

Establishing FMV in Physician-Hospital Affiliations

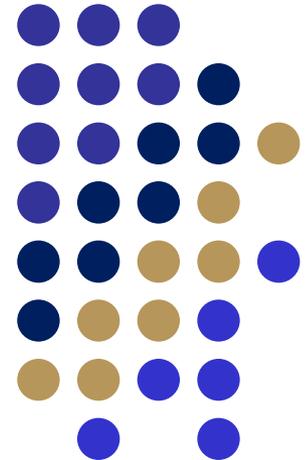
Presented By

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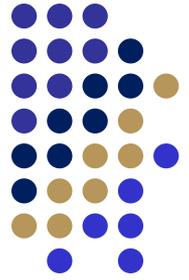
Managing Partner - HealthCare Appraisers, Inc.

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**Business Models for Successful Physician Collaboration:
*Moving from Transactional to Integrated Physician Relationships***

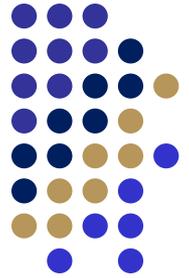


Service Line Co-Management Arrangements



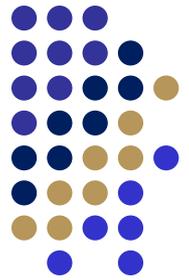
The purpose of the arrangement is to recognize and appropriately reward participating medical groups / physicians for their efforts in developing, managing, and improving quality and efficiency of a hospital's identified service line.

Service Line Co-Management Arrangements



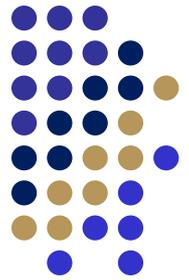
- Subject service lines –
 - Cardiology
 - Orthopedics
 - Surgery
 - GI
 - Wound care
 - OB-GYN
 - Sleep clinic
 - Burn
 - Hematology/Oncology

Co-Management Arrangements - Structural Considerations



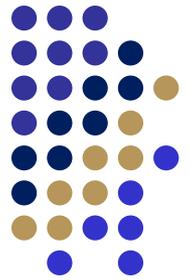
- In certain instances, the “service provider” may be a new entity (“NewCo”) consisting of multiple physicians and/or physician practices. The hospital may or may not have an ownership interest in NewCo.
- In other cases, the “service provider” may be a single physician practice. (In other words, the co-management arrangement is a contractual agreement existing between the hospital and an existing entity.)

Co-Management Arrangements - Structural Considerations



- The management services may be provided jointly by the hospital and participating physicians (*i.e.*, a co-management agreement), in which case the management fee is divided between the parties.
- The management services may be provided exclusively by participating physicians (obviously, in coordination with hospital management), in which case the management fee is paid solely to the physicians.

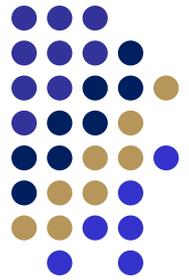
Co-Management Arrangements – Fee Structure



There are typically two levels of payment to physicians under the service line contract:

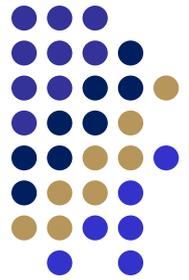
- Base fee – a fixed annual base fee that is consistent with the FMV of the time and efforts that the manager dedicates to the service line development, management, and oversight process
- Incentive fee – a series of pre-determined payment amounts contingent on achievement of specified, mutually agreed, objectively measurable, program development, quality improvement and efficiency goals

Co-Management Arrangements - FMV Considerations



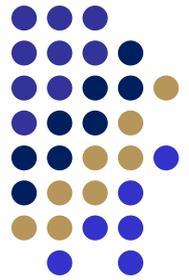
- Compliance with FMV is critical for regulatory adherence, but also for the ultimate success of the project.
- FMV compensation payable under a co-management arrangement is particularly subjective.
- As with other *management agreements*, the physician managers are not compensated based upon hours worked; compensation is based upon a specific set of management duties and desired performance metrics.

Co-Management Arrangements - FMV Considerations



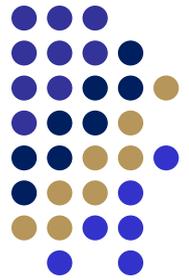
- The physicians are expected to provide those specific duties outlined in the co-management agreement.
 - Skeptics may say that there is a risk of overcompensating physicians' contributions to co-management arrangements.
- One means of envisioning/valuing a co-management fee is by comparison to other management arrangements (*e.g.*, ASC management or practice management).
 - Such management entities are expected to devote required time and resources to their management obligation, and there is little opportunity for the manager to “hide.”
- Specifically identified medical directors can still exist (and be compensated), but the medical director roles must be integrated with the overall financial analysis of the program.

Co-Management Arrangements - Establishing FMV



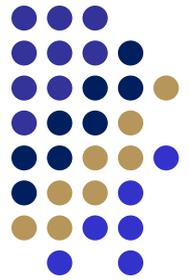
- Available valuation methodologies are limited and somewhat subjective.
- In considering the primary valuation approaches (cost, income and market), an income approach can likely be eliminated.
- Using a cost approach, FMV of the management fee can be established by assessing the estimated number of work hours needed to provide the management services multiplied by a FMV hourly rate.
 - However, the exact number of required work hours cannot reasonably be determined in advance.
- Further, a key ideal of most co-management arrangements is to reward *results* rather than time-based efforts.

Co-Management Arrangements - FMV Considerations



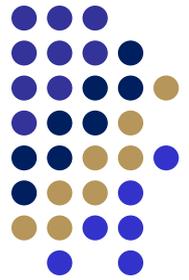
- A market approach recognizes that each co-management arrangement is unique, and considers specific market and operational factors related to the subject arrangement.
 - Break the services down into specific tasks and objectives, and then compare to other arrangements.
 - On an item-by-item basis, assess the relative worth of each task/objective, and determine necessary adjustments to the comparable arrangements.
- The cost and market valuation methodologies described above must be reconciled to arrive at a final conclusion of value. Consistency in approach aids in supporting the FMV of subjective compensation arrangements.
- The FMV of the *total management fee* must be established, as well as the *base* and *incentive* components.

Co-Management Arrangements - Valuation Expectations



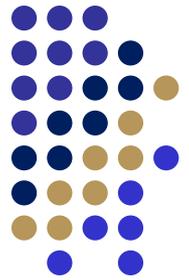
- The total management fee typically ranges from 3-6% of service line revenues. “So which one is it? 6% sounds better than 3%!”
- Key determinates of the FMV compensation:
 - Size (*e.g.*, net revenue) of the service line being managed
 - Complexity of the service line being managed
 - Extent and scope of services being provided
 - Service line maturity and growth opportunities
 - Unique attributes/considerations
 - Valuator’s judgment and experience

Co-Management Arrangements - Other FMV Considerations



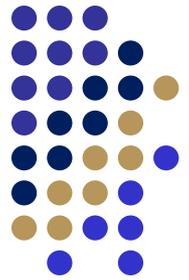
- Integration with other agreements:
 - Clinical staffing agreements
 - Call/coverage agreements
 - Medical directorship agreements
 - Department/division chair agreements
 - Physician lease/lease-back agreements
- Allocation of value among participating physicians/medical groups
- Engagement of valuator by counsel to obtain benefit of attorney-client privilege?

Co-Management Arrangements - FMV Pitfalls/Issues



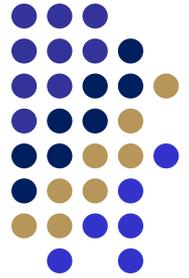
- No independent FMV analysis was obtained.
- The government fails to find the FMV analysis compelling.
- A retrospective review of facts and circumstances may cast the arrangement in a poor light (*e.g.*, if there is no record of active physician involvement, notwithstanding the fact that hours are not tracked).
- The government highlights a “bad apple” arrangement which casts a pall over all such arrangements.

Physician Practice Acquisitions Overview



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

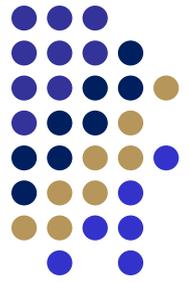
Practice Acquisitions



- Two primary approaches:
 - Practice purchase price equals tangible asset value, and future compensation to the physicians is unencumbered by the purchase transaction.
 - Practice purchase price includes value for specifically identified intangible assets (*e.g.*, workforce in place, trade name), but future compensation to the physicians must be consistent with past practices, or the purchase price must be reduced.

Physician Practice Acquisitions

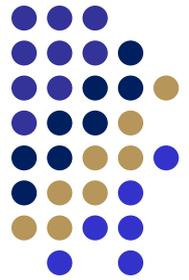
Divergent Valuator Opinions



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

Physician Practice Acquisitions

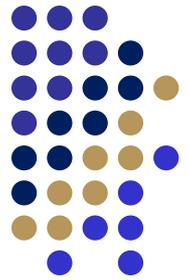
Divergent Valuator Opinions (cont.)



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

Physician Practice Acquisitions

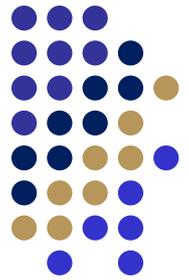
Divergent Valuator Opinions (cont.)



- What if the DCF shows no value? Will physicians sell their practices for the value of tangible assets?
- Does the valuation/payment for intangibles cause higher regulatory concern?
- In cases where purchase price includes intangible value, the purchase price and post-acquisition compensation are inextricably linked. The valuation community seems to be in agreement in this regard.

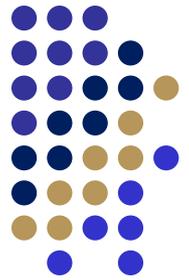
Physician Practice Acquisitions

Pre-Planning the Valuation Focus



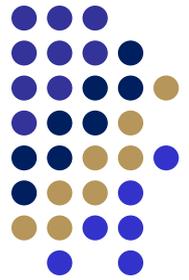
- If a practice acquisition consists only of tangible assets, most valuers tend to agree that post-acquisition compensation is unencumbered by the purchase transaction.
- If the goal is to maximize future compensation, there may be no benefit in conducting a business valuation (*i.e.*, a DCF or valuation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

“Synthetic” Employment Agreements (or Professional Service Agreement models)



- Instead of employment, new arrangements are gaining traction whereby physicians retain their own practice, and are compensated on a productivity basis (*e.g.*, per wRVU) for their clinical services.
- A transaction may involve the purchase of the physicians’ tangible assets and payment for workforce in place (or an employee leasing arrangement may be utilized).
- The wRVU rate payable to the physician group is a “gross” rate that includes remuneration for:
 - cash compensation;
 - taxes and benefits; and
 - “retained” practice expenses (*e.g.*, malpractice insurance, CPE costs, etc.).
- The FMV analysis should consider pre- and post-transaction compensation to the physicians.

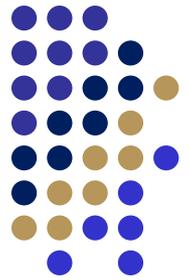
Physician Practice Acquisitions Consultants' Advice



- “Physician practices are worth a multiple of revenues.”
- “There is no valuation relationship between purchase price and post-acquisition compensation.”
- “The selected valuation firm is too conservative. Other firms yield much higher values.”

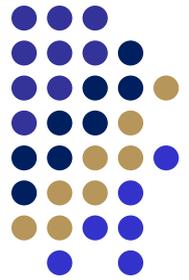
Employment Agreements

Overview



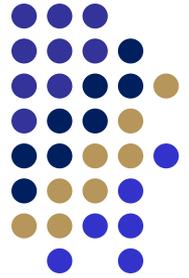
- Employment activity has seen a significant uptick in the past 12 months.
- Productivity-based models are in vogue; *median compensation per wRVU* is a widely viewed metric.
- Employment agreements have many moving parts... the “terms and features” are critically important.
- Can in-market physicians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

FMV Considerations in Employment and PSA Arrangements



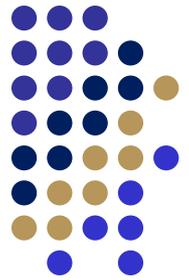
- Compensation “stacking”
 - Medical director fees
 - Management fees
 - Administrative fees
 - Quality bonuses
 - Sign-on bonuses
 - Retention bonuses
 - Tail coverage, etc.
- Consider that the data reported by the compensation surveys generally includes all sources of income.

Physician Compensation Data



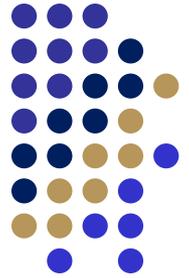
- Sources of compensation survey data:
 - Medical Group Management Association (MGMA)
 - Sullivan Cotter & Associates
 - Hospital & Healthcare Compensation Service
 - American Medical Group Assn (AMGA)
 - Towers Watson Data Services (fka Watson Wyatt)

FMV Considerations in Employment/PSA Arrangements



- Confucius Statisticians say...If you torture the data long enough, it will confess to the crime it did not commit.
- For certain specialties, available market data appears somewhat schizophrenic.
 - Are survey respondents reporting data in a consistent manner (*e.g.*, total collections vs. professional collections)?
- MGMA data can be misused in a variety of ways, including:
 - Cherry picking from among different tables (*e.g.*, regional data vs. state data)
 - 90th percentile compensation times 90th percentile wRVU productivity
- Failure to consider ownership/ancillary profits that may be inherent in 90th percentile compensation

MGMA Data Anomalies



For Hematology/Oncology:

- 90th percentile cash compensation - \$784,000
- 90th percentile wRVUs – 7,905
- 90th percentile compensation per wRVU - \$127

Where is this going?

- 90th percentile wRVUs x 90th percentile compensation per wRVU = \$1,004,000
- MGMA states that there is an *inverse* relationship between physician compensation and compensation per wRVU.
- *Median compensation and median compensation per wRVU* are two entirely different things.

Questions?

