Current Issues in Establishing and Defending FMV Compensation

HCCA 15th Annual Compliance Institute

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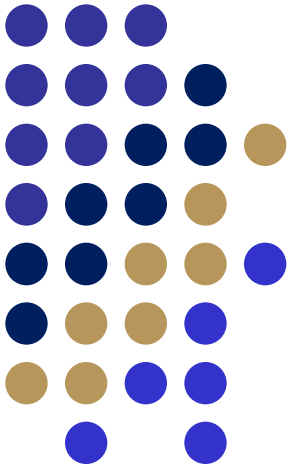

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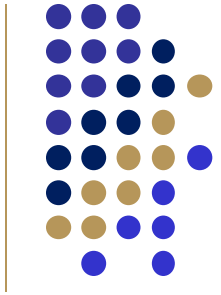
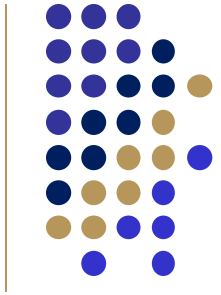
Overview of Presentation



- The Regulatory Environment – A Foundational Overview
- Current Trends, Issues and Pitfalls in Compensation Arrangements
- Contract Review and Preparation Process
- Living with the FMV requirement in the Real World
- Case Study

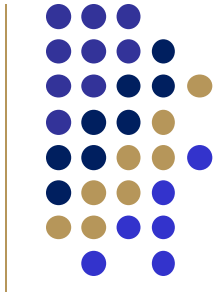
Regulatory Framework



Anti-Kickback Statute

- Criminal statute that prohibits ***any person*** from knowingly and willfully offering, paying, soliciting, or receiving remuneration, directly or indirectly, overtly or covertly, in cash or in kind, in exchange for or to induce the referral or any item or service.
- The statute is broadly written and has been broadly interpreted by the courts to have been violated "if one purpose of the payment was to induce future referrals."

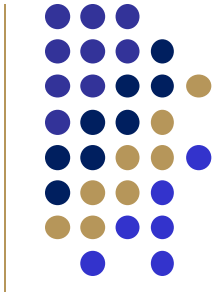
Regulatory Framework



Anti-kickback Safe Harbors

- Employment
- Personal Services and Management Contracts
- Space Rental
- Equipment Rental
- Sale of Practice
- Recruitment

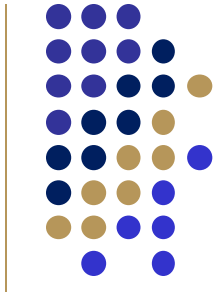
Regulatory Framework



Stark Law

- Physician with a financial relationship may not refer "Designated Health Services" unless the financial relationship fully satisfies an "Exception"
- Strict Liability – intent is not relevant; rather all referrals are prohibited unless an "Exception" is met
- Significant commentary to assist in interpretation of Exceptions

Regulatory Framework



Stark Exceptions

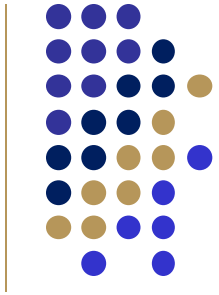
- Employment
- Personal Services
- Lease of Equipment/Space
- Indirect Compensation
- Fair Market Value
- Recruitment

Stark Exceptions

Employment Exception

- Employment is for identifiable services
- Amount of remuneration is –
  - FMV
  - Except as provided below, not determined based upon volume or value of referrals
- Remuneration is commercially reasonable
- Productivity bonus on personally performed services allowed

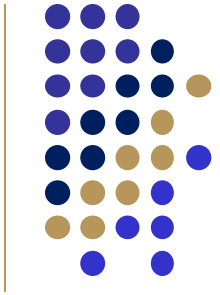
Common Themes For Safe Harbor/Stark Exceptions



Under the Safe Harbors/Stark Exceptions Compensation must be:

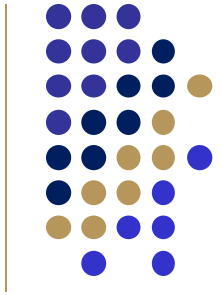
- fair market value,
- does not take into account the volume or value of referrals or other business generated between the parties, and
- is commercially reasonable

Fair Market Value



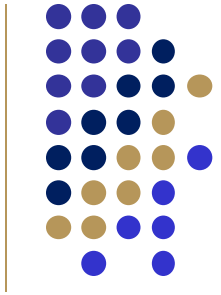
- Arm's-length transaction, consistent with general market value
- Bona fide bargaining between parties not otherwise in a position to refer to each other
- Rental arrangements should not reflect the additional value attributable to proximity or convenience to sources of referrals

Commercially Reasonable



- Serves legitimate business purposes and is necessary to achieve the business purpose
- Does not exceed what is reasonably necessary to accomplish the business purposes of the transaction
- For non-physician service contracts, commercial reasonableness should be readily apparent
  - Need and actual use of rented equipment or space
  - Hospital's collections/profit are irrelevant (*e.g.*, GE leasing would never ask/care)
  - A non-physician vendor should not be cheaper/more favorable terms

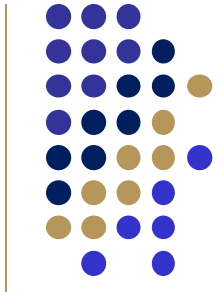
Commercially Reasonable



Physician Service Contracts

- Medical Director Services
  - Define need for service
  - Avoid multiple arrangements beyond legitimate need (e.g., does the hospital need every cardiologist to provide medical director services?)
  - Is the scope correct (*e.g.*, could the role be filled in 4 hours not 10?)
- Physician Employment
  - Overall business strategy of the Hospital
  - Rural vs. Urban Hospitals
  - Community need/Hospital need

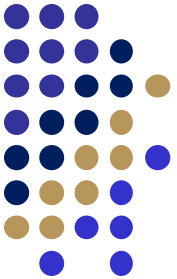
Commercially Reasonable



Other Considerations

- Selection process should not (or appear to be) based upon referrals from physicians
  - Reasonable minimum volume threshold
  - Willingness to take call
  - Support Hospital's educational/research endeavors
  - Willingness to meet performance criteria
- Policies and Procedures established to document and monitor services or items provided

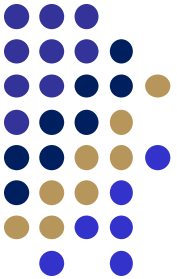
LESSONS LEARNED FROM RECENT CASES



United States ex rel. Singh, et al. v. Bradford Regional Medical Center (November 2010)

- A sublease of a nuclear camera by two physicians who were threatened with loss of privileges for competing with the hospital.
- The payment for the sub-lease and non-compete were both a fixed monthly fee; however, the valuation of a "non-compete" prepared by a CPA took into account anticipated referrals to the hospital and lost profits of the physicians.
- The hospital's position was that the fee was fixed and, as such, the fee could not vary based on the volume or value of referrals and the payment was supported by a fair market valuation.

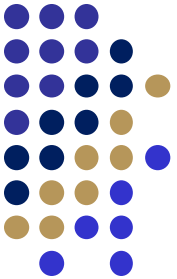
LESSONS LEARNED FROM RECENT CASES



Court Analysis:

- Hospital entered into the lease fully aware that the arrangement included a non-compete payment roughly equal to the referral business the hospital would gain from the physicians and the business the physicians would lose from abandoning its own nuclear camera.
- Because the physicians' anticipated referrals were taken into account in establishing the fixed fee, such fixed fee would vary or take into account the volume or value of referrals.
- The hospital admitted that the nuclear camera was not equipment that the hospital needed and that it had planned to upgrade to a new, more technologically advanced camera shortly after entering into the sub-lease. Further, the nuclear camera was never relocated to the hospital, but remained in the physicians' office, and was not used for nuclear imaging tests after a few months.

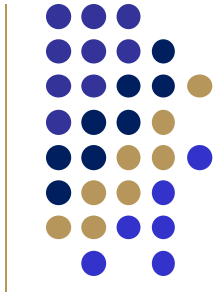
LESSONS LEARNED FROM RECENT CASES



United States of America ex rel. Michael K. Drakeford, M.D. v. Tuomey Healthcare System (decided March 2010).

- The case alleged that Tuomey's part-time employment contracts were designed to lock in patient referrals. Compensation allegedly exceeded fair-market value and, therefore, violated Stark.
- According to the lawsuit, increased competition for outpatient surgery prompted Tuomey to offer part-time employment agreements to 18 physicians. Under the 10-year part-time employment agreements, the physicians were required to perform all their outpatient procedures at Tuomey.

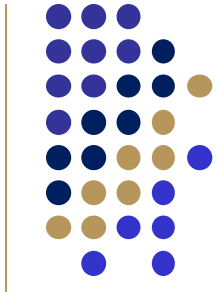
LESSONS LEARNED FROM RECENT CASES



Which Elements Concerned the Federal Government?

- Compensation: Compensation was in excess of 130% of the physicians' net collections (reasonable compensation ranges were in the 49% to 63% range) .
- Commercially Reasonable: The government also contended that even if the compensation was fair market value, compensating physicians at a level greater than collections would never be commercially reasonable.
- Exclusivity: The physicians were penalized if they did not refer to Tuomey for services.

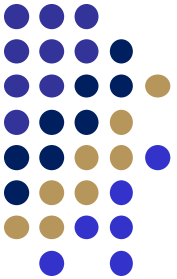
LESSONS LEARNED FROM RECENT CASES



Which Elements Concerned the Federal Government?

- Non-Compete Clauses: These provisions prevented the physicians from providing outpatient surgeries within a 30-mile radius of Tuomey during the agreement and for two years after the agreement's termination.
- Drop in Revenue: Perhaps one of the more problematic facts of the case was that the hospital's interest in the physicians arose only after the approval of the competing ASC and a financial analysis by the hospital showed an appreciable revenue drop if certain services were performed at the ASC versus at the hospital.

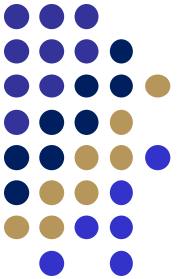
LESSONS LEARNED FROM RECENT CASES



What lessons can be learned from Tuomey?

- Employed physician arrangements are not immune from review or prosecution.
- Hospitals cannot blindly rely on valuation opinions. The government said Tuomey's reliance on the fair market value opinion was not reasonable. The valuator's own data in the opinion letters showed similar physicians were paid 49% to 63% of net collections, substantially less than the proposed compensation.
- If a proposed arrangement appears to have been developed in response to the threat or fear of losing a referral stream, the government may look closely at issues of commercial reasonableness and at a party's intent in entering into the transaction.

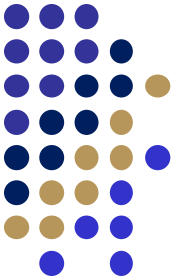
LESSONS LEARNED FROM RECENT CASES



Covenant Medical Center of Waterloo, Iowa (August 2009)

- Covenant agreed to pay the United States $4.5 million.
- The government alleged that Covenant violated the Stark Law by paying commercially unreasonable compensation, far above market value, to five employed physicians. According to the federal government, these physicians were among the highest paid hospital-employed physicians not just in Iowa, but in the entire United States. Two of the five physicians were reportedly each paid more than $2 million per year.
- The salaries were disclosed publicly in the health system's Form 990 tax filings.

LESSONS LEARNED FROM RECENT CASES



The Health Alliance of Greater Cincinnati and The Christ Hospital (May 2010)

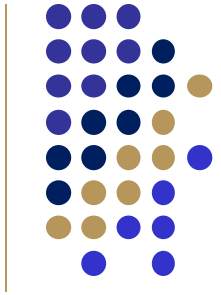
- Certain physicians were scheduled to perform hospital cardiac interpretations corresponding with physician's referrals to the hospital.
- Essentially, the federal government argued this arrangement, which provided the opportunity for the cardiologists to bill for diagnostic services and pick up new patients for follow-up appointments based upon referrals to the hospital constituted an illegal kickback scheme.
- The $108 million settlement is the largest ever under the health care Anti-Kickback Statute for the conduct of a single hospital.

LESSONS LEARNED FROM RECENT CASES

UMDNJ Case

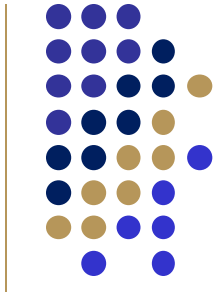
- UMDNJ entered into an $8.3 million settlement agreement with the DOJ.
- The DOJ alleged that UMDNJ focused on certain cardiologists to generate more referrals for cardiac procedures by entering into part-time employment agreements.
- While the agreements required the physicians to provide services (e.g., teaching, call coverage, lecturing, research), and the compensation ranged from $50,000 to $180,000, according to DOJ, the services were rarely, if ever, performed.
- The government alleged that UMDNJ did not expect the cardiologists to provide the services; rather, the arrangements were a mechanism to pay physicians who refer patients.
- Notably, the contracts at issue required the physicians to complete forms to document that the services were provided.

Practical Takeaways



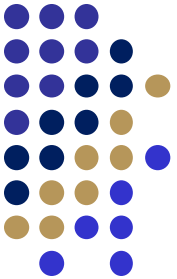
- Start with a good purpose (*e.g.*, community need, quality).
- Communicate/memorialize these good purposes.
- Be careful with part-time physician employees.
- Create a process for entering/monitoring physician compensation arrangements and ***follow it***
- Consider having board or a compensation committee approve certain physician arrangements.
- Have an outside appraiser opine on fair market value and commercially reasonableness for certain physician arrangements.
- Have executed agreements and a contract management process.

CFO Conundrum



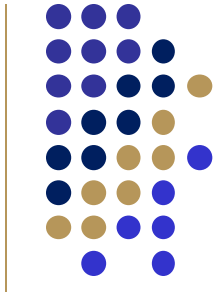
- Easy Answer – never track downstream/never perform service line pro forma for evaluation of deal
- How to balance the "Easy Answer" with the obligation to be a prudent steward of the Hospital's resources
  - For non-professional service arrangements (*e.g.*, rental, medical directors) never track referrals
  - For professional service arrangements
    - Never use downstream to evaluate compensation; determine compensation or support negotiated compensation
    - Macro vs. Micro analysis

Current Trends, Issues and Pitfalls in Compensation Arrangements



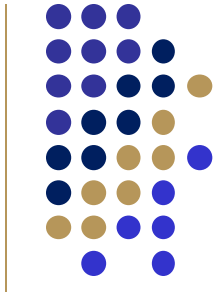
- Medical Director Agreements
- Call Coverage Agreements
- Physician Employment/Practice Acquisition
- Co-Management Agreements
- ACO's and Other FMV Implications of Healthcare Reform
- Current Controversy in Valuation Approaches

Medical Director Agreements



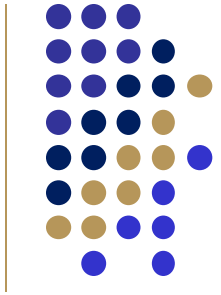
- First and foremost, is the arrangement *commercially reasonable*? Are the services needed, or is the only reason for the arrangement the fact that the physician makes referrals to the hospital?
- What is "opportunity cost," and is it a reliable indicator of FMV?
- Do physician compensation rates differ for clinical vs. administrative services? Does the government care which rates are applied to medical director agreements?

Medical Director Agreements



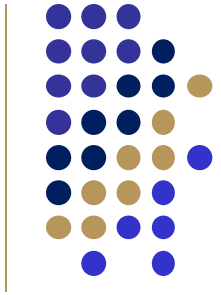
- Approaches to establishing/defending medical director rates
  - Beware of tainted data (a recurring FMV theme!)
    - How much reliance should you place on rates being paid by other area hospitals?
  - Traditional compensation surveys (*e.g.*, MGMA, Sullivan Cotter)
  - Integrated Healthcare Strategies survey
  - Comparison to comparably qualified professionals in non-healthcare settings

Medical Director Agreements



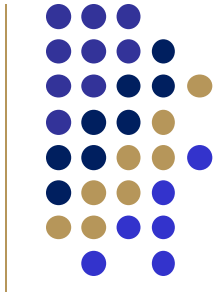
- Are time sheets (still) required?
- Should all medical directors be paid the same rate?
- Payment for quality
- Consider both the hourly rate and the number of hours per month
- Rates paid by hospitals vs. pharma/device companies for physician administrative services
  - Are the rates comparable?
  - HCA CIA vs. the device companies' deferred prosecution agreement

Call Coverage Arrangements



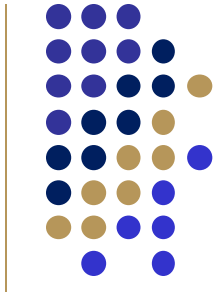
- Perhaps the most common type of physician compensation arrangement…involving lots of money paid to referring physicians!
- Again, beware of market data. If an area trauma hospital with a very high frequency of call events and a very poor payor mix pays $1,200 per day for general surgery coverage, does that establish the market rate for a hospital in an affluent neighborhood with a low frequency of call events?

Call Coverage Arrangements



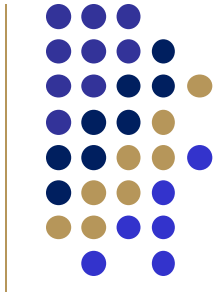
- Notwithstanding that market rates paid by other area hospitals may not be comparable to your hospital, "market data" as reported by physicians are frequently inaccurate
- So…market data is largely useless in establishing and defending call coverage compensation
- OK, now what?
- First, consider the guidance set for in OIG Advisory Opinion 07-10

Call Coverage Arrangements



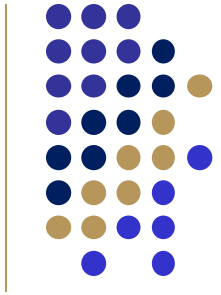
- The OIG gave several examples of "problematic compensation structures that might disguise kickback payments":
  - Payment structures based on "lost opportunity" or similarly designed payments that do not reflect *bona fide* lost income;
  - Payment structures that compensate physicians when no identifiable services are provided;
  - Aggregate on-call payments that are disproportionately high compared to the physician's regular medical practice income; or
  - Payment structures that compensate the on-call physician for professional services for which he or she receives separate reimbursement from insurers or patients, resulting in the physician essentially being paid twice for the same service.

Call Coverage Arrangements



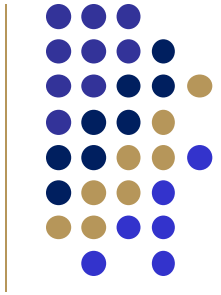
- Among the factors that the OIG found relevant to determination of the *per diem* rate are:
  - The severity of illness typically encountered by that specialty in treating a patient presenting at the ED;
  - The likelihood of having to respond when on-call at the ED;
  - The likelihood of having to respond to a request for inpatient consultative services for an uninsured patient when on-call; and,
  - The degree of inpatient care typically required of the specialty for patients that initially present at the ED.

Call Coverage Arrangements



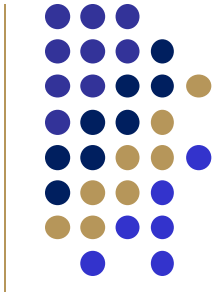
- Consider the hourly rate applicable for the physician specialty's clinical services
- Establish a percentage, or "on-call factor," that matches the *burden* of the call coverage arrangement
- Consider, but be cautious in the application of, survey data (*e.g.,* Sullivan Cotter's call coverage survey)
- Other call coverage issues –
  - Restricted vs. unrestricted call
  - Concurrent call
  - Compensation for unfunded care

Physician Employment/ Practice Acquisition



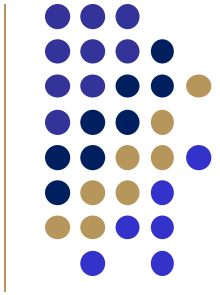
- Physician employment transactions are occurring at a feverish pace
- To establish FMV, you must first consider the proposed terms of the arrangement
- Employment agreements can have many, many different features…and all must be considered when establishing FMV

Physician Employment/ Practice Acquisition



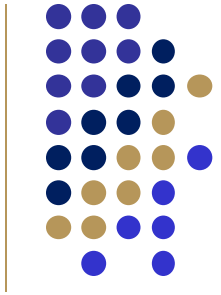
- Problematic areas –
  - The uses and misuses of survey (*e.g.,* MGMA) data
  - "In market" physicians
  - Keeping physicians whole - What happens when existing ancillary services are transitioned to facility-based services?
  - Compensation "stacking"
  - Compensation at the 90th percentile as compared to 90th percentile *compensation per wRVU*. Are they the same?
  - Establishing wRVUs
  - Employment agreements coupled with a practice acquisition

Physician Employment/ Practice Acquisition



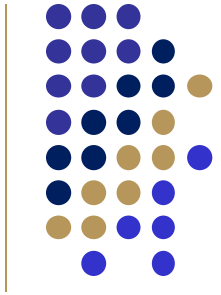
- The uses and misuses of survey (*e.g.,* MGMA) data
  - Confucius Statistician say…If you torture the data long enough, it will confess to the crime it did not commit.
  - Survey data can be misused in a variety of ways, including:
    - Cherry picking from among different tables (*e.g.,* national data vs. regional data; Compensation Report vs. the Cost Survey)
    - Cherry picking from among different surveys (*e.g.*, MGMA, Sullivan Cotter, AMGA)

Physician Employment/ Practice Acquisition



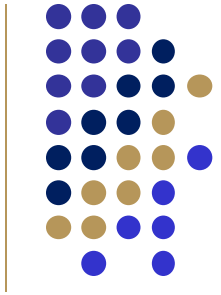
- "In market" physicians
  - Is it consistent with FMV to pay a physician to stay in the same market, but at a higher rate?
  - Consideration of payor mix, practice operating expenses and other operational issues
  - What about recruiting an "out of area" physician into the market?

Physician Employment/ Practice Acquisition



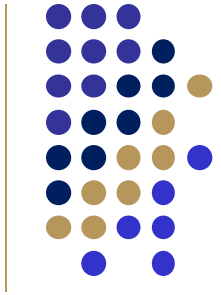
- Keeping physicians whole
  - Example 1 – Cardiologists with echo, EKG, stress testing
  - Example 2 – Medical oncologists with infusion services
  - Example 3 – Orthopedists with MRI

Physician Employment/ Practice Acquisition



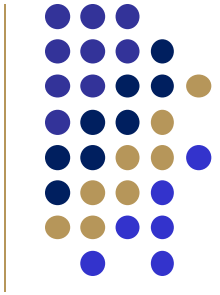
- A particular dilemma –
  - If a medical oncologist is employed by a hospital, the hospital likely will:
    - Bill for infusion services at a higher rate
    - Potentially benefit from 340b pricing (typically a savings of 30-35%)
  - Can these savings be shared with the physician?
  - Strategic /investment value vs. FMV

Physician Employment/ Practice Acquisition



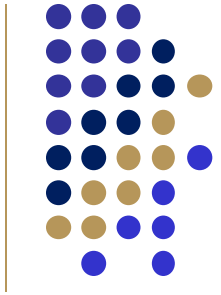
- Compensation “stacking”
  - A new industry watchword
  - If you call elements of compensation by enough different names, you can stack it taller and taller
  - All sources of compensation (including benefits) should be aggregated in considering compliance with FMV

Physician Employment/ Practice Acquisition



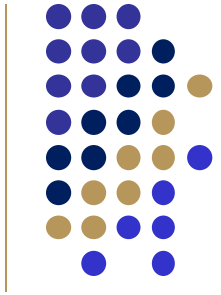
- Compensation at the 90th percentile as compared to 90th *percentile compensation per wRVU*. Are they the same?
  - No. If you are going to use MGMA data related to "compensation per wRVU," you really must understand what MGMA says about its own data and how it should be interpreted and applied.
  - As one example (from MGMA data), for orthopedic surgery:
    - 90th percentile cash compensation = $876,000
    - 90th percentile wRVUs = 13,977
    - 90th percentile compensation per wRVU = $103.71
    - Therefore, 13,977 x $103.71 = $1,450,000!!

Physician Employment/ Practice Acquisition



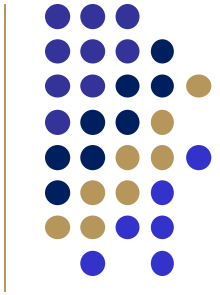
- Establishing wRVUs
  - Many hospitals have no Part B billing expertise prior to employing physicians under wRVU compensation models
  - wRVUs vs. total RVUs (A fairly simple mistake with big consequences)
  - Modifiers
    - Assistant at surgery, multiple procedures, bilateral procedure, etc.
    - We recommend following MGMA's guidance re: wRVUs to establish data comparable to their survey data
  - GPCI's/technical codes

Physician Employment/ Practice Acquisition



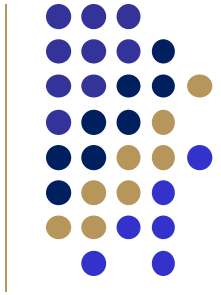
- Valuing physician practices –
  - What is goodwill? Does a particular practice have any? Can you pay for it?
  - Most physician acquisitions are based upon *tangible* asset value
  - What if physicians will be paid at higher rates subsequent to the acquisition of their practice?
  - Valuing medical records

Co-Management Agreements



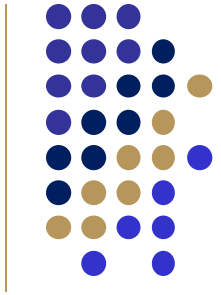
- The purpose of a co-management arrangement is to recognize and appropriately reward participating medical groups/physicians for their efforts in developing, managing and improving quality and efficiency of a particular hospital service line.
- Beware of wolves in sheep's clothing. A wide array of compensation arrangements are currently being termed "co-management agreements."

Co-Management Agreements



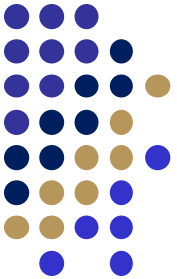
- There are typically two levels of payment to physicians under the service line management contract:
  - Base fee – a fixed annual base fee that is consistent with the FMV of the time and efforts participating physicians dedicate to the service line development, management and oversight process
  - Incentive fee – an incentive payment (up to a maximum amount) payable upon the achievement of pre-established incentive metrics

Co-Management Agreements



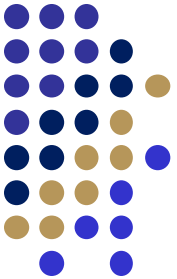
- FMV considerations –
  - Establishing the management fee is somewhat more subjective than with other compensation arrangements
  - Defining the "service line" to be managed
  - Applicable valuation approaches
  - Integration with existing medical directorships
  - Use of 3rd party managers
  - Selecting/monitoring the incentive metrics
  - Hindsight analysis

ACO's and Other FMV Implications of Healthcare Reform



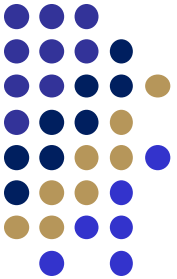
- What is an ACO?
- Is an ACO a new legal entity, or can one be created by a contractual arrangement?
- How does a hospital/physician ACO work? Are the "physicians" represented by a single, or multiple, specialties? What if an ACO lacks one or more required service providers?

ACO's and Other FMV Implications of Healthcare Reform



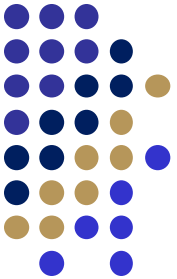
- There is still much uncertainty related to the development and operations of ACOs
  - How prevalent will ACOs become, and what organizational structures will they take?
  - To what extent will the Federal government provide guidance and/or relief from Stark/AKS constraints?
  - Even in the absence of Federal constraints, the operational need will exist to equitably distribute profits (or losses).
  - What is the magnitude of possible additional income that can be achieved through an ACO?
  - Can physicians participate in multiple ACOs?

ACO's and Other FMV Implications of Healthcare Reform



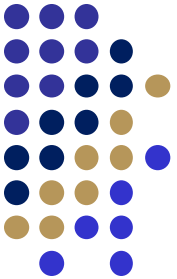
- What are the incentive criteria, and how are they tracked/monitored?

ACO's and Other FMV Implications of Healthcare Reform



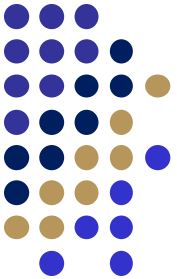
- Likely FMV issues:
  - For the ACO members, an increasing portion of income is expected to come from non-productivity sources. How should such income be divided among the members?
    - Certain members may be greater contributors than other members.
    - Certain members may bear a disproportionate share of administrative costs and efforts
    - Profits (or losses) may arise from managing capitated lives or bundled payments

ACO's and Other FMV Implications of Healthcare Reform



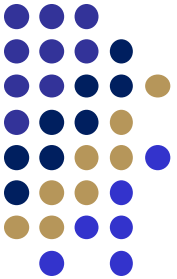
- If certain specialties are not utilized (or are underutilized), how do they share in ACO savings?

ACO's and Other FMV Implications of Healthcare Reform



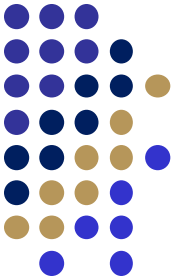
- Possible sources of additional income:
  - Quality/incentive payments from government
  - Quality/incentive payments from commercial payors
  - Cost efficiencies in connection with bundled payments
  - Profits (or losses) from managing capitated lives

ACO's and Other FMV Implications of Healthcare Reform



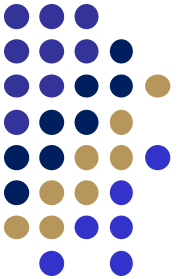
- FMV Guideposts
  - Compensation should shift from "guaranteed compensation" to incentive compensation
  - Consideration must be given to investments made by ACO members (whether in capital or other resources (*e.g.,* management, IT, etc.)
  - How are "savings" (or incremental revenues) identified?
  - How will an ACO determine who was primarily responsible for the cost savings?
  - How will disputes be resolved?

ACO's and Other FMV Implications of Healthcare Reform



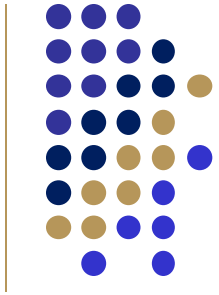
- Traditional measures of physician compensation (*e.g.*, per wRVU, % of collections, etc.) are no longer applicable under ACOs
- How can physicians' overall compensation be assessed if profits are coming from ACO savings (*e.g.*, above 90th percentile compensation)

Current Controversy in Valuation Approaches



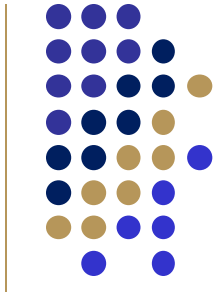
- Does “median compensation per wRVU” establish a “safe harbor” for physician compensation arrangements?
- Can value exist in a physician practice if not supported by a DCF analysis?
- If so, is such value subject to offset for increased future compensation to the physicians?

Goals of Contracting Review Process



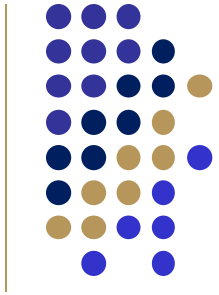
- Ensure that Hospital complies with federal law (Stark, Anti-Kickback, and IRS) in all arrangements with a referring Physician.
- Create uniform standards to strengthen, expand and centralize compliance.
- Provide a tool to support a culture of compliance.

Contracting Process



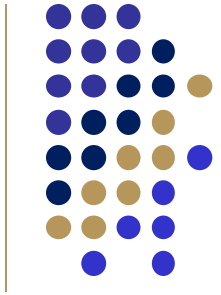
- **Step 1** – Contract Initiation – define who may initiate a physician contract
- **Step 2** – Review and approval of basic terms by Legal Counsel and Finance.
- **Step 3** - The written agreement and supporting documentation are prepared, including:
  - Standard agreement or other approved format
  - Legal involvement (who drafts/who can modify)
  - Documentation of FMV compensation
- **Step 4** – Consistent with policy, submit to the appropriate level of review and approval (e.g., CEO, Board or compensation committee)
- **Step 5** - Execute the agreement and add to contract management system.

Contract Request Form



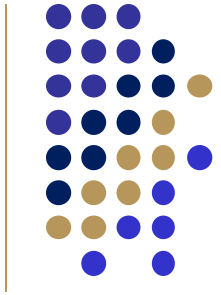
- Identify Key Contract Components
- Documentation of FMV
- Documentation of Legitimate Business Purpose/Business Rational
- Necessary Reviews/Sign Offs
  - Business Lead
  - Finance
  - Legal/Compliance
- Pre-Approved Compensation Models
  - Base/Productivity
  - Recruitment Support
  - Non-Productivity Incentives

Approval Requirements



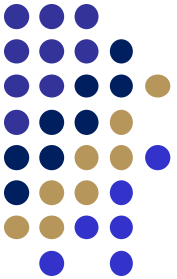
- Pre-Approved Compensation Model
- Compensation within Approved Survey Range
  - Annual Real Estate Survey
  - National Compensation Surveys
  - Personalized Surveys
- Board/Board Committee Review
  - Compensation in excess of 75th/90th percentile
  - Compensation varying from approved compensation model
  - Multiple arrangements with single physician/physician group

Approval Requirements



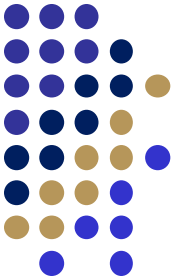
- Documentation for Board Review
  - Third party valuation opinion
  - National Surveys
- Other Factors For Consideration
  - Experience/National Prominence
  - Patient Satisfaction
  - Quality Performance
  - Alignment of productivity and compensation
  - Managed Care

Living with the FMV Requirement in the Real World



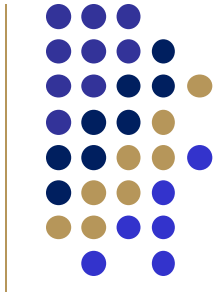
- Fundamental Tenets of FMV –
  - First, the arrangement must be commercially reasonable.
  - The definition of FMV is a specifically defined term. The lay person's assumption of the term FMV is often inaccurate. For example:
    - Rigorous, arm's-length negotiation may or may not result in a FMV outcome
    - Certain market data is simply not reliable (particularly in a healthcare setting)
    - Strategic value can never be credited to a seller (or an employee or an independent contractor)

Living with the FMV Requirement in the Real World



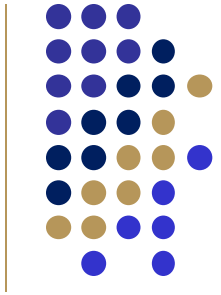
- Physicians' expectations are oftentimes difficult to counter.
- Consultants can establish expectations that may or may not be realistic (*i.e.,* not commercially reasonable and/or not FMV)
- An independent appraiser should not be inherently conservative. Discussion can take place regarding the perceived riskiness of any arrangement.

Case Study
Background Facts



- ABC Hospital desires to solidify its cardiology service line.
- It has identified an opportunity to acquire Big Hearts, PC, a local 20-person cardiology practice, and employ each of its physicians.
- In discussion with Big Hearts, ABC realizes that the practice is in discussions with a competing hospital. It would be devastating to ABC's cardiology program if the Big Hearts physicians became employees of their competitor.
- ABC engaged Hearts "R" Us, a cardiology consulting firm, to assist it in its endeavors to acquire Big Hearts.

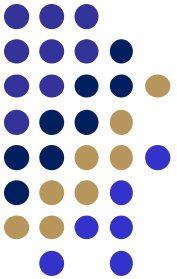
Case Study
Proposed Transaction Terms



Hearts "R" Us has provided the following guidance in order to facilitate the transaction:

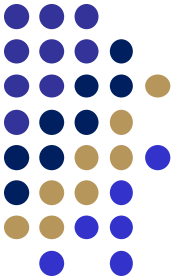
- Hearts "R" Us has determined that ABC will have a positive impact to its annual operating income of $22 million in the event it acquires Big Hearts. If its competitor acquires Big Hearts, ABC is expected to lose $10.5 million of operating income attributable to Big Hearts referrals.
- Based upon market transactions, Big Hearts, PC is worth 4x its last year's revenue. They are confident that their appraiser will support this value in their FMV opinion.
- Big Hearts' medical records are worth $25 per active chart.

Case Study
Proposed Transaction Terms (cont.)



- Each of the Big Hearts physicians will agree to enter into a non-compete agreement in exchange for $150,000 per physician.
- Post transaction, the physicians will be paid based upon the 75th percentile *compensation per wRVU* as indicated by MGMA. Historically, the physicians have achieved compensation equivalent to the MGMA 75th percentile.
- The physicians will receive a "sign on" bonus of $60,000 each.
- In the event that ABC is able to achieve increased net collections through ABC's managed care contracts, it will pay the physicians 10% of such increases.

Case Study
Proposed Transaction Terms (cont.)



- Twelve of the 20 physicians will be designated as medical directors, and will be paid at the 75th percentile compensation rate (per MGMA).
- A cardiology co-management agreement will be implemented that will allow the Big Hearts physicians to earn additional compensation for the management and achievement of incentive metrics related to the cardiology service line.
- Heart "R" Us will be engaged to assist in efforts to manage the service line.

Current Issues in Establishing and Defending FMV Compensation

HCCA 15th Annual Compliance Institute

Presented by:

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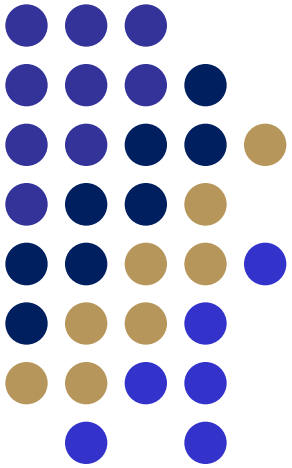
Managing Partner, HealthCare Appraisers

Arthur F. deVaux, Esq.
Attorney, Hall Render Killian Heath & Lyman, P.C.



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