

# Valuing Physician Practices in Uncertain Times

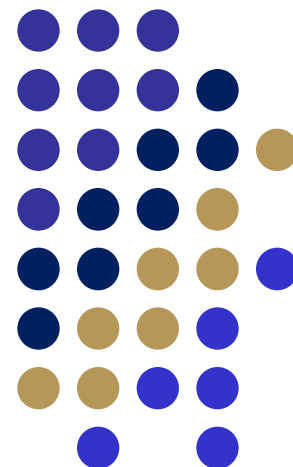
***SATRO® 13<sup>th</sup> Annual Conference***

Presented by:

Jim D. Carr, AM, MBA | Partner

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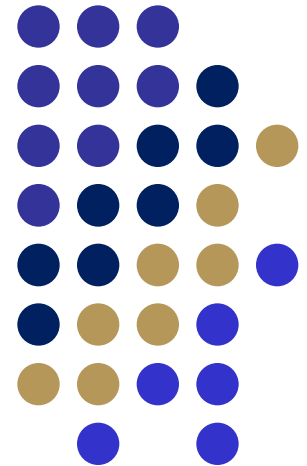
  
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*Current Transaction Trends  
Related to Physician Practices*



# Trends in Physician Practice Acquisitions



- A very significant number of practice acquisition transactions are taking place.
  - Primarily, buyers are hospitals/health systems
- In particular, cardiology and medical oncology practices are active targets.
- Targets range from solo practices to 100+ provider multispecialty groups.
- Most of recent deal flow is for specialist practices (*i.e.*, as opposed to primary care).



# Transaction Drivers

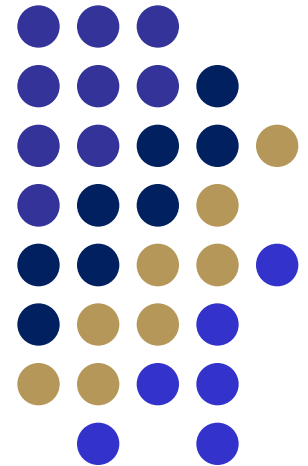


- Health Systems – Strategic Opportunities
  - Growing willingness by physicians to sell – lock up key players
  - New strategies for physician alignment – *e.g.*, co-management
  - Building “critical mass” for ACOs
- Docs - Continuing Cuts in Reimbursement
  - Professional services - cardiology
  - Office-based ancillaries – radiation therapy, chemo, cardiac imaging, cath lab
  - Utilization assumptions- CT/MRI
  - Final phase of ASC fee schedule reduction
  - ESRD bundling – dialysis centers and clinical labs

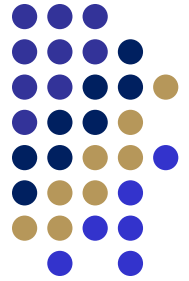
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*Business Valuation Basics*

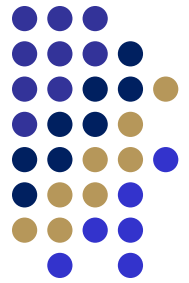


# FMV 101: Healthcare Arrangements & Transactions



- Generally, any transaction between potential referral sources must be:
  - consistent with FMV; and
  - commercially reasonable.
- A transaction can be “FMV,” but not commercially reasonable, and vice versa.
- Healthcare regulations impose specific guidance that directly impacts FMV analysis:
  - Avoid tainted market values
  - Avoid improper valuation methodologies

# Valuation Approaches

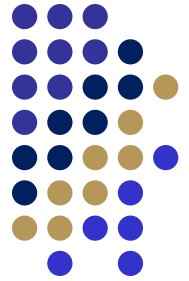


(Don't worry...we are only briefly touching on this topic!)

- 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, etc.).
- An Income approach discounts (or capitalizes) expected future cash flows to the buyer.



# Standards of Value



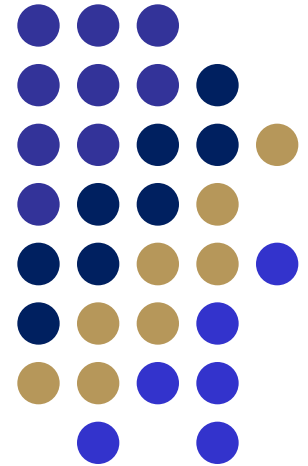
- Healthcare regulations stipulate ***fair market value*** as the applicable standard of value.
- The definition of **fair market value** (*i.e.*, the concept of a hypothetical willing buyer/willing seller) is counter-intuitive to the lay person.
- **Strategic value (or investment value)** is often confused with FMV.



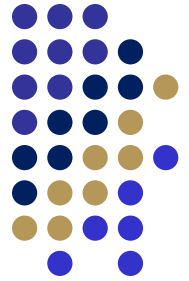
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## *Application of BV Principles to Physician Practices*



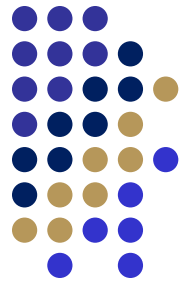
# Major Themes



- To establish FMV, you must understand and incorporate the proposed terms of the deal.
- Appraisers are polarized with respect to the appropriateness of certain valuation approaches.
- Relationship between purchase price and post-acquisition compensation.
- Some “deal” consultants can establish unreasonable expectations.

# Understanding the Deal

## Forms of Practice Acquisition



- Two primary strategies
  - Pay for tangible assets
    - Future compensation to the physicians is unencumbered by the purchase transaction.
  - Pay for specifically identified intangible assets (*e.g.*, workforce in place, trade name)
    - Future compensation to the physicians must be consistent with past income, or the purchase price must be reduced.
- Two primary structures
  - Asset purchase (95+% of practice transactions)
  - Stock purchase

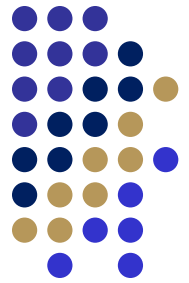
# Understanding the Deal

## Is a Business Appraisal Needed?



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

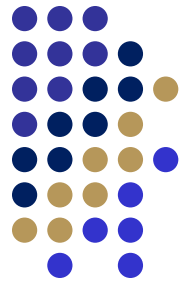
# Divergent Opinions in the Appraisal Community



- 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.
    - Concept of a willing buyer and a willing seller

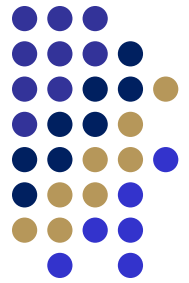


# Divergent Opinions in the Appraisal Community



- What if the DCF shows no value?
- Does the inclusion of value/payment for intangibles cause higher regulatory concern?
- If the purchase price exceeds expected cash flow, that means the practice will likely show little or no return on investment?
- Is it reasonable for hospitals to incur losses on their employed physicians?
- At a minimum, compensation models that preclude possible profitability should be avoided.

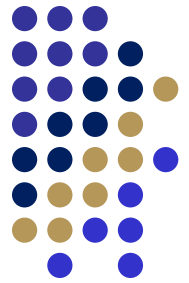
# Post-Acquisition Compensation



- In cases where purchase price includes a value beyond tangible assets, the purchase price and post-acquisition compensation are inextricably linked.
- The valuation community seems to be in agreement in this regard.
  - Much to the dismay of some consultants!



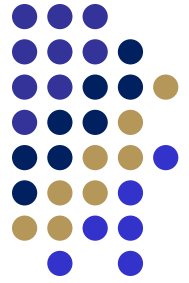
# Post-Acquisition Compensation



- Determining the “compensation offset”
  - Increased compensation is a form of purchase price consideration.
  - In a DCF, the cash flow can be adjusted to reflect the higher compensation – or – a direct purchase price offset can be computed.
  - If the practice value is based upon a Cost approach, the compensation offset is trickier (*e.g.*, Do you tax affect? Do you discount to PV?).
- On another note - Large purchase prices driven by physician pay *reductions* are seeing a revival.

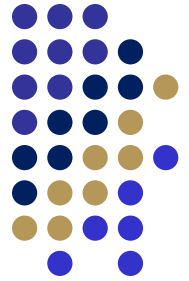


# Unrealistic Expectations



- “Physician practices can be valued using a multiple of revenue.”
- “There should be no relationship between a FMV purchase price and post-acquisition compensation.”
- “The selected valuation firm is too conservative. Other firms yield much higher values.”
- “If we break this deal up into five separate transactions, we can get you much higher value for your practice.”

# Other Issues



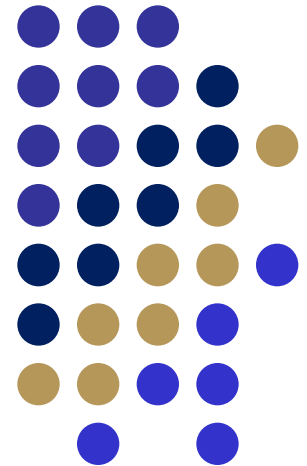
- Valuing in-office ancillaries that depend upon the future referrals of the selling physicians?
- Services that will be discontinued (*e.g.*, duplicative services or CON assets)
- Differentiating “equity value” and “transaction price”



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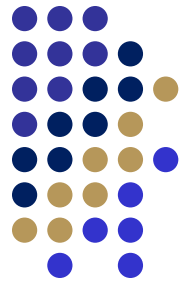
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## *Post-Transaction Employment Considerations*



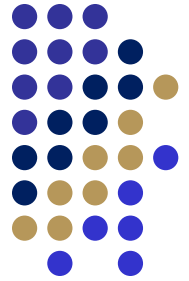
# Employment Agreements

## Overview



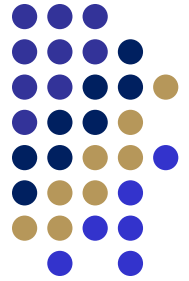
- Employment activity has seen a significant uptick in the past 12 months.
- Productivity-based models are in vogue; *median compensation per wRVU* is a very common metric.
- Employment agreements have many moving parts - the “terms and features” are critically important.
- Can in-market physicians be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

# Valuation Approaches



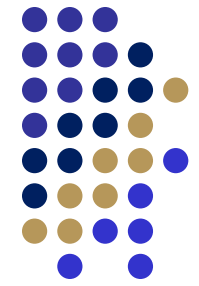
- Approaches to valuing employment compensation include Market, Cost and Income, just like for the practice acquisition.
- Market Approach
  - Benchmark production (*i.e.*, wRVUs, collections) against compensation surveys.
- Cost Approach
  - Determine historical income available to fund compensation after normalizing expenses and removing owner's return on assets and working capital.
- Income Approach
  - Estimate future income available to fund compensation after normalizing expenses and removing owner's return on assets and working capital.

# Physician Compensation Data

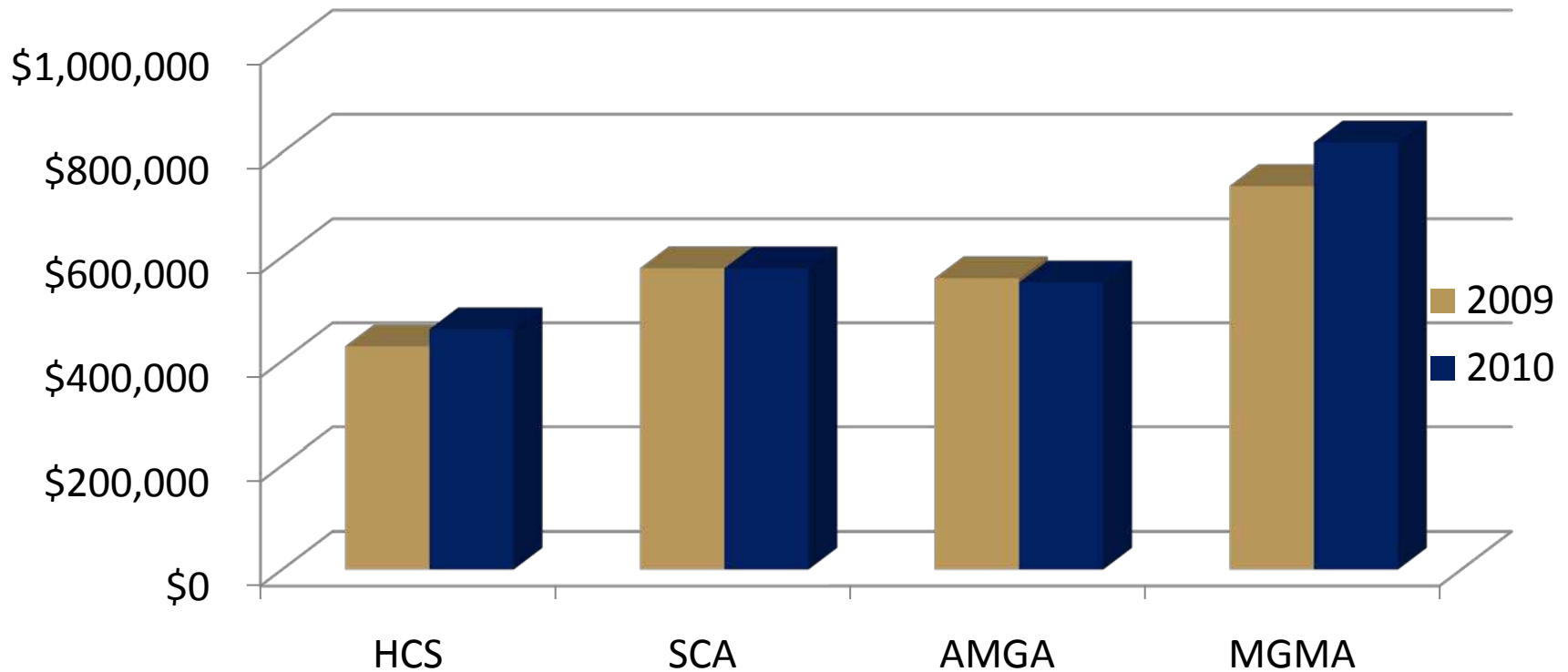


- Sources of compensation survey data:
  - Medical Group Management Association (MGMA)
  - Sullivan Cotter & Associates
  - Hospital & Healthcare Compensation Service
  - American Medical Group Assn (AMGA)
  - Towers Watson Data Services (fka Watson Wyatt)

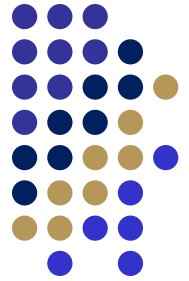
# Salary Survey Data Radiation Oncology – 2009/2010



## 90<sup>th</sup> Percentile



# Using Survey Data

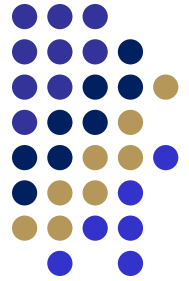


- Confucius Statistician say...If you torture the data long enough, it will confess to the crime it did not commit.
- Survey data can be misused in a variety of ways, including:
  - Cherry picking from among different tables (*e.g.*, national data vs. regional data; Compensation Survey vs. Cost Survey)
  - Failure to consider ownership/ancillary profits that may be inherent in 90<sup>th</sup> percentile compensation
  - Cherry picking from among different surveys (*e.g.*, MGMA, Sullivan Cotter, AMGA)
  - Do regional compensation differences exist?  
The grass is always greener...



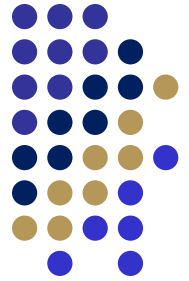


# Survey Data Anomalies



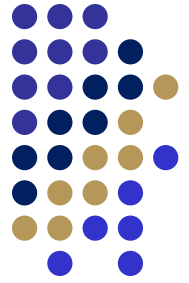
- Compensation at the 90<sup>th</sup> percentile as compared to 90<sup>th</sup> *percentile compensation per wRVU*. Are they the same?
  - No. If you are going to use survey data related to “compensation per wRVU,” you really must understand what the surveys say about their own data and how it should be interpreted and applied.
- For Radiation Oncology:
  - Doc performs MGMA 90th percentile wRVUs (13,330 wRVUs per year)
  - Seems reasonable to use MGMA 90th percentile compensation per wRVU, right? (\$98/wRVU)
- Where is this going?
  - 90th percentile wRVUs x 90th percentile compensation per wRVU = \$1,306,000
  - MGMA 90th percentile cash compensation - \$819,000
    - Divided by 13,330 wRVUs gives \$61, approximately the median value
  - MGMA states that there is an inverse relationship between physician compensation and compensation per wRVU.
    - Generally, the higher the wRVUs, the lower the median value of comp/wRVU

# Calculating RVUs



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

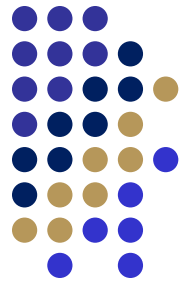
# Compensation “Stacking”



- A new industry watchword
- If you label compensation layers by different names, you can stack them higher and higher!
- All sources of compensation (including benefits) should be aggregated in considering compliance with FMV.

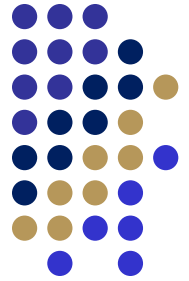


# “Synthetic” Employment Agreements (or Professional Service Agreement models)



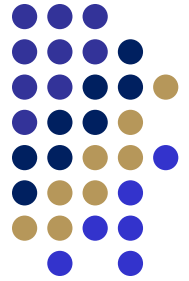
- Instead of employment, new arrangements are gaining traction whereby physicians retain their own practice, and are compensated on a productivity basis (*e.g.*, per wRVU) for their clinical services.
- A transaction may involve the purchase of the physicians’ tangible assets and payment for workforce 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.

# Other FMV Issues



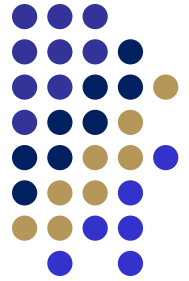
- Can physicians be “made whole” for ancillary profits if the ancillaries will be stripped from the practice and billed as a hospital service?
  - Defining “normal” ancillaries
    - Medical Oncology – Chemotherapy infusion
    - OB/GYN – Ultrasound tests?
    - Cardiology – Stress tests, Echo?
    - Orthopedic surgery – MRI?
- Part-time arrangements (*e.g.*, for procedures only)
- Perils of overly complicated compensation structures
- Valuing clinical vs. administrative duties

# Other FMV Issues



- “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?

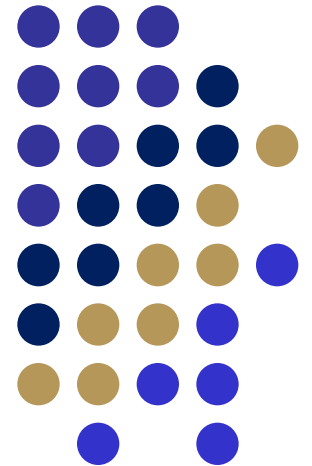
# Other FMV Issues



- 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

# Questions?

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