Establishing FMV in Physician-Hospital Affiliations

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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.
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 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?