HealthCare Appraisers
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2011 Report

FMVantage Point™

A Review of 2010 Trends and Transactions

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Disclaimer

The values provided in this report are intended to portray general FMV ranges applicable to a variety of healthcare compensation arrangements. No values from this report should be relied upon to establish or support the FMV of any particular transaction. The appropriate FMV range for any particular transaction is dependent on the facts and circumstances, and notably, the upper limit of FMV for a given arrangement may differ significantly from the values listed herein.

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This publication marks the second year that HealthCare Appraisers ("HAI") has compiled a report of notable trends and data related to U.S. healthcare transactions observed during the previous year. As a national healthcare valuation firm, we are in a unique position to be privy to, and to play an active role in, hundreds of healthcare transactions across the country each year. We have the opportunity, and thus the perspective, of working with hundreds of attorneys; consultants; hospitals and health systems; life sciences companies; physicians; and healthcare entrepreneurs.

We trust that you will find this report useful. In the event that we can answer any questions or offer any assistance with respect to the topics covered in this report, please contact us at:

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Health Reform Bill Impact

The biggest news of 2010 was the enactment of the comprehensive health reform law, known as the Patient Protection and Affordable Care Act ("PPACA"), which calls for widespread change to health insurance and other aspects of healthcare. The items affecting healthcare transactions and valuations include provisions encouraging the creation of Accountable Care Organizations (or "ACOs"), short-term changes to Medicare reimbursement for certain services, and long-term requirements for individuals to obtain their own insurance, which could impact payor mix experienced by many providers. While it is uncertain whether all of these provisions will survive judicial review or repeal efforts, there are also questions whether new insurance coverage for currently uninsured patients will be sufficient. The health reform package also included significant funding for increased fraud enforcement efforts and mandated the creation of the Stark Self-Referral Disclosure Protocol ("SRDP"), both of which are expected to increase the need for valuation of healthcare transactions that may have compliance risk.

CMS Publishes SRDP and Seeks EMTALA Comments

The Centers for Medicare and Medicaid Services ("CMS") published the SRDP, as mandated in the health reform law. The SRDP provides a mechanism for healthcare entities to self-report transactions that violate only the Physician Self-Referral prohibition (more commonly known as the "Stark" law), *versus* those that also violate the Anti-Kickback Statute (in which case, parties wishing to self-disclose must use the OIG Self-Disclosure Protocol). The main advantage of using the SRDP option is that CMS has the ability to settle the potential Stark claims at amounts below the mandated penalty levels. Part of the SRDP requires that parties detail the nature of the violation, which often will include detailed fair market value ("FMV") analysis to verify whether or not transactions were consistent with FMV, and the magnitude of any discrepancies.

CMS also published a notice seeking comment on changes it is considering for the EMTALA regulations, including consideration of whether to expand the EMTALA requirements to cover care provided to certain inpatients with emergent medical conditions. This could impact agreements for various hospital–based and specialist coverage arrangements.

OIG Activity – Sleep Center Advisory Opinions and United Shockwave Settlement

The Office of Inspector General ("OIG") released two Advisory Opinions (No's. 10-14 and 10-23) concerning sleep center "under arrangements" transactions between a hospital and a non physician-owned sleep testing provider, with compensation on a "per-click" basis for each test performed. The difference between the two opinions was that, in Opinion No. 10-14, the testing provider offered no marketing services of any kind, but in Opinion No. 10-23, the testing provider also performed marketing services by visiting referring physicians and educating them on the sleep center program. In the latter case, the OIG expressed concern that, even though the testing provider was not referring patients directly to the hospital, it was "in a position to influence referrals" and that its only remuneration for the marketing services was essentially "success-based" compensation.

The OIG entered into a settlement arrangement and corporate integrity agreement with United Shockwave Services, a lithotripsy services provider owned by urologists. United was accused of threatening hospitals in a given service area that it would divert referrals to other facilities if it did not win lithotripsy services contract awards. It was not alleged that compensation under the contracts exceeded FMV, but rather, that the trade of the contract award itself constituted the illegal inducement for purposes of violating the Anti-Kickback Statute. In addition, United was accused of improperly rewarding owner physicians based on their referral patterns.

Case Law – Tuomey and Bradford Spark Discussion of the Healthcare FMV Standard

Two *qui tam* cases had significant activity in 2010 that could have lasting impacts on healthcare transactions and valuation issues. They are discussed below.

The Tuomey Case *(US, ex rel. Drakeford v. Tuomey Healthcare System, Inc.)*

The Tuomey case concerned employment of physicians, on a part-time basis, by the hospital's wholly owned medical group, with the employment solely for the purpose of outpatient surgical procedures. The physicians remained in private practice with respect to their office-based patients and all inpatient work they performed at the hospital. Compensation was based on collections for outpatient surgeries performed, and also included employee benefits and malpractice insurance coverage applicable to full-time employees.

The principal issue at trial was whether the compensation under the transactions was consistent with FMV, and a "battle of valuation experts" ensued. Tuomey indicated that it had relied on an outside valuation performed at the time it entered into the transactions, which concluded the transactions were consistent with FMV. The government disputed that valuation by presenting its own valuation expert at trial who concluded that the transactions exceeded FMV. Tuomey then presented a third valuator as an expert at trial who agreed with the conclusion of its original valuation firm. The jury found that Tuomey had violated the Stark law, and the case is now on appeal with respect to various legal issues.

The Bradford Case *(US, ex rel. Singh et al v. Bradford Regional Med. Ctr. & S Med. Assoc. LLC et al)*

The Bradford case involves a transaction between a hospital and physicians who had purchased a nuclear camera, shifting referrals away from the hospital. The parties discussed entering into an "under arrangements" transaction, but in the interim, the hospital agreed to sublease the camera from the doctors, and to pay additional sums for rent, billing services, and "all other rights" including a non-compete covenant. The hospital had an FMV analysis done by a CPA prior to entering into the sublease transaction, and the valuation included analysis of the revenues the hospital could expect from the additional referrals. The hospital's CEO also indicated in deposition that he expected the deal to result in significant referrals and that he would not have otherwise entered into the deal.

The Court, in finding against the hospital, not only focused on the valuation and the hospital CEO's intent to pay for referrals, but also provided a lengthy discussion on the issue of whether the compensation was determined in a manner that "takes into account the volume or value of referrals," as that term is defined in the Stark regulations. There has been significant discussion and debate among lawyers about the Court's comments on that issue, and substantial question about what the ultimate impact of the case will be on healthcare valuation.

In both the Tuomey and Bradford cases, it is apparent that the government is no longer willing to accept valuation reports at face value, but instead, is willing to challenge the analysis through the use of its own valuation experts.

On-Call Arrangements

Trends

During 2010, we noted the following observations related to physician coverage arrangements for hospital emergency and inpatient departments.

- **Difficulty in Securing Coverage.** Even in the face of increasing *per diem* payments, many hospitals reported continued difficulty in securing continuous call coverage, as more and more physicians are focused on balanced lifestyle issues. In our experience, this is particularly prevalent with certain specialties, including, most notably, neurosurgery.
- **Increase in Compensation Rates.** We noted modest increases in rates paid for call coverage in 2010 as compared to 2009.
- **More Specialized Call Panels.** In addition to the physician specialists that commonly provide emergency call coverage (*e.g.*, orthopedics, general surgery, neurology, etc.), we noted an increase in the use of *sub-specialty* call panels, such as laborist, microsurgery, obstetric and orthopedic hospitalists, hyperbaric medicine, and interventional neurology.
- **Alternative Payment Structures.** While *per diem* compensation continues to be the most prevalent payment structure (comprising roughly 75% of all compensation arrangements that we analyzed), we noted an increase in the use of alternative payment structures, including *activation payments* and the inclusion of compensation for unfunded care in addition to a *per diem* payment. (An activation payment is a fixed payment per day that is paid only in the event that the on-call physician is required to respond to at least one call event at the hospital.)
- **Payment Incentives for Quality.** We noted a number of hospitals that incorporated call coverage duties into clinical co-management arrangements. (Refer to the Clinical Co-Management Arrangement section hereinafter.) By embedding compensation for on-call coverage into an annual management arrangement, this reflects the desire of many hospitals to avoid the "slippery slope" of implementing traditional on-call coverage arrangements.
- **Hospitals Increasingly Track Call Frequency Data.** As identified in OIG Advisory Opinion 07-10, the frequency and manner in which physicians respond to call events is a relevant factor in establishing the FMV of compensation rates. Accordingly, we noted that an increasing number of hospitals have implemented formal programs for capturing call frequency data, where previously, they relied upon estimates or anecdotal values. The data in the table on the facing page sets forth "call burden" statistics based upon hundreds of call coverage arrangements assessed by HAI.

Call Coverage By Specialty

	Weekly Call Events Requiring a Physician's Response to the ED				# of Physicians in the Call Rotation		Range of Unrestricted *Per Diems* ($/day)	
	In Person		Telephonically					
Specialty	Low	High	Low	High	Low	High	Low	High
Cardiology	<1.0x	>30.0x	<1.0x	>30.0x	2	15	$350	$2,060
Cardiothoracic Surgery	<1.0x	8.0x	<1.0x	26.0x	1	6	$370	$2,640
ENT	<1.0x	18.0x	<1.0x	26.0x	2	10	$270	$2,070
Gastroenterology	<1.0x	15.0x	<1.0x	25.0x	1	12	$280	$1,750
General Surgery	<1.0x	29.0x	<1.0x	>30.0x	2	20	$340	$2,210
Hand Surgery	<1.0x	2.0x	<1.0x	5.0x	1	3	$660	$ 970
Internal Medicine	4.0x	30.0x	<1.0x	>30.0x	6	30	$250	$1,170
Intervent. Cardiology	2.0x	20.0x	<1.0x	>30.0x	3	10	$420	$1,560
Neurology	<1.0x	26.0x	<1.0x	25.0x	1	15	$160	$1,040
Neurology - Stroke	1.0x	7.0x	<1.0x	23.0x	2	10	$250	$ 870
Neurosurgery	<1.0x	21.0x	<1.0x	24.0x	1	30	$480	$2,540
OB-GYN	<1.0x	15.0x	<1.0x	>30.0x	1	20	$170	$1,250
Ophthalmology	<1.0x	5.0x	<1.0x	17.0x	1	12	$190	$1,420
Oral Surgery	<1.0x	13.5x	<1.0x	1.0x	1	4	$210	$ 820
Orthopedic Surgery	<1.0x	>20.0x	<1.0x	>30.0x	1	25	$340	$2,250
Pediatrics	3.0x	>20.0x	1.5x	22.0x	4	20	$170	$1,070
Pediatric Surgery	<1.0x	8.0x	<1.0x	3.0x	3	5	$420	$1,340
Plastic Surgery	<1.0x	7.0x	<1.0x	4.0x	1	15	$290	$1,320
Psychiatry	<1.0x	>20.0x	<1.0x	>30.0x	2	10	$160	$ 790
Pulmonary Medicine	<1.0x	1.0x	<1.0x	21.0x	2	8	$280	$ 510
Trauma Surgery	4.0x	5.0x	<1.0x	17.0x	3	12	$900	$2,540
Urology	<1.0x	13.0x	<1.0x	15.0x	2	15	$280	$1,280
Vascular Surgery	<1.0x	5.0x	<1.0x	4.0x	1	7	$300	$ 730

The above data is based upon a review of HAI's proprietary database of on-call transactions in 2010 and 2009.

Trends in Collections Guarantees / Subsidies for Hospital-based Physicians

During 2010, we noticed the following trends in the structure and implementation of collections guarantees / stipend arrangements:

- **In-Sourcing.** An increasing number of hospitals are opting to employ hospital-based physicians. This model eliminates the need to provide income support through a collections guarantee to independent physician group practices or a physician staffing company, and provides the hospital with greater control over the physician services.

- **Quality Incentives.** An increasing number of collections guarantee arrangements include quality incentives to ensure that provider groups are not paid for substandard performance, or to allow rewards for exceeding average quality. The quality metrics used typically conform to the best practices for the particular specialty. For example, we encountered many arrangements which relied on core measures as specified by The Joint Commission.

- **Increased Use of Mid-Level Providers.** The shortage of hospital-based physicians has resulted in an increased reliance on mid-level providers such as nurse practitioners and physician assistants. When hospitals turn to independent physician group practices to provide coverage of crucial service lines, we noticed that a significant proportion of these contractors are deploying their own mid-level providers in order to secure continuity of care, while reducing costs.

- **Expansion of Hospitalist Service Lines.** Hospitals are continuing to implement hospitalist programs in order to treat unassigned patients and ensure the continuity of care of all patients. The increasing prominence of this practice specialty has resulted in further specialization among hospitalists towards specific types of care, such as after-hours care (nocturnists), obstetrics (laborists), neurology (neuro-hospitalist), and surgery (surgical hospitalist). Such hospitalist specialists allow physicians of the same specialty to focus on their own services while leaving the responsibility of pre and post-treatment care to the hospitalist. Although hospitalists provide hospitals with a vital option for reducing costs while improving quality, their professional revenue is often insufficient to cover practice costs. Therefore, collections guarantees will increasingly serve as a practical tool for securing the services of these physicians.

Summary of 2010 Collections Guarantee/Subsidy Arrangements

	# of FTE Providers			Guarantee Amount *per FTE*		
Specialty	**Low**	**Median**	**High**	**Low**	**Median**	**High**
Anesthesiology	2.3	7.0	35.0	$194,933	$426,451	$626,087
Emergency Medicine	3.0	25.0	28.5	$256,120	$318,891	$412,667
Hospitalist	1.2	5.5	32.7	$138,043	$343,400	$689,259
Intensivist	2.0	6.7	12.5	$264,320	$394,295	$598,000
NICU	2.0	8.6	16.6	$118,193	$340,592	$915,333
Radiology	3.2	4.0	24.8	$571,818	$750,625	$1,026,875
Surgicalist	2.5	3.5	6.0	$329,000	$545,350	$712,333

Trends in Service Line Co-Management Arrangements

Service line co-management arrangements are relatively new programs whereby hospitals engage physicians, either directly or through the creation of a joint venture with the hospital, to manage and improve entire hospital service lines. These arrangements place emphasis on achievement of pre-established quality and performance metrics, in addition to day-to-day management activities, and can offer significant improvements over traditional physician medical director involvement in hospital operations. Under this type of arrangement, the primary purpose is to align physician and hospital objectives while recognizing and appropriately rewarding participating physicians for their efforts in managing and improving the overall quality and efficiency of the service line.

In 2010, service line co-management arrangements not only gained popularity, but also became increasingly diverse, being utilized within a broad spectrum of inpatient and outpatient service lines, ranging from comprehensive orthopedic and cardiovascular service lines to hematology/oncology services and outpatient surgery centers. In addition to the popularity and diversity of service line co-management arrangements, we noted the following trends in 2010:

- **Co-Management Structures**. We continue to see co-management arrangements structured in a variety of manners, including (i) a joint venture between both the hospital and the participating physicians as investors; (ii) a new entity comprised entirely of participating physician investors; and (iii) in a case where the service line co-management agreement involves an already organized group of physicians, no new entity is created. (Options (ii) and (iii) are referred to as management, as opposed to co-management, arrangements.)
- **Ownership and Responsibilities**. When a joint venture consisting of the hospital and physician investors is formed, there is most often an equal (*i.e.*, 50% hospital/50% physicians) ownership split. Less frequently, we observed larger ownership positions for the physicians, ranging up to 80%. With respect to the responsibilities of the parties, regardless of the ultimate ownership split, it is imperative that the responsibility for the completion of the management duties matches the ownership (*i.e.*, there are no passive investors).
- **Aggregation of Services.** Frequently, co-management arrangements are broadened to encompass on-call coverage. By aggregating on-call coverage (and the associated compensation) into the service line co-management agreement, hospitals are able to fulfill their call coverage obligations through the physician managers. Furthermore, for those hospitals that do not wish to provide *per diem* payments for on-call coverage, the use of the service line co-management vehicle helps avoid the precedent of *per diem* payments.
- **Streamlined Integration.** Co-management arrangements most often involve the management of several acute care facilities, hospital outpatient department sites and satellite offices. By incorporating all of the service line's points of service into the co-management arrangement, hospitals are able to easily standardize policies and procedures among multiple locations. In 2010, a significant number of cardiology, hematology/oncology and surgery co-management arrangements involved the management of a newly acquired hospital outpatient department, which enabled the hospital to quickly integrate the new department into the overall service line.
- **Use of Hospital-Employed Physicians.** There is a small but increasing trend to utilize hospital-employed physicians as managers within service line co-management arrangements. Typically, the employed physicians associated with the co-management arrangement are compensated by their employment agreements on the basis of work RVUs and compensated by the co-management arrangement on the basis of tasks completed and performance metrics achieved. Thus, the two arrangements tend to be "self-normalizing." However, if the employment arrangement is time-based, a mechanism for tracking and documenting time spent performing required duties should be incorporated into the structure of at least one of the arrangements, such that "compensation stacking" does not become an issue.

Trends in Service Line Co-Management Arrangements (cont.)

- **Basis of Compensation**. Service line co-management arrangements typically include two components: (i) a base fee, which is a fixed payment that provides compensation for the day-to-day time and effort of the participating physicians in overseeing, managing and improving the service line; and (ii) an incentive fee, which is at risk and payable to the extent that pre-determined service line objectives are met. In 2010, the majority of the arrangements included an equal split between the base (or fixed) fee and incentive fee; however, we observed arrangements with base fees ranging from 25% to 65% of total compensation.

Important Considerations Related to the Structure of a Service Line Co-Management Arrangement

Given the increasing size and complexity of service line co-management arrangements, it is important to consider the following items related to the structure and administration of co-management arrangements:

- Co-management arrangements must be established with consideration to tracking the actual performance of co-management tasks and incentives.
- Service line co-management tasks must be reviewed on an annual basis to ensure that they are still appropriate.
- Incentive metrics must (i) be set in advance *and* reset at the end of each year; (ii) be measureable; and (iii) reward improvement.
- Care must be taken to ensure that there are no compensated individuals providing services substantially similar to service line co-management tasks (*e.g.*, traditional hospital medical directors and/or service line administrators).
- When utilizing hospital-employed physicians as managers within the co-management arrangement, consideration must be given to the totality of the potential compensation, including the possibility that the physician has overcommitted him/herself.

Our analyses of proposed service line co-management (and management) arrangements in 2010 included service lines ranging from $2 million to over $429 million in net revenue. While the revenue size of the service line is only one of numerous metrics considered in the analysis of individual transactions, the following table provides a summary comparison of service line net revenue and total management fees from our database, listed by specialty.

Service Line Co-Management Arrangements By Specialty

	Service Line Net Revenue		FMV Range of Total Management Fees	
Service Line	**Up To**	**Average**	**Low**	**High**
Cardiology	$163,000,000	$ 65,000,000	$197,000	$4,215,000
Hematology / Oncology	$429,000,000	$147,000,000	$502,000	$5,291,000
Neurosurgery	$276,000,000	$162,000,000	$530,000	$6,425,000
Orthopedics	$ 52,000,000	$ 36,000,000	$274,000	$1,947,000
Surgery (IP & OP)	$ 95,000,000	$ 33,000,000	$222,000	$2,763,000
Surgery (OP & Amb only)	$ 33,000,000	$ 17,000,000	$167,000	$1,429,000

Trends in Physician Employment Arrangements

Health Systems Seeking Physicians

- Hospitals and health systems continued to increase their employment of physicians in 2010. We noticed that large group practices, particularly cardiology groups, were employed *en masse* as part of acquisition transactions, while hospitals and health systems also sought to employ individual physicians with existing practices or otherwise recruit from outside the local market.
- Further, hospitals and health systems are increasingly turning to employing physicians specializing in hospital-based medicine where they once contracted with independent physician groups.
- The trend towards employment will become more and more prevalent as employing physicians serves to (i) provide adequate specialty coverage to meet community needs; (ii) expand service lines or physician network coverage; (iii) ensure physician staffing of hospital departments, including ED call coverage; and (iv) prepare hospitals and health systems for the anticipation of new delivery models as part of healthcare reform.

Physicians Seeking Employment

A greater number of physicians pursued hospital or health system employment in response to current market forces. Some examples include:

- Anticipation of new reimbursement models resulting from healthcare reform, including accountable care organizations, medical homes, and payment bundling
- Changes in third-party payor reimbursement rates and decreasing bargaining power with commercial payors
- Difficulties in recruiting new or replacement physicians into existing physician groups
- Assistance with business operations and practice management
- Lifestyle considerations

Compensation Models

- Employment compensation in 2010 trended towards more productivity-based compensation models, with compensation per work relative value unit ("wRVU") being the predominate model used for productivity-based compensation in employment.
- Although many employers continued to offer salaries or base compensation as part of an initial employment term for physicians, we found that employers are also combining it with forms of incentive compensation, including sign-on, retention and quality bonuses, or requiring physicians to reach targeted levels of productivity in order to maintain their base compensation.
- Physician groups employed *en masse* as part of an acquisition deal generally opted for group-level compensation models in which all the physicians in the group were placed on the same model with the same pay rates.
- "Stacking" of various compensation incentives such as base compensation, compensation per wRVU, on-call pay, medical directorships, and various types of incentive bonuses, continued as a major trend for employment arrangements.

Trends in FMV Compensation

- FMV compensation levels varied among physicians of the same specialty based on an analysis of several key factors affecting the determination of FMV, including:
  - The physician's qualifications;
  - Market supply and demand for the specialty;
  - The physician's historical productivity;
  - Reimbursement levels in the local service market;
  - The physician's resource utilization and operating cost profile;
  - Levels of technical revenue streams meeting the In-Office Ancillary Exception under the Stark Regulations; and
  - Levels of other professional service revenues generated by a physician or practice.

Trends (cont.)

- The interplay of these factors often produced a wide range of FMV indications for physicians across varying marketplaces. For example, in 2010, HAI's indications of FMV compensation per wRVU for cardiology practices ranged from $38 to $68 per wRVU.
- The FMV indications for some physicians included a material increase over reported historical compensation levels, despite the fact that many physician practices were not optimized with respect to operations, including revenue cycle areas and overhead.

The Growing Use of the "Foundation" Model. Many physician groups are opting for a different kind of contracting structure other than employment, for affiliating with hospitals and health systems – the "Foundation" Model (commonly referred to as a "synthetic" employment arrangement). Under the typical Foundation Model, the physicians maintain their group practice entity, which continues to employ the physicians. The health system will employ all non-physician or non-provider staff of the group practice and contract with the group practice to provide professional services to a health system-owned and operated physician practice.

Compensation to the group practice will occur through common marketplace compensation models and includes a market-based allowance for benefits and malpractice insurance, since the physicians are independent contractors. Appealing to physicians is the ability to determine how the compensation paid to the practice group is distributed among the members, and the ability to maintain their own benefits plans based on personal preference.

For health systems, the Foundation Model offers both advantages and disadvantages. It affords flexibility in acquiring a group that has significant concerns related to the loss of autonomy as well as changes in benefit plan options and internal income distribution that come with employment by a hospital or health system. Conversely, the Foundation Model may not afford the control over physician staffing or the regulatory compliance safeguards that are offered in a traditional employment model.

FMV Pitfalls

- **Over-Reliance on Physician Compensation Surveys.** Many players in the hospital-physician employment marketplace use physician compensation survey data as the *only* analysis for setting employment compensation. The result of this practice can often lead to significant operating losses for employed physicians, as national, regional, and state data from the surveys may not reflect the dynamics of a particular service market or the operating profile of individual employed physicians.
- **Overuse of Reported Median Rates from the Surveys**. While survey medians can serve as an indication of market compensation, their sole use can result in compensation levels that may not be consistent with FMV. Many healthcare players automatically assume that median rates are "market" or that they represent a market "floor" for compensation. Yet, such views reflect a misunderstanding of statistical data. A median, by definition, represents the middle value of a data set. Half of the data is below the median and half is above. The question to ask when using a median rate is whether the subject physician should be below or above the median rate. The answer to this question is often determined by consideration of further analysis and the use of other valuation methods, such as the Cost and Income Approaches.
- **Misunderstanding of Compensation per wRVU Rates.** Like median rates, many healthcare employers have misconceptions about the survey data for compensation per wRVU rates. A critical misconception frequently observed is the idea that the compensation per wRVU rate should correlate with the benchmarked level of wRVUs. In other words, if a physician is benchmarked at the 85th percentile for wRVUs, the thinking is that the physician should be paid the equivalent 85th percentile compensation per wRVU rate.

  According to MGMA, however, there is an inverse relationship between a physician's wRVU level and his or her compensation level per wRVU. In 2010, MGMA published data from a variety of physician specialties that shows a consistently inverse pattern for compensation per wRVU. As the level of wRVUs increased for a physician, the compensation per

FMV Pitfalls (cont.)

wRVU rate actually declined. What is striking about this data is that compensation per wRVU declines generally below the reported median for all physicians in the top two quartiles of production. Generally, physicians with wRVU productivity above the median level experience a compensation per wRVU rate that trends below the reported median rate for all physicians in the survey.[1]

- **Compensation "Stacking."** Stacking occurs when multiple incentive elements are combined in a compensation model. Many employers assume that compensation data in physician compensation surveys relates solely to clinical compensation or to compensation from professional component services only. In reality, the surveys report total cash compensation received from the practice, apart from benefits. Thus, the compensation reported in the surveys may include compensation from not only clinical or professional component services, but also administrative services, earnings from ancillary services, on-call pay, medical directorships, interpretation contracts, research, clinical trials, and owner compensation for those physicians who own their practices. The amount of compensation from such services in the surveys is not known because the surveys do not segregate compensation by source.

  An FMV pitfall can occur when base compensation is set using the survey data, and then a series of additional compensation incentives are "stacked" on top of this base creating a material level of additional compensation to the physician. In reality, the survey data already contains a normalized, or typical level, of such additional incentives for a given specialty. As a result, survey data should generally be used for comparison with the *total level of proposed compensation*.

  Another pitfall related to stacking can occur when contractual terms in an employment agreement do not include safeguards for duplication or overpayment for services provided. Such safeguards can be effected when administrative or other professional services are required to be provided, and are paid for over and above clinical or patient care services. In addition, the compensation for each type of service should be analyzed to determine if there are any overlapping elements. For example, an employed physician who is paid on a compensation per wRVU basis should not be paid for uncompensated care as part of a separate call coverage stipend. The employed physician is not financially at risk for uncompensated care.

  *The requirement that additional services be provided **in addition to** the physician's clinical services is especially important when compensation stacking includes a clinical co-management of hospital service line management incentive in the context of employment.*

[1] We note that MGMA reports the median compensation per wRVU rate by quartile of production. The median rate necessarily implies that there are some observed rates that are above and below this rate. It is possible, therefore, that some respondents in the top quartiles of production may achieve a compensation per wRVU rate in excess of the reported median for all respondents. Nonetheless, the trend is downward as production increases as discussed at length by MGMA in its *Physician Compensation and Production Survey* for both 2009 and 2010.

Trends in "Synthetic" Employment Arrangements

Many independent private physician practices continue to struggle with a variety of challenging factors that are negatively impacting their compensation outcomes. These factors include shrinking reimbursement, ever increasing practice operating expenses, expensive ancillary equipment, recruiting difficulties, heightened regulatory and compliance scrutiny, and the additional cost burden associated with implementing and maintaining required electronic medical record systems. For those physicians opposed to outright hospital-based employment, a variety of synthetic employment arrangements allow such practitioners the opportunity to "test the waters" of hospital affiliation without fully sacrificing the autonomy and control available in the private practice setting.

- Under the synthetic employment model, the hospital becomes the billing provider, and the hospital contracts with the physician practice to provide the underlying professional services.
- In addition, the hospital may contract with the practice for the provision of administrative services that might include non-physician staffing services, equipment leasing, space leasing and non-clinical administrative duties.
- We observed an increase in synthetic employment activity in 2010, predominately in the specialties of orthopedics, cardiology, and oncology, and expect such trend to gain momentum in 2011.
- These arrangements can be viable options for both primary care and specialty physician practices of all sizes, including solo practitioners, group practices, single-specialty practices and multi-specialty practices.
- Underlying compensation models are typically structured to align provider compensation outcomes with both financial and operational objectives of the parties.
- Financial objectives are achieved with incentive-based models designed to align physician compensation with related physician productivity, typically measured either in the form of professional service revenues or wRVUs.
- Operational objectives typically incorporate mutually-determined and desired improvements to patient satisfaction, as well as clinical outcomes with respect to professional services provided by the practice providers. These "pay for quality" compensation models are becoming more commonplace, and may be structured as a partial "holdback" to current compensation levels, potential additional compensation incremental to current compensation levels, or a combination of both.
- Compensation per wRVU models, which have been far and away the most common, require that the parties accurately compute and track wRVUs by provider. While most billing systems offer the functionality of generating such wRVU amounts by provider, most practices do not have the knowledge and/or experience to understand and utilize such information correctly in their current operations, and often times generate inaccurate wRVU reports or calculations based on outdated conversion factors.
- The treatment of practice operating expenses is another important aspect of synthetic employment arrangements that warrants careful consideration by the parties. Under these arrangements, the hospital becomes the provider and is therefore the recipient of payor reimbursement for services provided by the practice. Therefore, the hospital must compensate the practice for any legitimate operating expenses incurred in connection with the provision of services to the hospital. Such expenses may include physician benefits, non-physician compensation and benefits, equipment, office space, drugs and supplies. Preferred models in the current marketplace range from direct cost reimbursement on a monthly basis to a gross-up of the compensation per wRVU rate.

"Synthetic" Employment Arrangements (cont.)

- To the extent practice expense reimbursement is incorporated into the compensation per wRVU rate, it is imperative that proper controls are incorporated into such structures to eliminate the risk of unintended under- or over-provider compensation outcomes. Such outcomes may arise to the extent actual retained practice operating expenses are materially different from the wRVU-based funding of the same. These concerns can be mitigated with the implementation of both formal annual budgeting processes and reasonable compensation caps, as well as limits on practice expense savings paid to practice providers.
- When assessing the FMV of proposed synthetic employment arrangements, historical practice income and expense details must be analyzed to properly identify *actual* (as opposed to reported) compensation earned by practice physicians, as this can be in the form of excessive benefits, discretionary personal expenditures *(i.e.*, gifts, trips, donations, etc.) and internally subsidized new physician losses.

Physician Recruitment Arrangements

More than a decade ago HAI's first engagement was related to an income guarantee being offered to a physician to relocate to a hospital's geographic area. Even though ten years have lapsed since this initial project, physician recruitment arrangements have continued to be a focus area for HAI and our clients. In 2010, the following were notable trends of activity:

- **Assessment of FMV salary and other cash compensation for physicians who are candidates for recruitment.** While arguably the most basic form of recruitment arrangement, analyses include consideration of the general factors that may affect market compensation, such as the physician candidate's practice specialty and post-relocation geographic market, as well as more specific factors that may affect compensation, including:
  - The physician candidate's years of post-training experience;
  - The physician candidate's distinguishing certifications and/or training;
  - The physician candidate's practice setting; and
  - Any teaching or administrative responsibilities that the physician candidate has or will have.
- **Assessment of the FMV of non-cash remuneration and incentives to physicians who are candidates for recruitment.** In one example, we performed a valuation analysis related to a recruitment arrangement in which part of the physician's income guarantee was derived from an agreement by the recruiting hospital to make mortgage payments and/or assume the mortgage on a home that the physician needed to vacate in order to relocate, and could not sell or rent quickly in the current real estate market.
- **Assessment of FMV guarantee amounts for physicians being recruited to an existing practice, versus physicians who will be relocated to a hospital's geographic area to establish a new practice.** An increasing number of our clients are planning three-party physician recruitment arrangements under which a hospital pays an income guarantee to, or through, an existing group practice in the hospital's geographic area. Many hospitals perceive a three-party agreement with a physician and existing practice as a more cost effective option for recruiting physicians than a two-party income guarantee with a physician alone.
  - In these instances, we are frequently asked to provide a comparative analysis of FMV for recruitment to an *existing* practice (*i.e.*, when the costs that may be factored into income guarantee payments are limited to the "incremental" expenses that the existing practice incurs as a result of the recruited physician joining the practice) as compared to FMV for recruitment and relocation of a physician to establish a *new* practice (*i.e.*, when the costs that may be factored into the income guarantee include all the costs that the physician may incur to start and operate a practice of the specialty).
- **Revenue analysis to determine whether at least 75% of a recruited physician's revenue will come from care provided to new patients.** In cases where a physician candidate will not relocate his or her practice from a distance of more than 25 miles, parties may require revenue analysis to determine whether they still meet the relocation requirement in the physician recruitment exception under Stark, by a showing that at least 75% of the recruited physician's revenues will come from patients who were not patients of the recruited physician in the former practice location.

Trends in Physician Practice Acquisition

2010 marked a year of significant change in the healthcare industry. As was mentioned earlier, PPACA was enacted and signed into law on March 23, 2010. For physicians of all specialties, the law has several implications, not the least of which is the possibility of adding an additional 30 million insured lives into the healthcare system, and the associated cost of providing care for these individuals. The Congressional Budget Office stated that the bill would "substantially reduce the growth of Medicare's payment rates for most services." In fact, there are many cost reductions built into the law, many of which may be illusory, including the notable failure to address the sustainable growth rate (SGR) in the formula for reimbursement under the Medicare Physician Fee Schedule. Absent a correction to the SGR, as contemplated in the Act, physicians would receive an immediate 25% reduction in reimbursement under Medicare.

After several temporary "fixes" to delay the SGR problem, in December 2010, Congress passed yet another one-year delay to allow time to find a more permanent solution to fix the payment mechanism. For many physicians, a future where they will be required to provide care for more patients with *less* reimbursement is troubling. Concerned about their future economic well being, we are finding that many physicians are opting to give up their independence to gain the income stability afforded by hospital employment. This has led to a significant increase in physician practice acquisition activity by hospitals. In addition to reimbursement pressures, in our experience, acquisition activity has been driven by:

1. Continued hospital focus on physician alignment and integration to gain competitive advantages;
2. A desire by physicians to alleviate the administrative burdens and ongoing capital investment associated with running a professional practice; and
3. A more favorable view of hospital employment of physicians by both the physician groups and hospitals.

During 2010, the focus of most physician practice acquisition activity was on the following specialties (in order of activity):

- **Cardiology.** Cardiology is of significant strategic importance to hospitals and health systems, and competition for the acquisition and subsequent employment of cardiologists remained at very high levels during 2010. Though acquisition activity during late 2009 and early 2010 was focused on large, market-dominating physician groups, smaller practices are now also being targeted.
- **Primary Care.** According to Merritt Hawkins, primary care has been the most requested specialty for the last two years. With a national shortage of primary care physicians and strong push towards more integrated delivery models (such as accountable care organizations), the demand for primary care has increased notably during 2010. Unlike the acquisition models of the 1990s, however, pricing models are significantly more conservative with a heavy focus on creating sustainable compensation models post-acquisition.
- **Obstetrics/Gynecology.** Like primary care, we continued to observe a strong demand for OB/GYN practices. This is driven partially by a continued high number of uninsured patients, as hospitals are finding that engaging physicians to provide obstetric coverage for emergent patients is more difficult. It is unclear what impact health reform will have on this trend, as:
  - Practices are having a difficult time recruiting staff willing to provide hospital coverage, as a higher percentage of obstetric medical school graduates are female and graduating at an age in which they would like to begin a family; and
  - The average number of years that a new medical school graduate spends providing obstetric services before converting their practice strictly to gynecology is declining.

Trends in Physician Practice Acquisition (cont.)

- **Multi-Specialty Groups**. For many of the same reasons noted for acquisition activity in cardiology, primary care, and OB/GYN, large multi-specialty groups are also experiencing strong acquisition interest by health systems. These groups often have significant market share, and provide a host of necessary services.

Other Notable Trends

- In certain market areas, we have observed significant competition for the acquisition/ employment of dominant physician groups. From a regulatory standpoint, this is concerning as a bidding war between potential suitors may ultimately result in a purchase price that is inconsistent with fair market value. Regardless of the strategic importance of the acquisition, hospitals must be very cautious about paying in excess of FMV and should not be tempted to inflate their offer price in light of competitive bids.
- Most valuation analyses for smaller practices indicate that the only appreciable value lies in tangible assets (with subsequent employment of the selling physician(s)), unless otherwise supported by the cash flows of the business.

Trends in Ambulatory Surgery Center Acquisition

During 2010 we observed a significant increase in acquisition activity in the Ambulatory Surgery Center ("ASC") market, driven by a number of factors:

Multiples for Controlling Interests

After falling from their peak levels in the mid to late 2000s, the multiples paid for controlling interests have been relatively stable. During 2010 we have seen the trend start to shift slightly upward, and we anticipate stronger pricing for controlling interests in the coming year. This is driven by a number of factors including continued flow of investment capital into the sector, a loosening of the credit markets and a renewed interest in controlling interest acquisitions of free standing centers by hospitals. Though multiples will not likely return to the levels observed prior to 2006, we have seen an increase in the high end of the observed ranges paid for top quality centers. Valuation multiples, expressed as a multiple of earnings before interest, taxes, depreciation and amortization ("EBITDA") were generally in the range of 6.0x to 7.0x less debt during the last year, with top quality centers approaching 8.0x in some markets.

What is driving the increase in multiples?

- Hospitals are making significantly more ASC acquisitions, in some cases acquiring 100% of the outstanding equity in freestanding centers. There is also an increase in hospital/physician ASC joint ventures where the hospital seeks majority control. In some instances a freestanding ASC can benefit from a hospital's payor contracts, which leads physician investors to be more favorable to partnering with the hospital.
- Major ASC development companies have significant cash available for investment, and after a period of relatively moderate acquisition activity, these companies are now in full acquisition mode. Because development companies may not be subject to the same regulations governing hospital acquisitions, transactions with development companies may permit higher pricing multiples.
- The capital markets are starting to become less restrictive and we are seeing a return of debt financing and private capital in the ASC markets. The availability of capital helps to facilitate the larger controlling interest transactions.

Multiples for Minority Interests

Unlike controlling interests, the pricing of minority shares in ASCs has remained relatively stable with the majority of transactions occurring between 3.0x to 3.5x EBTIDA less prorata debt. This stability is largely a result of the large number of possible investment alternatives and the limited pool of physician investors. Our annual ASC Valuation Survey also continues to reflect the prevalence of predetermined pricing formulas for physician transactions. The use of predetermined formulas lends itself to greater stability in the pricing of shares (regardless of market changes). The pricing mechanism found in the operating agreement may only undergo periodic updating.

What are the key factors tempering minority multiples?

- There is a very limited pool of potential physician investors for ASCs. This pool is generally limited to new physicians or relocated physicians. Paired with loss of retiring physicians and those moving to hospital employment models, the number of available ASC investment options exceeds the number of possible physician investors. When the supply of investments is greater than the demand, a buyer's market is created and pricing will generally be lower.
- *De novo* development is starting to experience a resurgence after more than a two-year hiatus. Unfortunately, this makes many existing profitable centers a victim of their own success. Pricing of shares for a highly profitable center may be too large of an investment for many physicians. Despite the added risks, the lure of a lower buy-in price for the *de novo* center may lead certain investors to pursue this option.

Out-of-Network Centers

In 2010 the battle over out-of network benefits and out-of-network focused ASCs intensified. Commercial payors are now using many direct and covert tactics to try and force the hands of these centers. Tactics include:

- Significant delays or denials of charges, including remission of "reasonable and customary" payment for services conducted at OON centers.
- Threats and direct action to remove a physician's professional practice from the payor network.
- Legal action against ASCs to recover prior payments based on a variety of allegations of impropriety. Regardless of merit, such litigation can disrupt business and delay payment of legitimate charges indefinitely.

For many industry participants, the out-of-network strategy is becoming less and less of a viable option, with some predicting the final days of this model. Due to the inherent risk of significant revenue reductions from going in-network the pricing multiples for OON centers is significantly lower than their in-network peers. Development and management companies base their valuations of these centers on a discounted cash flow model that assumes conversion to in-network reimbursement. The resulting valuation multiples are frequently 1.0x to 3.0x EBITDA for controlling interests.