measures
- Read the survey introduction, definitions, and questionnaire!
- Use sensitivity testing on compensation models
- Prepare a solid and thorough pro forma

Multiple On-Call Payments

Physicians can be on call at multiple hospitals. However, if the same physician is being paid by multiple hospitals, physician must have dedicated backup for multiple on-call payments to be defensible.

Misapplication of a FMV Opinion

- Examples –
  - Opinion was valid only over a range of outcomes
  - Misapplied “units” (e.g., surgical cases vs. procedures; 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

Reimbursement of Clinical Expenses for Administrative Role

If a hospital has an administrative compensation arrangement with a physician (i.e., medical directorship), hospital should only reimburse expenses that are directly related to the administrative role.

Bad Examples: Clinically-oriented CME, compensation for administrative role when billing for clinical services.

Use of Tainted Market Data

- On-Call compensation - 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

Source: *2008 Physician On-Call Pay Survey Report*, SullivanCotter and Associates, Inc.

Use of Tainted Market Data

- The all time favorite…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 if lithotripsy margins are inordinately high.
- Consequences to a hospital include loss of lithotripsy procedures…and loss of all other procedures performed by urologists.

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.

Memorial Health University Center

- In 2008, Memorial Health negotiated new contracts with Provident Eye Physicians, its affiliate that provides ophthalmologic services to its patients
- The 2003 contracts did not account for the physicians' teaching and indigent care services
- To correct error, Memorial Health paid Provident Eye Physicians $500,000 per year between 2008 and 2005, and $600,000 per year for 2006

Memorial Health University Center

- The annual payments were not distributed to the physicians performing the teaching and indigent care services
- Instead, the payments were channeled to a small number of high referring physicians that Memorial wanted to keep content
- As a result, the payments constituted an indirect compensation arrangement between the physicians and Medical Center

Memorial Health University Center

- No applicable Stark exception was met. The payments to Provident "varied with the volume or value of referrals or other business generated by the referring Provident physicians" and Memorial acted in reckless disregard of the arrangement
- Memorial settled with the OIG for $5.08 million

Covenant Medical Center

- Covenant Medical Center paid five employed physicians amounts that the government alleged were above fair market value and commercially unreasonable.
- Compensation formulas were based on personally performed services and, according to the defendant, consistent with fair market value.
- Salaries were among the highest in the nation, according to DOJ.
- Covenant settled the FCA allegations, based on the underlying Stark violations, for $4.5 million.

Medtronic Whistleblower Lawsuit

- Targeted physicians for improper consulting and royalty agreements in violation of the Anti-Kickback Statute
  - Targeted over 100 orthopedic spine surgeons, neurosurgeons, medical practices and distributors of taking kickbacks from Medtronic for using their products, promoting off-label use of FDA-approved devices, and filing Medicare claims in violation of the False Claims Act

Medtronic Whistleblower Lawsuit

- Allegations that physicians accepted:
  - Consulting fees when no services were performed
  - Consulting fees for more than fair market value of their services
  - Royalties for patents on which they were not true inventor
  - Improper gifts given, including textbooks
  - Excessive travel
  - Consulting compensation based on amount of business they created

Medtronic Whistleblower Lawsuit

- Lawsuit dismissed in March of 2009. Judge stated that the plaintiffs were barred from going forward because plaintiffs in other lawsuits and the news media had aired the lawsuit's allegations previously.
- Nevertheless, the lawsuit forced all parties, including individual physicians, to spend countless dollars on legal fees.

United States v. Rogan

- 7th Circuit upheld $64 million fine against Peter Rogan, manager and financial beneficiary of Edgewater Medical Center for False Claims Act Violation
  - Anti-Kickback Statute and Stark Act violated through improper payments to physicians
    - Medical director agreements, physician recruiting contracts, teaching contracts, EKG-reading contracts, and physician loan agreements, which provided doctors with compensation that court found was “grossly” above fair market value for services never substantially performed

Christ Hospital (Cincinnati)

- Qui tam lawsuit, filed by cardiologist Dr. Harry Fry, settled with government on February 2, 2010
- Agreement must be finalized by March 30, 2010
- $424 Million aggregate exposure from Heart Alliance, $123 Million for Christ Hospital
- Cardiologists allocated time at Heart Station to perform electrocardiograms, echocardiograms and stress tests based upon revenue generated for Christ Hospital the previous year