Addressing Fair Market Value in Hospital and Physician integration

Health Care Compliance Association (HCCA) Webinar

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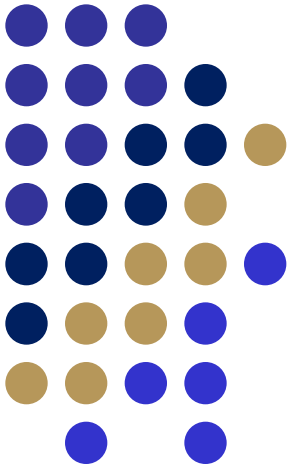
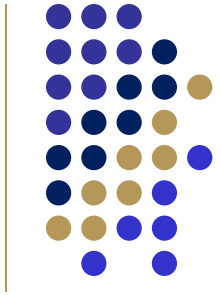


Presentation Outline



- FMV & Commercial Reasonableness
  - Regulatory Definitions
  - Practical Interpretation
- Valuation Standards
- FMV Approaches & Pitfalls w/Common Alignment Structures
  - Call Coverage
  - Employment
  - Co-Management
  - PSA/Foundation Model
- Questions

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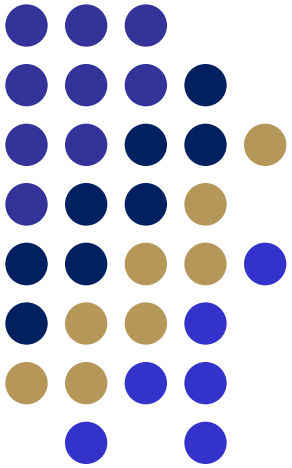
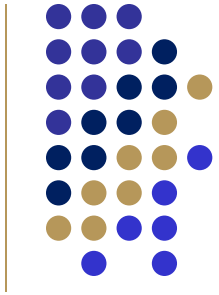
FMV and Commercial Reasonableness



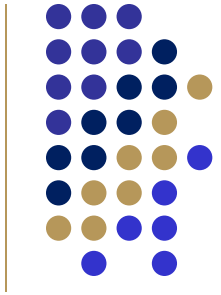
So, how is FMV Defined?



Stark Law Guidance

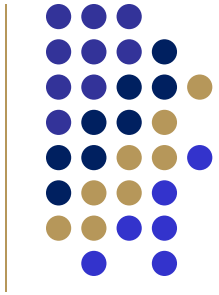
- Fair market value means the value in arm's-length transactions, consistent with the ***general market value***.
- "General market value" means the price that an asset would bring as ***the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party***, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement.
- Usually, the fair market price is the price at which bona fide sales have been consummated ***for assets of like type, quality, and quantity*** in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with ***comparable terms*** at the time of the agreement, where the price or compensation has not been determined in any manner that ***takes into account the volume or value of anticipated or actual referrals.***

FMV definitions…



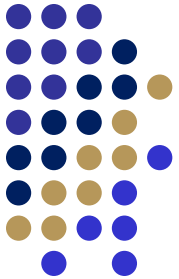
- Anti-kickback Statute
  - No definition in 42 C.F.R. §1001.2
  - OIG will not opine as to whether an arrangement is or is not FMV and, in fact, is precluded from opining on same (See 42 U.S.C.. § 1320-a7d(b)(3)(A))
  - Many safe harbors, which incorporate FMV language merely provide as follows:
    - ..the aggregate amount of compensation is ***set in advance***, is consistent with fair market value in ***arm's-length transactions*** and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made by Medicare, Medicaid, or other Federal health care programs;

And, what is *commercial reasonableness ?*



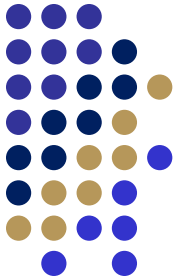
- Although used repeatedly in the law, no definition has been offered by CMS in 42 C.F.R. §411.351 or otherwise. The rules provide as follows:
  - Commercially reasonable even if ***no referrals*** were made between the parties.. (but, is that possible?)
  - Reasonable and necessary for the legitimate business purposes of the arrangement(s)
  - Commercially reasonable even if the physician ***made no referrals*** to the entity
  - Commercially reasonable (taking into account the nature and scope of the transaction) and furthers the legitimate business purposes of the parties

Stark Law Guidance Through the Years



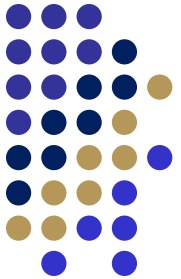
- **63 Fed. Reg., 1659, 1700 (Proposed Rule, Jan. 9, 1998).** "A number of compensation exceptions in section 1877(e) include the requirement that remuneration provided under an agreement ***'would be commercially reasonable***' even if no referrals were made between the parties. We are interpreting ***'commercially reasonable'*** to mean that an arrangement appears to be a sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of any potential referrals."
- **66 Fed. Reg. 856, 919 (Phase I Final Rule, Jan. 4, 2001)** – "With respect to determining what is ***'commercially reasonable,'*** any reasonable method of valuation is acceptable, and the determination should be based upon the specific business in which the parties are involved, not business in general. In addition, we strongly suggest that the parties maintain good documentation supporting valuation. Finally, with respect to difficult cases, the parties should seek an advisory opinion…."

Stark Law Guidance Through the Years



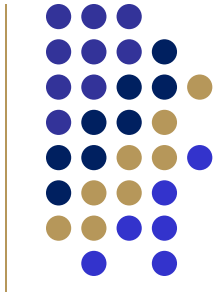
- **69 Fed. Reg. 16,054, 16,093 (Phase II Final Rule, Mar. 26, 2004)** – CMS stated: "An arrangement will be considered ***'commercially reasonable***' in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential DHS referrals."

Stark Law Guidance Through the Years



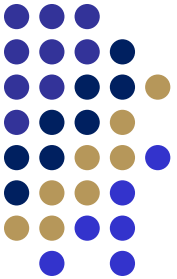
- **73 Fed. Reg. 48,434, 48,714 (IPPS 2009 Final Rule, Aug. 19, 2008)** – CMS' comments (under the per-click arrangements section) noted:
  "We are also taking this opportunity to remind parties to per-use leasing arrangements that the existing exceptions include the requirements that the leasing agreement be at fair market value (§411.357(a)(4) and 411.357(b)(4)) and that it be ***commercially reasonable*** even if no referrals were made between the parties (§411.357(a)(6) and §411.357(b)(5)). For example, we do not consider an agreement to be at fair market value if the lessee is paying a physician substantially more for a lithotripter or other equipment and a technologist than it would have to pay a non-physician-owned company for the same or similar equipment and service. As a further example, we would also have a serious question as to whether an agreement is ***commercially reasonable*** if the lessee is performing a sufficiently high volume of procedures, such that it would be economically feasible to purchase the equipment rather than continuing to lease it from a physician or physician entity that refers patients to the lessee for DHS. ***Such agreements raise the questions of whether the lessee is paying the lessor more than what it would have to pay another lessor, or is leasing equipment rather than purchasing it, because the lessee wishes to reward the lessor for referrals*** and/or because it is concerned that, absent such a leasing arrangement, referrals from the lessor would cease.

Commercial Reasonableness Simplified



- Does the arrangement make sense (without considering any physician referrals)? If it weren't for possible referrals, would the arrangement even be suggested?
- Would the arrangement make sense in a non-healthcare setting?
- What is the fundamental business purpose of the transaction?

Examples of arrangements that *may not be* commercially reasonable



- A hospital enters into multiple medical director agreements for the same service line;
- A hospital leases space from physician-owned MOB at FMV, but, has no present intention of using the space;
- A hospital compensates cardiologists for inpatient procedures and the cardiologists no longer have to bill and collect and have no risk of collections;
- A hospital leases equipment from physicians that it could obtain from an outside leasing company or similar terms;
- A hospital enters into a transaction with physicians group whereby the transaction costs (*e.g.*, management time, attorney fees, valuator fees) substantially exceed the expected benefit of the arrangement;
- A hospital enters into an agreement for lease/space/services or equipment for 5 years.

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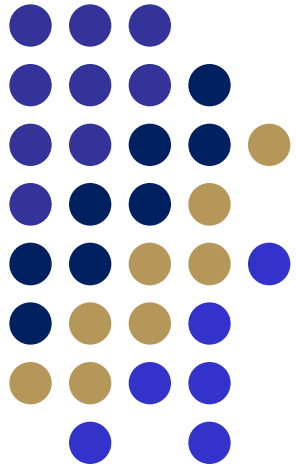
Valuation Approaches



Establishing FMV: Market Approach

Market Approach as defined by the International Glossary of Business Valuation Terms:

A general way of determining a value indication of a business, business ownership interest, security or intangible asset by using one or more methods that compare the subject to similar businesses, business ownership interests, securities or intangible assets that have been sold.

In general valuation terms, the Market Approach looks to comparable transactions to value the asset.

Establishing FMV: Cost Approach

Cost Approach as defined by the International Glossary of Business Valuation Terms:

> *A general way of determining a value indication of an individual asset by quantifying the amount of money required to replace the future service capability of that asset*.

- In general valuation terms, the Cost Approach looks to the cost to replace or recreate the asset.

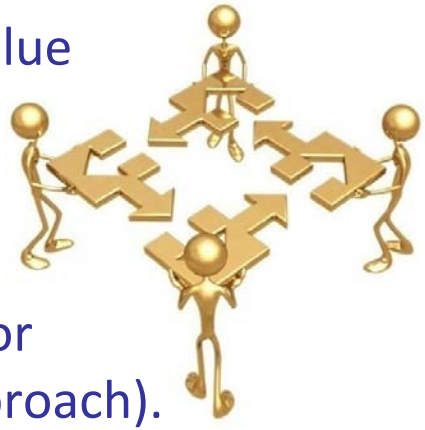
Establishing FMV: Income Approach

Income Approach as defined by the International Glossary of Business Valuation Terms:

> *A general way of determining a value indication of a business, business ownership interest, security, or intangible asset using one or more methods that convert anticipated economic benefits into a present single amount.*

FMV Opinion Synthesis

- In appraisal practice generally, the appraiser evaluates the indications of value provided under each approach to arrive at an opinion of value.
- The appraiser has to assess the relative strengths and weaknesses of each approach and/or method relative to the subject arrangement.
- The results of one approach may or may not be the best reflection of the appropriate level of compensation for a service.
- Professional judgment is required to determine the value range based on the information gathered and the valuation analyses completed.
- Professional judgment is also required to determine when and how to use the various methods available for healthcare compensation valuation work (Income Approach).



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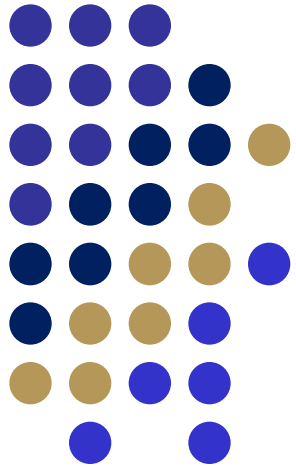
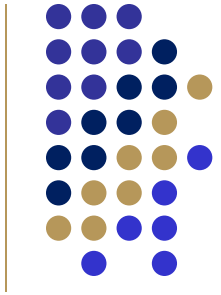
FMV Approaches and Pitfalls – Common Alignment Structures



FMV 101 Recap: Healthcare Arrangements & Transactions

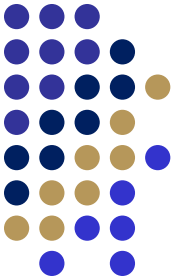
- Generally, any transaction between potential referral sources must be:
  - consistent with FMV; and
  - commercially reasonable.
- A transaction can be "FMV," but not commercially reasonable, and vice versa.
- Healthcare regulations impose specific guidance that directly impacts FMV analysis:
  - Avoid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

Common Alignment Structures



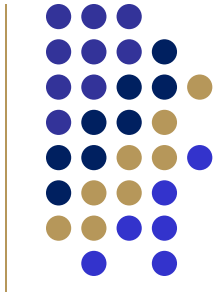
- Call Coverage
- Employment
- Co-Management
- PSA/Foundation Model

Common Alignment Structure: Call Coverage



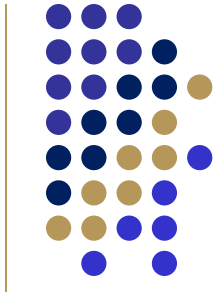
- **What:** Remote call coverage for hospital emergency department and emergent inpatient needs
- **Why (pay):** Hospital has EMTALA requirements mandating coverage and physician's not willing to do without compensation
- **How (pay)**: Per Diem/Activation Fee/Unfunded Care

On-Call Arrangements Relevant Valuation Factors



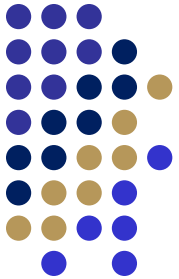
- Frequency and nature of call events
  - Telephone consults
  - Required presence at the ED
  - Required response time
  - Integrity/availability of data
  - Call frequency surveys
- Nature of the specialty
  - OB (typically unfunded patients with no prenatal care)
  - Surgeons (a surgical procedure is likely required, including follow-up care)
- Compensation earned by such specialists for clinical work
- Number of physicians available to participate in call rotation

On-Call Arrangements Relevant Valuation Factors



- Exposure to unfunded care
  - Unfunded patients
  - Low-pay patients (*e.g.,* Medicaid)
- Additional considerations
  - "Restricted" vs. "unrestricted" call
  - Required rapid response (*e.g.,* TPA administration)
  - Professional liability exposure
  - Required coverage by medical staff bylaws
  - Call compensation to employed physicians

Common Alignment Structure: Employment



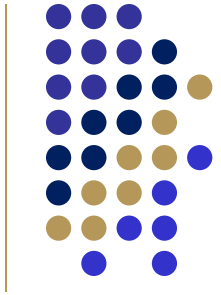
- **What:** Physicians employed by hospital to provide professional medical services
- **Why (do):** Full alignment of incentives and goals. Reduced regulatory issues. Buy-in of both parties to model
- **How (pay)**: per WRVU, Base + Incentive, Split of pre-compensation earnings

Perils of wRVU Models

Hospitals implementing wRVU models must understand their nuances:

- "Total" RVUs vs. "work" RVUs
- GPCI adjustments
- Assistant at surgery
- Multiple procedures
- Mid-level providers
- Site-of-service differences
- CMS rebasing of wRVUs
- New or discontinued CPT codes

FMV Pitfalls
Employment



Example of misuse of MGMA data:

- For General Orthopedic Surgery
  - 90th percentile cash compensation - $934,000
  - 90th percentile wRVUs – 13,795
  - 90th percentile compensation per wRVU - $105.18

Where is this going?

  - 90th percentile wRVUs x 90th percentile compensation per wRVU = $1,451,000… or 155% of 90th %ile compensation!!

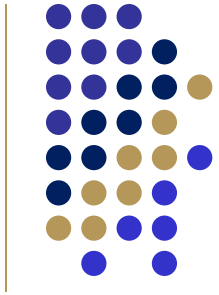
- MGMA data reflects a material *inverse relationship* between physician compensation and compensation per wRVU
- *Median compensation per wRVU* is dramatically different than *median compensation*.

FMV Pitfalls - Employment "Stacking"

Some believe if you label compensation layers by different names, you can stack them higher and higher!

- Sign-on bonus
- Productivity bonus
- Medical directorship
- Co-management agreement
- Quality bonus
- Retention bonus
- Call pay
- Tail insurance
- Excess vacation
- Relocation costs
- Excess benefits

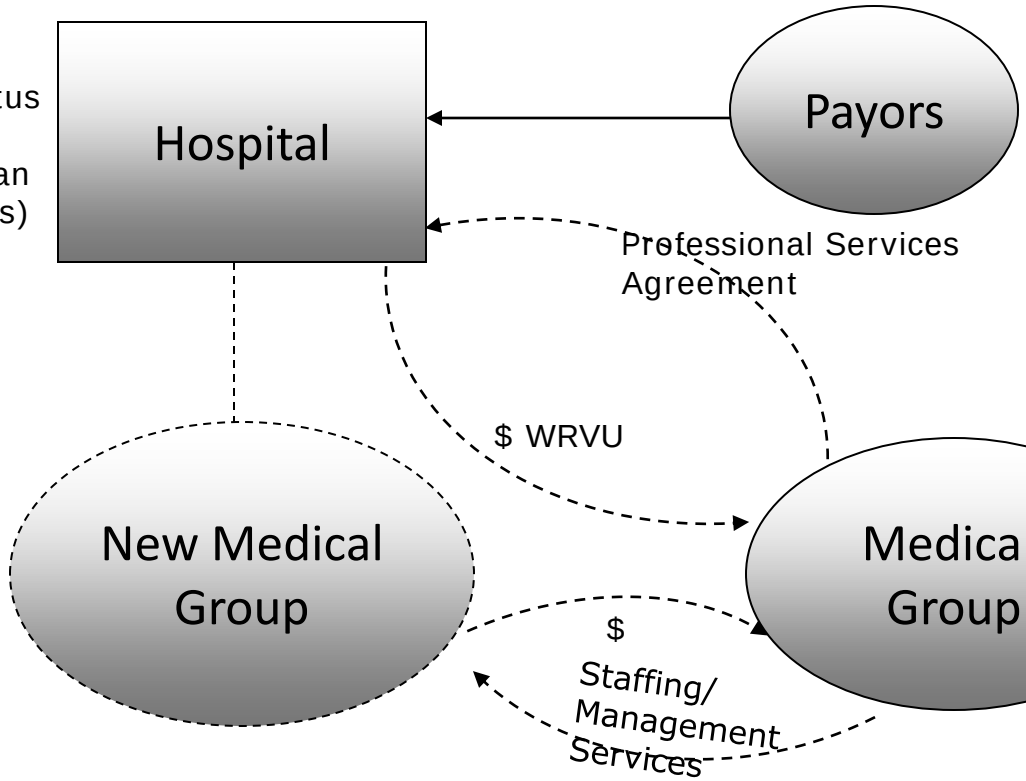
Common Alignment Structure: PSA Conversion



- **What:** Practice provides all or some practice services to hospital through one or more PSA's (clinical services, equipment lease, employee lease, management) but physicians remain employees/partners of their own business
- **Why (do):** Hospital and physician practice interested in greater alignment, but one or both not interested in employment structure. Try before you buy.
- **How (pay)**: Varies - per WRVU is common + payment of specified practice expenses

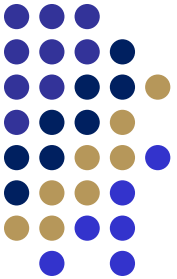
PSA Conversion Transaction

Hospital provides:
- License
- Provider-based status
- Space/equipment
- Mid-levels other than NP/PAs (off-campus)



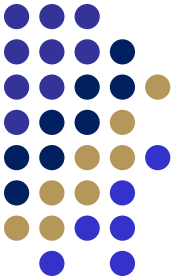
Group Provides:
- Physician staffing
- Non-clinical staff
- NP/PAs
- Management services

FMV Pitfalls - PSA Conversion



- Approach and many pitfalls similar to employment
- PSA specific issues:
  - Operating expenses:
    - Per WRVU,
    - Fixed pass through (budgeted),
    - Pass through (not budgeted)
  - Holistic view – Sum of the new parts vs. prior whole
    - Related practice management services
    - Margining operating expenses

Common Alignment Structure: Service Line Co-Management



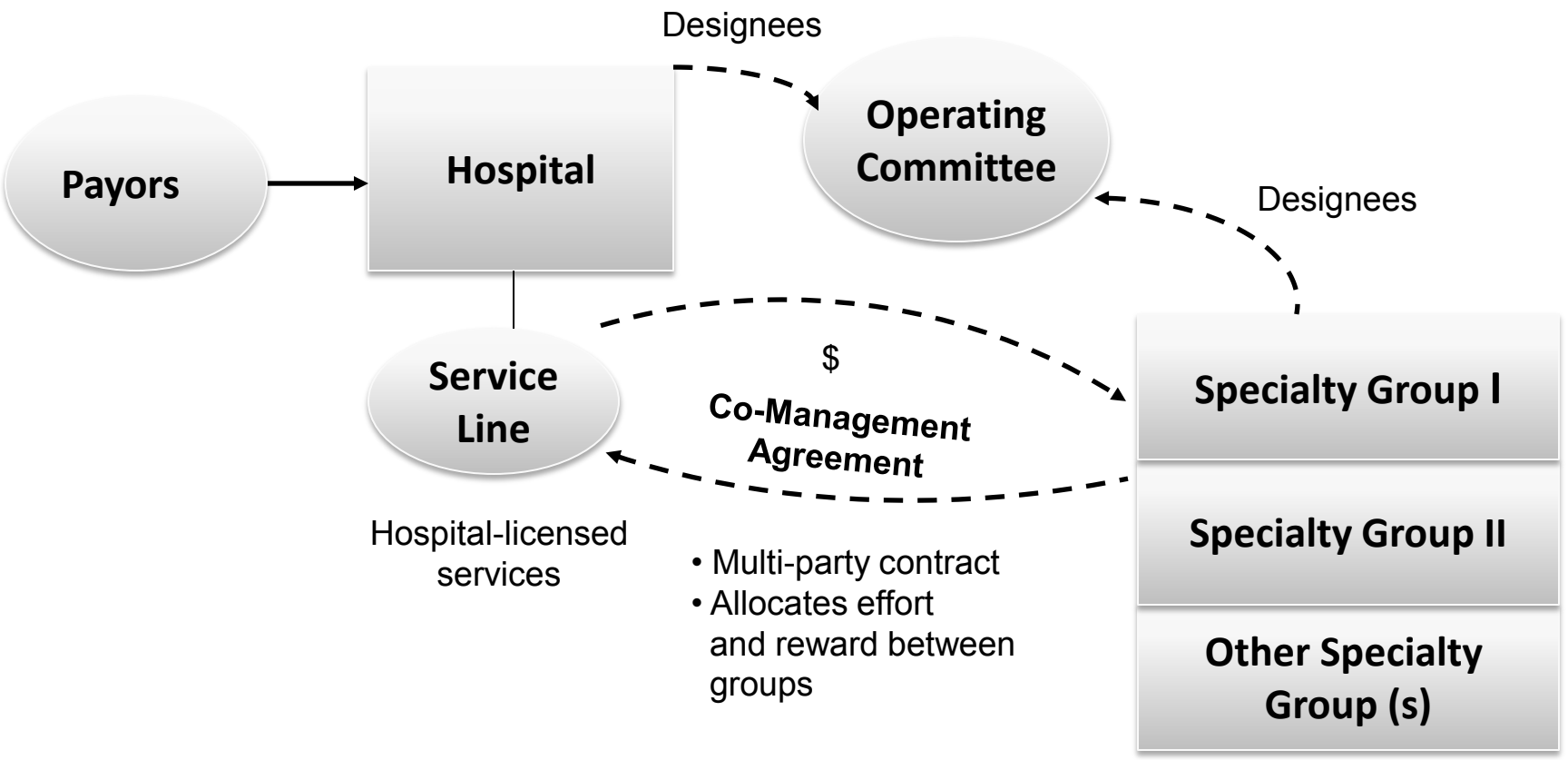
- **What:** Physician management of a hospital service line
- **Who:** Management company comprised of physicians of same specialty; or, co-management company comprised of same plus hospital administrative and clinical leaders
- **Why (do):** Hospital's quality goals and desired integration among clinical leaders for the service line are greater than can be achieved through medical directorship(s).
- **How (pay)**: Base fee + Incentive fee

Service Line Co-Management Arrangements

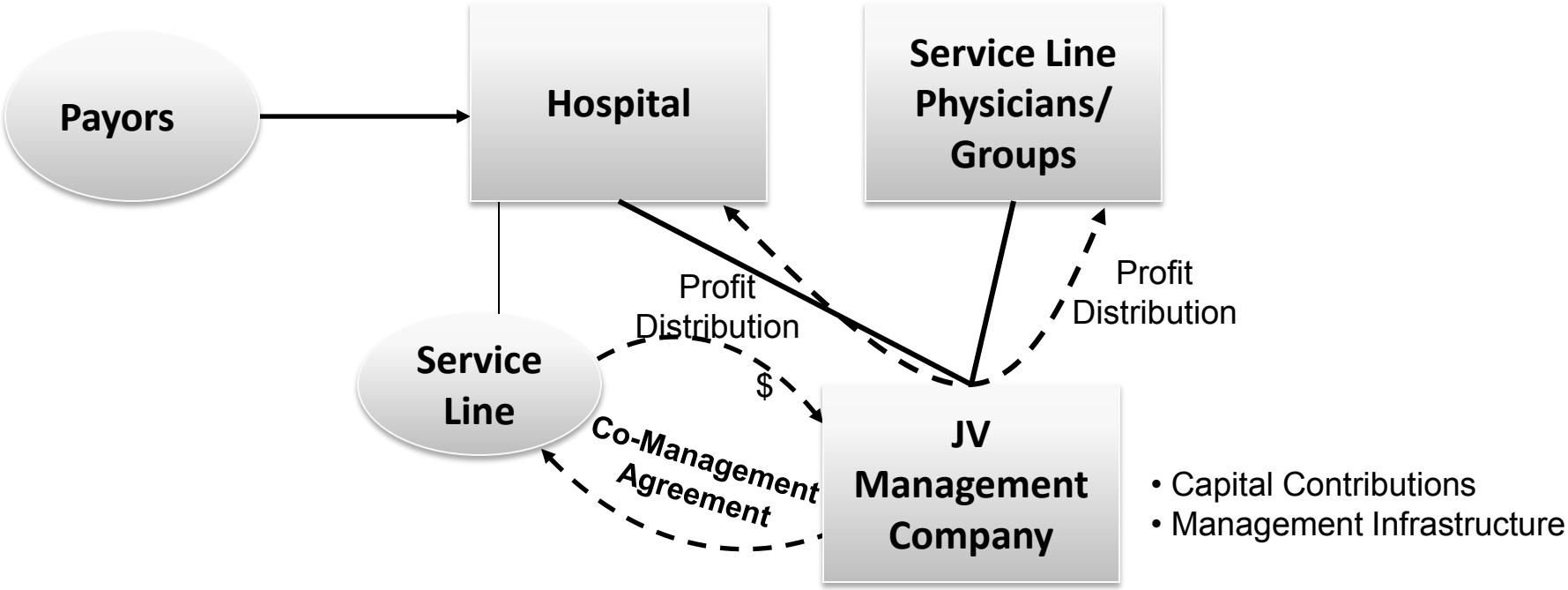
Example: Potential Scope of Cardiology Service Line

- Open Heart Surgery
- Cath Lab
- Echocardiography
- Vascular Surgery
- Invasive Radiology
- PVL
- Inpatient Cardiac & Vascular
- PCU
- Stress Lab
- ECG
- Cardiac Rehabilitation

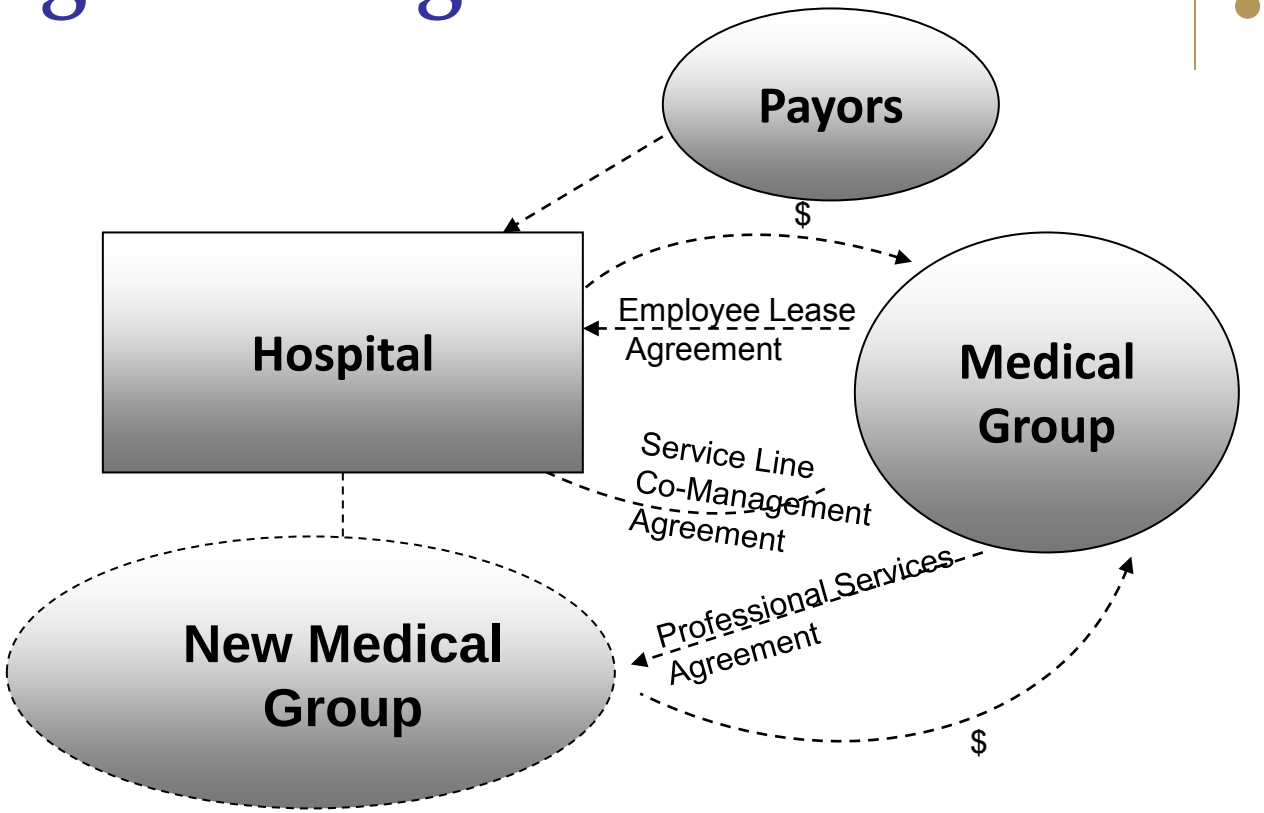
Service Line Co-Management Arrangements - Direct Contract Model



Service Line Co-Management Arrangements - Joint Venture Model



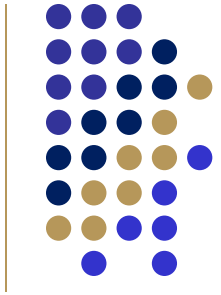
(PSA with) Service Line Co-Management Agreement



Notes:

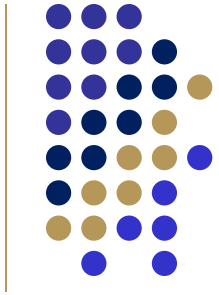
- PSA arrangement, plus
- Service Line Co-Management Agreement (3-6% of Service Line revenue)
  - PSA component – WRVU rate equal to aggregate current physician comp/benefits
  - Employee Lease – cost plus
  - Co-management component – fixed fair market value fee
  - Incentive component contingent on meeting specified quality and efficiency improvement standards – fixed FMV fee per standard

Service Line Co-Management Valuation Approaches



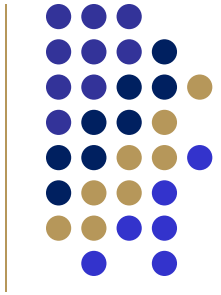
- The Cost Approach can be used to estimate the "replacement" or "replication" cost of the management/administrative services to be provided by the manager.
- The Market Approach considers compensation as compared to independent management arrangements.
  - On an item-by-item basis, the relative worth of each task/responsibility is "scored" relative to other comparable arrangements.
  - An indication of value of the management services is then established by comparing the "scoring" of the subject agreement to other service arrangements in the marketplace

FMV Pitfalls - Co-Management



- Services
  - Services detailed in agreement, and considered in valuation, are not fully provided
  - Ongoing medical director arrangements appear to result in duplication of services (and compensation)
- Incentives:
  - Is there appropriate balance between base and incentive fee?
  - To what extent are incentive metrics payable for maintenance
  - Bar is set too low for incentive quality metrics
- Co-management:
  - Valuation of contributions to co-management entity (Hospital's contribute cash and get 50%/Physicians contribute none and get 50%) ,
  - Is the allocation of duties and responsibilities commensurate with the compensation?

Integration/FMV - In Closing



- Alignment options present great opportunities in a brave new health care world
- All alignment and integration options are inherently complex and there is no “one size fits all”
- Virtually all alignment strategies involve some type of compensation arrangement and, hence, raise valuation issues.
- FMV and Commercial Reasonableness are two distinct and different concepts and they may or may not align.
- The law is less than clear on what constitutes FMV or what factors establish commercial reasonableness


STOP

QUESTIONS?

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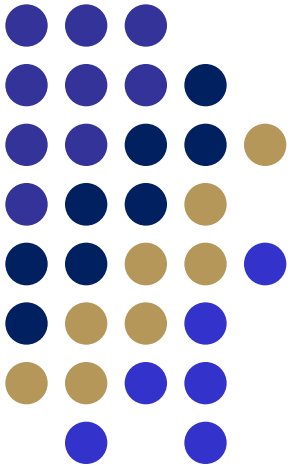
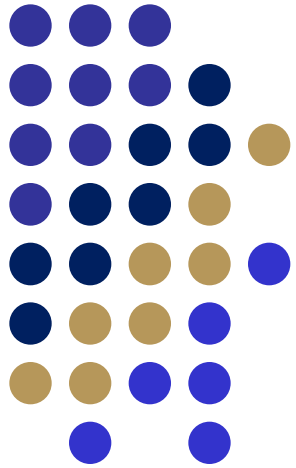
HealthCare Appraisers, Inc.

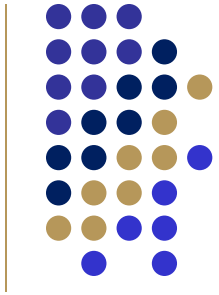
January 30, 2013



Tips and Tidbits for Valuation

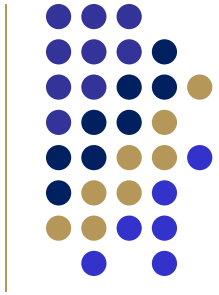


Use of Valuator—Do's and Don'ts



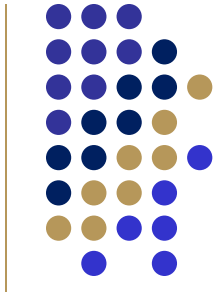
- The valuator is not the party to drive the transaction—oftentimes, parties attempt to use the valuator to resolve business issues. This makes a bad valuation and/or a bad transaction.
- Decide when you need to engage a valuator as early as possible in the transaction cycle.
  - If the parties wait until the end and the valuation does not support the business goals, extreme frustration (or worse) sets in.
  - Many valuators will consider a two-phased engagement with the first phase merely to provide general guidance and direction to confirm the parties' business valuation objectives and a second phase to "provide the opinion."

Use of Valuator—Do's and Don'ts



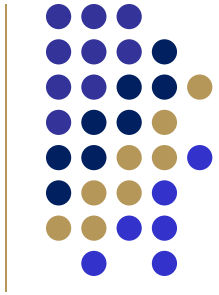
- Openly discuss the valuator's preferred approach for a specific deal. What types of intangibles can be valued and how will they be valued?
- Healthcare consultants may provide strategic and business advice to a deal, but, some will not deliver an actual valuation if they are the deal "consultant". Evaluate this issue early on.
- Commercial reasonableness. Do you want the valuator to opinion on same (yes!). What does the valuator need in order to include in his/her opinion?
- Who should actually engage the valuator? Seller? Buyer? Both (can that even be done)?

Use of Valuator—Do's and Don'ts



- Carefully consider assumptions in the valuation. For example, if the practice is being acquired for $X and the valuator assumes no increase in compensation—but, in fact, there will be an increase in compensation post-closing, there is a disconnect with the facts of the deal.
- Always request a conference call or meeting to discuss preliminary valuation findings *before* 'finger to keyboard.' And, ensure that drafts of valuation report are tightly controlled. (Assume that all drafts are subject to production).
- Understand your client's risk tolerance—particularly as you add back intangibles of some type into the valuation.

FMV Pitfalls
Misapplication of an FMV Opinion



Examples :

- Opinion was valid only over a specified range of outcomes.
- Misapplied “units”
  - Surgical cases vs. procedures; patients vs. “fractions”
  - Unrestricted vs. restricted call
  - 24-hour on-call rate applied to a 14-hour call period
- FMV opinion is ambiguous or conditional.
- FMV opinion included critical governing assumptions that were not considered in its application.
- Consider the “shelf life” of the appraisal, and whether there are any post-closing obligations (such as a true-up).

FMV Pitfalls
Use of Tainted Market Data

- Generally, any market data used to establish FMV must be "arm's-length". Healthcare transactions are frequently suspect.
- A market approach is the preferred valuation approach for many types of compensation arrangements.
- For certain types of arrangements, virtually no "non-tainted" data is available.
- The valuator must consider alternate approaches.
  - Consider whether the arrangement can be "cross-walked" to a non-healthcare setting. If the arrangement would make sense in a non-healthcare setting, it may make sense in healthcare (provided that referrals are never considered/valued).

Addressing Fair Market Value in Hospital and Physician integration

Health Care Compliance Association (HCCA) Webinar

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