


HealthCare Appraisers
INCORPORATED

2013 Report

FMVantage Point™

**A Review of Recent
Trends and Transactions**

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PREFACE.....2

REGULATORY/CASE LAW UPDATE.....3

 Affordable Care Act

 Case Law Update

PHYSICIAN COMPENSATION6

 Employment Arrangements

 Collections Guarantees & Subsidies

 On-Call Arrangements

 Co-Management Arrangements

ACCOUNTABLE CARE ORGANIZATIONS.....15

ACQUISITION ACTIVITY16

 Physician Practices

 Urgent Care Centers

 Ambulatory Surgery Centers

 Imaging Centers

 Fixed Asset Appraisals

 Intellectual Property

LIFE SCIENCES24

Dear Colleague:

The healthcare regulatory environment established fair market value (FMV) as a linchpin in structuring and defending compliant financial arrangements and transactions. While paramount from a regulatory perspective, establishing FMV is challenging for a number of reasons, including:

- The government provides very little guidance with respect to establishing FMV for healthcare arrangements. Further, the federal government is precluded from rendering any advance opinion regarding whether proposed compensation is consistent with FMV.
- In addition to compliance with the FMV standard, most healthcare arrangements must also meet the separate and distinct standard of being commercially reasonable.
- Valuation firms differ, sometimes dramatically, in their approaches and findings with respect to healthcare arrangements.
- Healthcare attorneys differ in their opinions, regulatory interpretations, and the resulting guidance they provide to valuers regarding particular FMV assignments.
- The general definition of FMV (*i.e.*, a hypothetical transaction between a willing buyer and a willing seller) is somewhat counterintuitive to a lay person who tends to believe that FMV equals whatever parties to a transaction negotiate. Further, while a market approach is commonly used in many valuation settings, use of this approach in a healthcare transaction raises the risk of reliance upon tainted market data.
- Physicians are frequently suspicious of the FMV process, believing that FMV constraints are merely negotiating ploys.
- Some participants in healthcare transactions seem to play by their own rules. There is intense pressure for physician alignment, and transactions are often driven by economic considerations.
- With benefit of hindsight, regulators and whistleblowers are ready to challenge healthcare transactions through the use of their own valuation experts. The cost of non-compliance (and even the cost of defending compliant arrangements) can be extreme.

This publication marks the third year that HealthCare Appraisers, Inc. (HAI) has compiled a report of notable trends and data related to U.S. healthcare transactions. As a national healthcare valuation firm, we are in a unique position to have firsthand knowledge and involvement in thousands of healthcare transactions each year, 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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Survival of the Affordable Care Act

The biggest news of 2012 was the survival of the Patient Protection and Affordable Care Act (PPACA). First, the Supreme Court issued its ruling upholding the constitutionality of the “mandate” provisions in PPACA requiring individuals to obtain their own insurance, but also striking down provisions requiring states to expand Medicaid coverage. The ruling, combined with the outcome of the 2012 elections, ensured that further efforts of stakeholders to repeal or modify PPACA will be slow moving, at best.

There are several items in PPACA that significantly affect healthcare transactions and valuations, including provisions regarding Accountable Care Organizations (ACOs), disclosure provisions for pharmaceutical and device companies, and notably, significant funding for increased fraud enforcement efforts. Further, the insurance provisions will impact the payor mix experienced by many providers, and while new coverage for patients who are currently uninsured may be at low levels (*i.e.*, similar to Medicaid), that is still a significant shift of financial burden for those patients from hospitals to insurance providers, or ultimately, the government.

Also of note, the Stark Self-Referral Disclosure Protocol mandated by PPACA has been implemented by the Centers for Medicare and Medicaid Services (CMS), and while valuations are likely key to the disclosure process, it is unclear whether the volume of disclosures to date has been meaningful.

Case Law Update

Tuomey Case – Appellate Court Comments on Key Stark Questions

The U.S. Court of Appeals for the 4th Circuit issued a ruling in the Tuomey case (*US, ex rel. Drakeford v. Tuomey Healthcare System, Inc., 4th Cir., No. 10-1819, March 30, 2012*) reversing the lower court decision, and remanding it to the lower court for a new trial. The 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 performing 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 under the arrangement was based on collections for outpatient surgeries performed, and also included employee benefits and malpractice insurance coverage applicable to full-time employees.

The Appellate Court commented on two issues it felt were likely to recur on retrial and offered insight into the definition of FMV contained in the Stark Law. In particular, the Court indicated that when a physician personally performs a procedure at a hospital (*e.g.*, the outpatient surgeries at issue in the case), the facility component of the charges constitutes a referral to the hospital within the meaning of the Stark Law. Second, the Court indicated that fixed compensation that considers *anticipated referrals* “by necessity takes into account the volume or value of such referrals” under the Stark Law, which appears to contradict key CMS commentary in the Stark regulatory guidance suggesting that certain fixed payments would be deemed not to take into account the volume or value of referrals. The precedential significance of the Court’s comments is uncertain, as noted by the dissenting opinions, but regardless, the ruling signaled that parties need to use particular caution in how fixed compensation is determined.

Case Law Update (cont.)

OIG Advisory Opinions

The Office of Inspector General for the Department of Health and Human Services (OIG) issued three notable advisory opinions in 2012, discussed below.

- **Advisory Opinion 12-06 – ASC Transactions with Anesthesia Providers**

Advisory Opinion 12-06 addressed two arrangements between an ambulatory surgical center (“ASC”) with physician owners and the anesthesia provider who provides anesthesia services at the ASC. The first arrangement involved a requirement by the ASC that the anesthesia provider pay the ASC for certain management and administrative services connected with their services. The OIG found that this arrangement essentially resulted in “double payment” to the ASC, as reimbursement for the same services was already included in payments the ASC received from Medicare and other third-party insurance companies.

The second arrangement involved a related company formed by the physician owners of the ASC for the purpose of providing anesthesia services to the ASC. The new company would bill and collect for the anesthesia services and then contract with the anesthesia provider to provide the anesthesia services on its behalf. The anesthesia provider would be paid for its services based on a percentage of the collections, and the new company would retain the balance of any collections. The OIG found that this arrangement was essentially a circumvention, or brokering scheme, stating that the ASC owners were accomplishing indirectly what they could not otherwise do directly.

- **Advisory Opinion 12-15 – ED Call Coverage**

Advisory Opinion 12-15 addressed arrangements between a hospital and physicians of various specialties to provide emergency department (“ED”) call coverage to the hospital and its patients. This Advisory Opinion was very similar to earlier opinions issued by the OIG on the same subject (namely, Advisory Opinions 07-10 and 09-05), repeating significant sections verbatim. Once again, the OIG pointed out the potential risk of payments for call coverage, including potentially problematic structures (identical to the earlier opinions), and commented that the FMV certification appeared reasonable because the compensation rates were tailored to match the burden of providing coverage.

What is significant about this new opinion was the OIG’s focus on two factors that were not emphasized or covered in the prior opinion. In particular, the OIG noted that the physicians would be required to treat a significant number of uninsured or underinsured patients who present to the hospital’s ED. The payor mix of patients was discussed in prior opinions, but given greater emphasis in the new opinion. Additionally, the OIG highlighted the fact that the arrangements frequently would result in the physicians being required to provide follow-up care to ED patients in their practice offices, potentially disrupting their schedules and with potentially unfavorable reimbursement (regardless of whether or not the physician had contact with the patient at the hospital).

Case Law Update (cont.)

▪ Advisory Opinion 12-22 – Service Line Co-Management Arrangements

In Advisory Opinion 12-22, the OIG addressed, for the first time, a clinical co-management arrangement. The arrangement involved a physician group providing management and medical direction oversight to a designated service line of a hospital (cardiology), in exchange for a fee comprised of a guaranteed fixed payment, and a performance-based payment for the achievement of cost savings and a defined set of quality metrics.

The Advisory Opinion addressed the OIG's concerns regarding compliance with (i) the Civil Monetary Penalty for reductions or limitations of services provided to Medicare and Medicaid beneficiaries; (ii) the anti-kickback statute; and (iii) the Stark law. The OIG noted some specific areas of concern with this type of arrangement, including: "(i) stinting on patient care, (ii) 'cherry picking' healthy patients and steering sicker (and more costly) patients to hospitals that do not offer such arrangements, (iii) payments to induce patient referrals, and (iv) unfair competition among hospitals offering incentive compensation programs to foster physician loyalty and to attract more referrals." Ultimately, the OIG determined that it would not impose sanctions, in part, for the reasons set forth below.

With respect to the anti-kickback statute, the OIG noted the following factors in its determination: (i) the hospital's certification and independent analysis determining that the compensation is FMV for the services provided; (ii) the group provides substantial services, thereby reducing the risk that the compensation is intended to reward referrals; (iii) pay does not vary with the number of patients treated; (iv) the hospital's cardiac catheterization lab is the only one within a 50-mile radius, and the group does not provide services at any other labs, making it unlikely that the compensation is intended as incentive to induce referrals; and (v) the specificity of the performance measures and the limited duration of the arrangement.

▪ Two Significant Settlements – Parkridge and Renown

Parkridge Medical Center, an HCA-owned facility in Tennessee, settled a *qui tam* allegation that lease rates were outside FMV. One of the reported allegations being made to support the claim was that the parties obtained additional valuations of the lease rate in an attempt to arrive at a more favorable rate for the physicians than prior valuations of the same transaction.

Renown Health entered into a settlement with the Federal Trade Commission (FTC) regarding the acquisition of a physician practice. The FTC claimed that the acquisition resulted in unfair market advantage due to lack of competition after the acquisition was completed. As part of the settlement, Renown Health agreed to divest certain assets to satisfy the FTC's concerns about relative lack of competition in the market.

Physician Compensation Arrangements

Physician employment and quasi-employment transactions remained among the most frequent types of hospital-physician integration activities in 2011-2012. The primary forces driving these transactions included (i) the desire of hospitals and health systems to expand their affiliated physician network; (ii) continued pressure and uncertainty on physician reimbursement; and (iii) the anticipation of new delivery models (*e.g.*, ACOs). Such forces are expected to drive continuing levels of physician employment or professional services arrangements for the foreseeable future.

While 2009 and 2010 were notable for a significant number of affiliation arrangements with large cardiology group practices, many hospitals and health systems shifted their acquisition and employment targets to large multi-specialty and primary care groups.

Hospitals and health systems also continued to employ smaller *in-market* physician groups, while continuing recruiting efforts from outside their local markets. In addition to primary care, we saw heightened activity in the specialties of neurology, medical oncology, general surgery, urology, interventional radiology, interventional neurology, and neurointensivists. Additionally, we observed a continuation of the trend to employ, rather than to contract with, hospital-based specialists, particularly hospitalists.

Employment and quasi-employment arrangements remain attractive to many physicians as a result of changing market dynamics and personal preferences. Some of the most frequent reasons cited by physicians moving from private practice to an employment setting include:

- Declining reimbursement rates and decreased bargaining power with commercial payors;
- Uncertainty regarding future reimbursement and healthcare delivery models initiated by PPACA;
- Practices with more senior founders seeking an exit strategy;
- Perception that employment offers opportunity to “lock-in” compensation at existing levels;
- Reports of positive benefits from peers that have recently transitioned to employment; and
- Lifestyle considerations.

Employment Arrangements

- Many employers continue to offer physicians base salary guarantees combined with incentive programs during the initial employment term. Examples of commonly observed incentive programs include production bonuses, quality bonuses, and retention bonuses. We noted that some employers attempted to lessen the risk of waning productivity from newly employed physicians by using a declining guaranteed base compensation over the initial of years of employment, or by shifting to a pure productivity model after the first year of employment.
- Consistent with past observations, the employment compensation models we observed in recent transactions often included a productivity-based component, with compensation per work relative value unit (wRVU) being the most commonly used productivity metric. Many large physician practice acquisition and employment transactions were based upon group level (or specialty level) compensation per wRVU. This structure allows the physicians to retain some control of the compensation levels paid to the individual physicians.

Quasi-Employment Models

- Over the past two years, many hospitals and health systems entered into employment-like arrangements, rather than statutory employment arrangements. These quasi-employment structures allow the hospital or health system to secure the full-time professional services and affiliation of a physician group without legally employing the group's physicians, and, in certain cases, without acquiring any of the group's assets. These transactions allow the group to maintain certain autonomy, while also providing for a "toe in the water" approach.
- Typically, the compensation provided to the contracted group for its professional services is production-based. However, similar to traditional employment arrangements, we noted a number of instances of guaranteed base compensation amounts.
- In numerous cases, we observed hospitals entering into a service line co-management arrangement simultaneously with the quasi-employment arrangement to integrate the group into the achievement of the hospital's quality, operational, and financial performance goals.
- The increase in compensation reported by MGMA does not correlate well with changes in reimbursement. Specifically, median collections (from professional charges) by specialists increased at an average annual rate of only 3.6% from 2009 to 2011, while median collections for primary care providers *declined* at an average annual rate of 2.3% during the same period.
- The increase in the proportion of employed physicians was predictably reflected in the most widely-utilized physician compensation surveys over the past two years. In 2009, private practice physicians represented 46% of MGMA's *Physician Compensation and Production Survey* respondents, while hospital-owned practices represented 43%. In 2011, private practice physicians represented 41% of respondents, while hospital-owned practices increased to 49%. Similarly, the proportion of hospital-owned practices responding to MGMA's *Cost Survey for Single-Specialty Practices* shifted from 50% in 2009 to 69% in 2011.

Trends in Physician Compensation and Survey Data

- Despite continued reimbursement pressure and growing expenses, median physician income generally has continued to rise for both primary care providers and specialists over the past two years.
- From 2009 to 2011, MGMA reported a 5.5% average annual increase in median compensation for all primary care providers and an 8.6% average annual increase in median compensation for all specialist providers. MGMA also reported 4.5% and 5.0% annual increases in median first-year guaranteed compensation for primary care providers and specialists, respectively, during this period.
- Outlook for Employment**
- With the Supreme Court's ruling on PPACA, we expect the development of ACO structures to continue at least for the near term. As such, we anticipate the continued integration of large primary care and multispecialty practices.
- The 2013 Medicare Physician Fee Schedule includes significant reimbursement cuts for neurology and radiation oncology. As the impact of these cuts begins to be absorbed by independent physician groups, we believe employment arrangements will become an attractive alternative for such physicians.
- As the cost of providing healthcare coverage for employees continues to skyrocket, many businesses are being forced to consider how to best to control such costs. One strategy is to shift more costs to the employee or reduce or eliminate health benefits. These actions would likely result in a more cost-

Outlook for Employment (cont.)

cost-conscious healthcare consumer and a lower mix of patients with commercial group coverage. Therefore, those specialties that are not targeted for significant reimbursement cuts may still wrestle with declining reimbursement, which is a primary driver for physicians considering an employment arrangement.

- The migration of a large number of physicians into hospital employment settings will make it increasingly difficult for independent physician groups to add members to their practices. As a result, the competition to attract top physician talent that is occurring primarily between competing hospitals/health systems today may expand to include physician groups as well. Starting physician compensation will likely continue to rise despite declines in reimbursement, which will negatively impact the compensation of group owners, and may ultimately reduce their desire to remain independent.
- The initial term of the employment agreements for many physicians whose practices were acquired in recent years will expire in the near future. For some of these physicians, the ancillary services that supported their historical compensation have been carved out into hospital-based departments. For others, professional collections may have declined materially due to changes in payor mix and the assumption of billing responsibility for the practice by the acquiring hospital. As a result, some of the valuation techniques used to establish FMV compensation when the practice was acquired may no longer yield meaningful results. In these circumstances, the determination of FMV compensation may be limited to production-based market approach techniques, with wRVUs serving as the most applicable production metric.

Unique Issues Associated with Medical Oncology

Over the past year, we observed many transactions involving hospital acquisition of medical oncology practices, with post-acquisition employment of the medical oncologists. There are specific valuation issues associated with these medical oncology transactions.

- First, an economic driver for many of these transactions is the more favorable reimbursement that a hospital typically receives as a facility-based provider of infusion services.
- Second, if a hospital is eligible for 340B drug pricing, the economics are further enhanced. Physicians taking note of these income enhancement opportunities frequently assume that they should be able to directly benefit from the hospital's reimbursement and the possible 340B drug pricing. However, consideration of the income associated with a hospital's reimbursement rates or its ability to purchase drugs at a discount clearly fall into the realm of strategic benefits, or synergies, that are specifically associated with a hospital. Therefore, when determining FMV of compensation payable to medical oncologists, care must be taken to ensure that the benefits of the hospital's synergies are not passed along to the physicians.

Even without giving consideration to the improvements in infusion profits that may arise from a hospital affiliation, we have seen a number of situations whereby a hospital has considered the purchase of a physician group's "infusion service line," valued using an income approach (*e.g.*, a discounted cash flow). We point out that particular caution should be exercised with such transactions, considering the following typical characteristics of infusion services: (i) minimal invested capital is required; (ii) the physical facility requirements are consistent with general medical office space; (iii) minimal startup/lead time is required; (iv) regulatory requirements are generally minimal (*e.g.*, a certificate of need is not required); and (v) the referral base to the infusion business is generally limited to the particular group of medical oncologists. Given the relatively low barriers to entry, coupled with the fact that most

Unique Issues Associated with Medical Oncology (cont.)

hospitals have long histories of providing outpatient infusion services of one type or another, it may be difficult to rationalize the use of an income approach in valuing a medical oncologist's infusion business.

A final noteworthy aspect of medical oncology employment arrangements relates to the supervision of infusion services. As a Part B provider, physicians receive wRVU credit associated with infusion procedures (albeit a very low value on a per procedure basis). This reimbursement is associated with the oversight of the infusion services. Once a hospital begins billing for the infusion services on a provider basis, the direct wRVU credit associated with the infusion CPT codes no longer exists. Therefore, we note that hospitals utilize other means to fairly compensate physicians for the continued oversight of infusion services. Methodologies that we have seen in the marketplace include: (i) "grossing up" the wRVU compensation rate based upon the physicians' historical ratio of infusion wRVUs to total wRVUs; (ii) "grossing up" the number of compensable wRVUs based upon ongoing estimates of the infusion-related wRVUs; or (iii) payment on an hourly basis, based upon the actual or estimated hours associated with infusion supervision.

Collections Guarantees and Subsidies for Hospital-based Physicians

Over the past two years, we have observed the following with respect to collections guarantees:

- **Expansion of Hospitalist Service Lines.** Hospitals have continued to turn to hospitalists in order to treat unassigned patients and ensure the continuity of care/treatment of all patients. The increasing prominence of this practice specialty has resulted in further specialization among hospitalists such as after-hours care (nocturnists), obstetrics (laborists), and surgery (surgicalists). Collections guarantees continue to serve as a practical tool for securing the services of these physicians.
- **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 productivity. The quality metrics used typically conform to the best practices for the particular specialty. For example, we encountered many arrangements that relied on "core measures," as specified by The Joint Commission.

Summary of 2012 Collections Guarantee/Subsidy Arrangements

Specialty	# of FTE Providers			Guarantee Amount per FTE		
	Low	Median	High	Low	Median	High
Anesthesiology*	2.5	13.2	76.8	\$268,000	\$459,000	\$628,000
Emergency Medicine*	2.4	11.8	39.0	\$251,000	\$351,000	\$496,000
General Hospitalist*	3.2	6.0	22.4	\$228,000	\$307,000	\$466,000
Intensivist*	2.0	3.7	9.0	\$240,000	\$395,000	\$582,000
Laborist	3.0	4.7	4.7	\$291,000	\$393,000	\$526,000
NICU/PICU*	1.6	4.0	11.6	\$167,000	\$356,000	\$644,000
Pediatric Hospitalist*	4.5	4.9	12.3	\$207,000	\$229,000	\$308,000
Radiation Oncology	0.6	1.3	2.0	\$588,000	\$726,000	\$961,000
Radiology	3.0	3.2	11.2	\$514,000	\$651,000	\$902,000
Surgicalist	0.1	2.4	2.7	\$337,000	\$514,000	\$689,000

* Some arrangements included non-physician providers, which may have skewed the low end of guarantee amount downward.

On-Call Arrangements

One of the largest challenges continuing to face hospitals is adequate on-call emergency coverage. Factors contributing to this challenge include:

- Aging physicians relying on staff by-laws to opt-out of call coverage;
- Physician work-life balance;
- A decrease in the supply of physicians; and
- Fundamental shifts from care provided in hospital settings to ambulatory surgery centers.

Statistics and Trends

- We noted an increase in the use of mid-level providers to perform initial triaging of emergent call events, in an effort to reduce the on-call physician's burden of coverage.
- Information technologies and telecommunication (*i.e.*, telemedicine) continues to be a valuable resource for call coverage of specialties such as neurology-stroke and critical care units. The use of remote physician monitoring allows physicians to provide more efficient medical services that might not otherwise be available, particularly in rural communities.
- We noted that on-call compensation rates paid in 2012 were marginally higher as compared to 2011 and 2010.
- *Per diem* compensation continues to be the most common payment structure; however, we observed the growing use of "activation" payments (whereby the on-call physician receives a fixed payment only for those days during which the physician had to present to the hospital). We also noted a growing use of a *per diem*, coupled with compensation for unfunded care (typically based on a percentage of the applicable Medicare rate).
- We continue to observe the increased utilization of on-call arrangements involving less common specialties such as: laborists; surgicalists; orthopedic hospitalists; microsurgery; detoxification services; hyperbaric medicine; and interventional neuroradiology.
- There has been an increase in the number of compensated coverage arrangements that include performance requirements and/or incentives based upon pre-identified metrics.
- As hospitals recognize the importance of the frequency of on-call events as a factor in establishing FMV for call coverage, a greater number of hospitals have developed tracking mechanisms to enable accurate reporting of call frequency events (including telephonic and in-person responses).

Call Coverage By Specialty

Weekly Call Events Requiring a Physician's Response to the ED

Specialty	In Person		Telephonically		# of Physicians in the Call Rotation		Range of Unrestricted Per Diems (\$/day)	
	Low	High	Low	High	Low	High	Low	High
Cardiology	<1.0x	>30.0x	<1.0x	>30.0x	2	30	\$420	\$2,130
Cardiothoracic Surgery	<1.0x	6.0x	<1.0x	10.0x	1	5	\$640	\$1,730
ENT	<1.0x	21.0x	<1.0x	>30.0x	1	20	\$380	\$1,950
Gastroenterology	<1.0x	>30.0x	<1.0x	>30.0x	1	12	\$440	\$2,190
General Surgery	<1.0x	>30.0x	<1.0x	>30.0x	1	20	\$580	\$1,680
Hand Surgery	<1.0x	3.0x	<1.0x	12.0x	1	15	\$440	\$1,060
Internal Medicine	<1.0x	>30.0x	<1.0x	>30.0x	2	60	\$220	\$1,230
Intervent. Cardiology	<1.0x	>30.0x	<1.0x	>30.0x	1	20	\$510	\$2,020
Neurology	<1.0x	>30.0x	<1.0x	>30.0x	1	25	\$260	\$1,070
Neurology-Stroke	1.0x	10.0x	<1.0x	18.0x	3	9	\$680	\$1,280
Neurosurgery	<1.0x	>30.0x	<1.0x	22.0x	1	20	\$950	\$2,850
OB-GYN	<1.0x	>30.0x	<1.0x	>30.0x	2	30	\$330	\$1,820
Ophthalmology	<1.0x	7.0x	<1.0x	5.0x	1	20	\$300	\$ 810
Oral Surgery	<1.0x	13.5x	<1.0x	5.0x	1	15	\$390	\$ 910
Orthopedic Surgery	<1.0x	>25.0x	<1.0x	>30.0x	1	20	\$580	\$2,330
Pediatrics	3.0x	14.0x	1.5x	>30.0x	2	46	\$220	\$1,150
Pediatric Surgery	<1.0x	12.0x	<1.0x	12.0x	2	7	\$500	\$1,680
Plastic Surgery	<1.0x	8.0x	<1.0x	10.0x	1	15	\$390	\$1,570
Psychiatry	<1.0x	>20.0x	<1.0x	>30.0x	1	15	\$250	\$1,180
Pulmonary Medicine	<1.0x	>20.0x	<1.0x	>20.0x	1	12	\$250	\$1,420
Trauma Surgery	4.0x	>20.0x	<1.0x	>20.0x	4	7	\$580	\$2,180
Urology	<1.0x	>20.0x	<1.0x	>20.0x	1	20	\$320	\$1,480
Vascular Surgery	<1.0x	>20.0x	<1.0x	>20.0x	1	15	\$330	\$1,660

The above data is based upon a review of HAI's proprietary database of on-call transactions for 2011 and 2012.

Co-Management Arrangements

In anticipation of the shift to payment structures based on clinical outcomes and best practices, hospitals continue to seek ways to align with their physicians and promote quality and operational efficiency through shared goals. This increasing focus on alignment strategies is evidenced by growing interest in employment agreements, practice acquisitions and co-management arrangements.

Predicated on the belief that shared responsibility and common goals will result in quality and operational efficiencies, the service line co-management arrangement has emerged as a popular vehicle for facilitating working partnerships between hospitals and their physicians. These arrangements are based on two component parts: (i) the performance of base management tasks, which address the daily management requirements of the clinical service line; and (ii) performance-based incentives, which place a portion of the management fee “at risk,” and require the achievement of specific objectives and performance thresholds in order for the managers to receive the full allocation of this component of compensation. Generally, compensation for completing the base management tasks is paid monthly or quarterly; whereas, the incentive management fee is usually paid to the managers on an annual basis, after actual performance is determined and compared against the identified incentive thresholds.

These arrangements, which place emphasis on achievement of pre-established quality and performance metrics, offer significant improvements over traditional medical directorships. By aligning physician and hospital objectives while recognizing and appropriately rewarding participating physicians for their efforts in managing a clinical service line, service line co-management arrangements are uniquely structured to facilitate the attainment of quality, operational and new program development goals and objectives.

In addition to the popularity and diversity of service line co-management arrangements, we noticed the following trends in recent years:

- **Co-Management Structures.** We continue to see a variety of service line co-management arrangement structures, including: (i) joint venture arrangements owned by *both* the hospital and the participating physicians; (ii) joint venture arrangements that include multiple physician entities; and (iii) management companies that consist of a single group practice. In 2012, we noted that the vast majority of analyses we completed *did not* involve hospital ownership in the service line management entity. Specifically, of the co-management arrangements that we analyzed (i) 76% were management arrangements where the physicians owned the management company, and (ii) 24% involved a joint venture management company between a hospital and physicians. With respect to the 76% where the physicians owned the entire management company, the hospital contracts directly with the physician group (or multiple groups and/or individual physicians) to perform the management services. Within the framework of this type of arrangement, the physicians assume full responsibility for performing the management duties, and therefore, receive the entirety of the management fee. This type of arrangement is sometimes referred to as a “management,” rather than a “co-management,” arrangement.¹
- **Ownership and Responsibilities.** Joint venture arrangements, consisting of both hospital and physician investors, continue to demonstrate a broad diversity in terms of ownership percentages. In 2012, we observed that the physician members of the joint ventures owned a majority of the shares (and are correspondingly tasked with performing the majority of the management services). This is in contrast to prior years, where we observed a

¹We will continue to use the term “co-management” in this section to include both joint venture arrangements and management arrangements.

Co-Management Arrangements (cont.)

greater number of equal ownership structures, and to a lesser extent, hospital majority-owned entities.

- **Aggregation of Services.** Frequently, the requirements of co-management arrangements are broadened to encompass traditional emergency department on-call coverage.
- **Streamlined Integration.** Co-management arrangements sometimes involve the management of multiple acute care facilities, hospital outpatient department sites, and/or satellite offices. By incorporating all of the service line's care delivery locations into a comprehensive co-management arrangement, hospitals are able to standardize operations and associated policies/procedures across the service line.
- **Use of Hospital-Employed Physicians.** Over the past year, we noted an increasing trend to utilize hospital-employed physicians as managers within service line co-management arrangements. Typically, employed physicians participating in co-management arrangements are compensated (i) on the basis of wRVUs through their employment agreement, and (ii) on the basis of tasks completed and performance metrics achieved through the co-management arrangement.
- **Performance Improvement Incentives.** Incentive metrics, which should be set in advance and reset at the end of each contract year, must be measurable and based on rewarding actual improvement.² Generally, service line co-management arrangements should include incentive metrics applicable to each sub-specialty included within the service line. In our recent observations, the majority of co-management arrangements contained between 7 and 10 unique incentive metrics. However, we observed that some smaller service lines included as few as 5 metrics, while certain larger programs included as many as 15 unique incentive metrics.

- **New Program Development Incentives.** In 2012, we noted a general increase in the number of new program development incentives included in co-management agreements. This increase seems to indicate that co-management arrangements are being used to expand service line offerings as well as to improve overall quality and operational efficiency of existing clinical capabilities. In particular, we noted the frequent incentive milestone of the attainment of "Center of Excellence" designation.

Our analyses of service line co-management arrangements in 2012 included service lines ranging from approximately \$2 million to \$240 million. While the revenue size of the service line is only one of numerous factors contributing to the FMV of the arrangement, the following table provides a summary of service line net revenue and the resulting total management fees, listed by specialty.

Specialty	% of Analyses
Orthopedics	37.9%
Cardiology	20.7%
Surgery	13.8%
Hematology/Oncology	6.9%
Gastroenterology	5.3%
Pain	3.5%
Whole Hospital	3.4%
Intensive Care	1.7%
Neurosurgery	1.7%
Physical Therapy Rehab	1.7%
Urology	1.7%
Vascular Surgery	1.7%
	100.0%

²In other words, the total maximum payout for a particular incentive metric is achieved only if the baseline performance is exceeded.

Co-Management Arrangements (cont.)

Service Line Co-Management Arrangements By Specialty

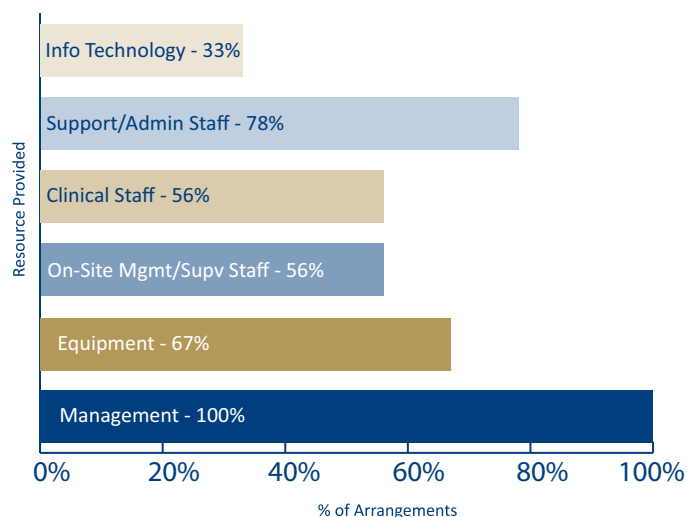
Service Line	Service Line Net Revenue		FMV Range of Total Management Fees	
	Low	High	Low	High
Cardiology	\$12,600,000	\$113,900,000	\$277,000	\$2,375,000
Gastroenterology	\$ 3,400,000	\$ 8,700,000	\$ 92,000	\$ 284,000
Hematology / Oncology	\$94,900,000	\$238,200,000	\$332,000	\$3,410,000
Orthopedics	\$12,712,000	\$109,400,000	\$219,000	\$3,485,000
Pain Management	\$ 2,100,000	\$ 4,300,000	\$ 97,000	\$ 231,000
Surgery (IP & OP)	\$ 5,900,000	\$ 59,200,000	\$141,000	\$ 868,000
Surgery (OP & Amb only)	\$25,400,000	\$ 95,300,000	\$141,000	\$ 519,000
Urology	\$ 7,500,000	\$ 10,500,000	\$222,000	\$ 314,000
Whole Hospital	\$20,790,000	\$ 55,700,000	\$490,000	\$2,100,000

Program Management Arrangements

In addition to service line co-management arrangements, healthcare organizations enter into traditional program management arrangements with physicians. We have observed such arrangements for the management of pain centers, ASCs, sleep centers, endoscopy centers, and wound care centers.

In addition to the management and programmatic expertise obtained through such arrangements, these arrangements often include access to other resources. The prevalence of other resources included in program management arrangements is shown in the chart shown at right.

The compensation structure for these arrangements is most typically a fixed fee plus a variable payment. However, the structure is dependent on the resources included in the arrangement.



Accountable Care Organizations

In late 2011, the federal government issued waivers of the Stark and anti-kickback statutes for ACOs participating in the Medicare Shared Savings Program (MSSP). The waivers broadly exempted most arrangements that relate to the formation and operation of ACOs from the purview of the Stark Law and antikickback statute, and thereby eliminated the need for such arrangements to comply with the requirements of a Stark exception and/or anti-kickback safe harbor. Regardless of these waivers (and of the ostensible elimination of any need for concern about FMV or commercial reasonableness), HAI noted an increase in the number of requests for FMV and commercial reasonableness opinions related to ACO formation and operation during 2012, which we believe is a result of a combination of the following factors:

- CMS and OIG have both issued statements indicating that the broad legal waivers for ACOs may be reconsidered at a future date, suggesting that non-FMV transactions that are not problematic now may become problematic in the near future, if and when the waivers are narrowed or eliminated.
 - Some arrangements involving drug and device manufacturers, drug and device distributors, durable medical equipment suppliers, or home health suppliers are not covered by the waivers.
 - FMV transactions make good business sense, regardless of the Stark and anti-kickback waivers.
 - Non-profit entities have reasons for concern that a non-FMV ACO transaction could jeopardize their tax exempt status.³
- Questions and issues that have arisen in our valuation of ACO-related arrangements and transactions include the following:
- Given the existence of Stark and anti-kickback waivers, what is the applicable definition of “FMV?” Does the applicable definition permit consideration of the volume or value of referrals or other business generated between the parties? Does the applicable definition allow consideration of data from transactions involving parties who are in a position to refer to one another?
 - When contributions made to an ACO are not measurable in cash or time units, how should the valuator assign value? Is an income approach/future benefit assessment appropriate?
 - If a party to the arrangement receives hourly cash compensation for services to an ACO, can those services be counted as contributions to the ACO for purposes of determining the party’s FMV share of any MSSP shared savings payments, or would consideration of these services amount to inappropriate “double-counting” of contributions? What if the value of the services exceeds the hourly cash compensation that will be paid to the party? Should the difference between the FMV of the services and the amount of hourly cash compensation be a basis for calculating FMV for shared savings distributions? Is the FMV of shared savings distributions then *limited to* the difference between the FMV of the services and the total of hourly cash payments?
 - Is the FMV of ACO contributions affected by a party’s relative risk of losses?
 - Should losses in one year be carried forward to establish/apply toward FMV shared savings payments in a future year, or should each year of an arrangement be considered separately when assessing FMV?

³We note that the IRS has issued guidance for 501(c)(3) organizations that are participating in the MSSP and identified five factors that, generally, will establish that a tax-exempt organization’s participation in the MSSP through an ACO will not result in impermissible private benefit. One of the five factors requires that all contracts and transactions entered into by the tax-exempt organization with the ACO and the ACO’s participants, and by the ACO with the ACO’s participants and any other parties, are at FMV.

Physician Practices

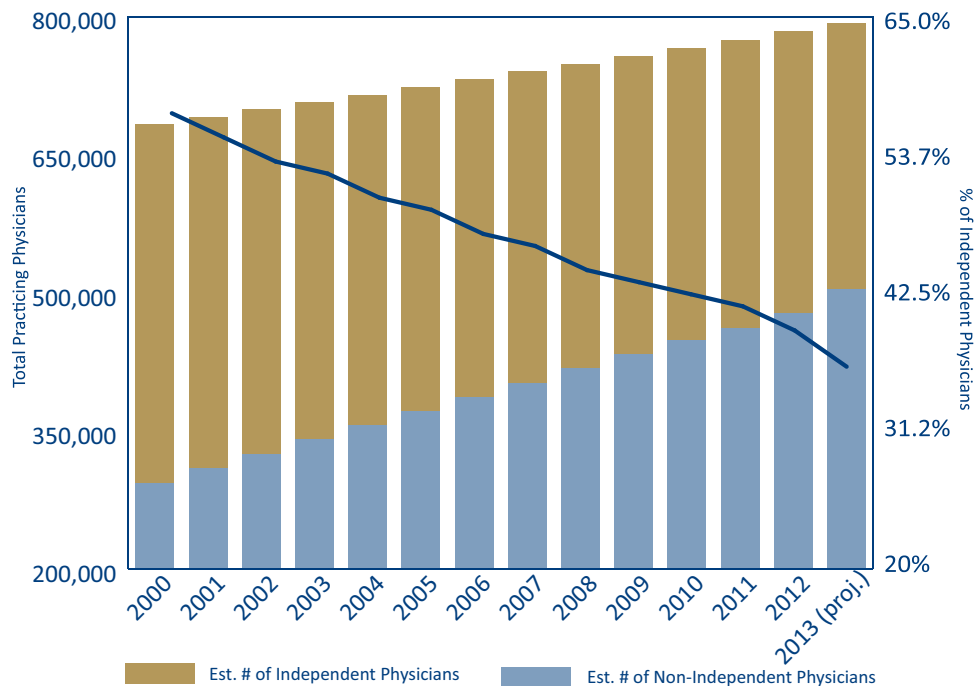
Over the past decade, HAI has valued hundreds of physician practices for potential acquisition purposes, with a significant increase in these arrangements during the past five years. The majority of these acquisitions have been for health system clients, though we have also worked with physician practices, insurance providers, and other corporate clients.

Negative reimbursement pressures, increasing operating costs, expanding healthcare regulation, increasing investment costs associated with items such as electronic health records, and an overall generational shift towards work-life balance have led to physician practices and health systems seeking alignment opportunities. The patient volume outlook for the majority of physician practices is positive, as an aging population, higher percentage of the population covered by insurance, and increasing percent of the population suffering from chronic diseases, will lead to an increased demand for the services provided by

physician practices. While primary care physicians may expect to see higher reimbursement rates for their services rendered, the majority of physician specialties have seen, and will continue to see, pressure on reimbursement from both government and commercial payors. In addition to reducing staff and other operating expenses, practices have been higher utilizers of mid-level providers in an effort to service more patients in a given day. Despite such efforts, many physician practices have seen their financial performance deteriorate in recent years, and have become more open to the idea of health system alignment.

As shown in the following chart⁴, the number of practicing physicians in the U.S. has increased from approximately 682,000 in 2000 to a projected 793,000 in 2013, while the proportion of these physicians remaining in private practice has decreased from 57% to 36% over the same time period.

Independent vs. Non-Independent Physicians



⁴ Accenture, "Clinical Transformation: New Business Models for a New Era in Healthcare," [Accenture](#), September 27, 2012.

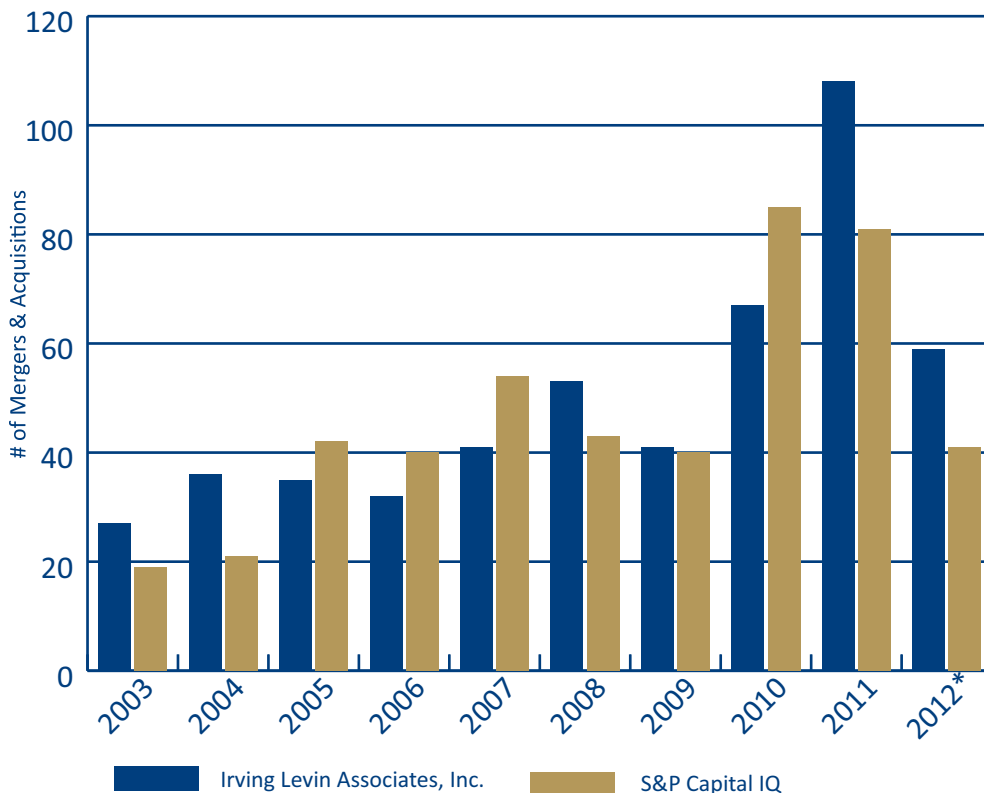
Physician Practices (cont.)

From 2008 through 2011, most acquisition activity was focused on specialty physician practices, with particular focus on cardiology. During 2011 and 2012, HAI observed the physician practice acquisition activity shift from cardiology and other single-specialty practices, to primary care and multi-specialty practices. While expected reimbursement for primary care practices is positive, the alignment activity is largely the result of expanding healthcare regulation under PPACA. Primary care and multi-specialty practices are the cornerstone for health systems developing ACOs. Further, as many hospitals were focused on acquiring specialty physician practices prior to 2012, primary care practices are key to the continued success of these specialty physician practices through continued referral patterns and the overall shift towards a gate-keeper type model that is expected through expansion of healthcare regulation.

Though only a fraction of actual deal volume, the following graph illustrates the number of reported physician practice transactions over the past decade from two well-known databases.

In our experience, the vast majority of acquisition transactions are structured as asset purchases, with the buyer typically purchasing inventory, fixed assets, and other specifically identified intangible assets. In all cases, the post-acquisition compensation model has a direct connection to the purchase consideration paid for the practice, and should be analyzed concurrently with the business valuation. Frequently, the compensation model will offset some or all of the intangible value that would otherwise be paid as purchase price.

Reported Mergers & Acquisitions



*2012 data through December 2

Physician Practices (cont.)

Following are HAI's expectations for 2013:

- Acquisition activity will intensify with the re-election of President Obama and the certainty of further implementation of PPACA.
- Large primary care and multi-specialty practices will be the continued focus of most acquisition activity.
- Reimbursement cuts set forth in the 2013 final rule will have an adverse effect on the valuations for certain specialty practices, including:
 - medical and radiation oncology (-7%);
 - neurology (-7%);
 - pathology (-6%); and
 - physical medicine (-4%).

Further information regarding the approaches used in valuing physician practices can be found in:

A Balanced Approach to Valuation of Physician Practices, authored by Jason L. Ruchaber, CFA, ASA, and Albert "Chip" Hutzler, JD, MBA, AVA

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Urgent Care Centers

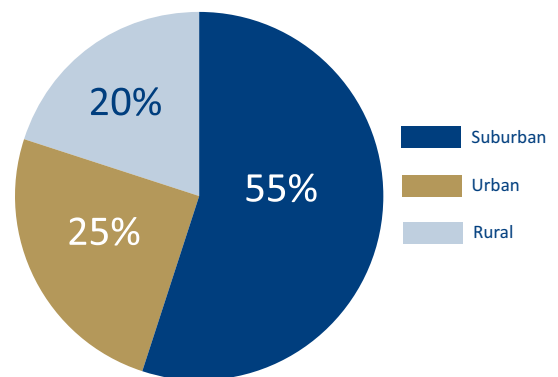
A combination of the declining overall health in the U.S., an aging population, and anticipated expansion of healthcare coverage has increased demand for healthcare services, which has resulted in overcrowded emergency rooms, extended wait times, inadequate access to same-day care and frustrated patients. Urgent care centers help fulfill this unmet consumer need for convenient, affordable and high quality medical services.

Recent data indicates that the average urgent care center sees 342 patients per week.⁵ Approximately 50% of urgent care centers are owned by a physician or a group of physicians and are staffed primarily with physicians specializing in family practice, emergency medicine or internal medicine. See the chart at right for an analysis by specialty.

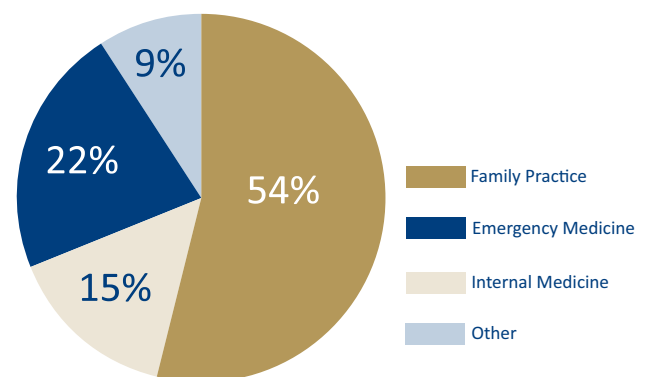
Urgent Care Centers (cont.)

Approximately 60% of all urgent care centers have a wait time of less than 15 minutes to see a physician or mid-level provider, and 65% of all centers have a physician on-site at all times. Urgent care centers tend to be more common in suburban areas. See the chart below for 2011 urgent care locations:

Urgent Care Localities⁷



Urgent Care Center Staffing by Specialty⁶



⁵ Data collected from 2011 Urgent Care Industry Information Kit from the Urgent Care Association of America.

⁶ Ibid.

⁷ Ibid.

Urgent Care Centers (cont.)

Industry Growth

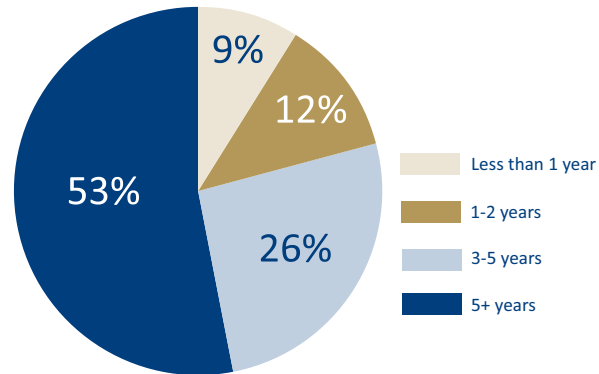
Within the urgent care market, we have observed a consistent increase in new entrants over the past few years due to low barriers to entry and attractive revenue opportunities. Nearly 47% of the urgent care centers have been developed within the last five years, as shown at right.⁸

While the number of new centers increased modestly, the average center experienced an increase of 28 additional patients per month, which demonstrates increasing consumer acceptance of this form of care. This trend is expected to increase urgent care revenue from approximately \$13.7 billion in 2011 to \$17.9 billion by 2017. The revenue opportunity, combined with low start-up costs, a generic service offering, and minimal regulatory hurdles, will drive new entrants into the market and entice existing operators to broaden their market footprint through acquisitions.

Reimbursement

Average reimbursement for an urgent care visit is approximately \$103 per patient, while average reimbursement per patient within a hospital ED is approximately \$302. Despite the large difference in reimbursement, a survey of billing and administrative staff for hospital emergency departments indicated that unit reimbursement-specific CPT codes will not increase faster than the rate of inflation. Increased review activities, including chart review, are expected to follow the Medicare program's lead. For the next five years, emergency physicians should expect that reimbursement will be flat (*note*: 2013 final rule estimated 0% increase) while costs associated with coding and billing will increase much faster than in previous years.

Urgent Care Center Time in Operation



Acquisitions

The urgent care sector is highly fragmented, with the top ten largest urgent care providers accounting for roughly 10% of all centers. Most operators own less than three centers and do not have a dominant market presence. With the exception of a few large urgent care providers, most urgent care providers attempt to gain market share in a defined geographical market and attempt growth in adjacent markets in order to take advantage of name recognition. Given the high-level of fragmentation and a significant demand for scale, the urgent care industry is well positioned for consolidation as many smaller providers will either be acquired or exit the business. As such, many of the large urgent care providers (and even health systems) are acquiring small urgent care centers in order to grow market share (*e.g.*, Dignity Health's acquisition of U.S. HealthWorks, announced July 2012). A trend of increased acquisition activity should continue throughout 2013.

⁸ Data collected from 2011 Urgent Care Industry Information Kit from the Urgent Care Association of America.

Ambulatory Surgery Centers

Within the ASC market, we have observed (i) declining growth in the number of Medicare-licensed ASCs; (ii) pressure on Medicare and commercial reimbursement rates; (iii) rising drug costs; and (iv) increased acquisition activity among ASC management companies and hospitals.

Declining Growth Rate of New Centers

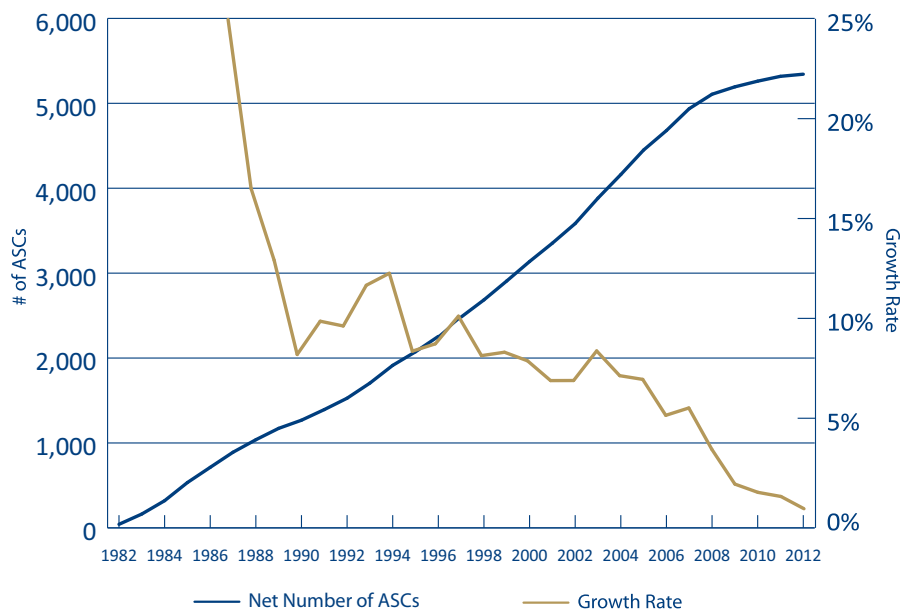
The overall growth rate of the number of ASCs in the U.S. continues to decrease. The total number of Medicare-certified ASCs increased by 57 centers in 2011 and 25 centers during the first half of 2012. According to CMS, 152 ASCs stopped participating in Medicare in 2011 and 2012, of which the average center age was 11.6 years and 12.5 years, respectively. This is consistent with the typical life cycle of ASCs and associated need for major capital re-investments as original equipment and facilities age.

Reimbursement Pressure

The OIG indicated in its 2013 work plan that it will review two important issues related to ASC Medicare reimbursement. First, the OIG indicated that it will evaluate the extent to which hospitals acquire ASCs and convert them to hospital outpatient departments, as well as the effect of such acquisitions on Medicare payments and beneficiary cost sharing. Second, the OIG will review the appropriateness of Medicare's methodology for setting ASC payment rates, in order to evaluate the payment disparity between the ASC and hospital outpatient department payment rates for similar surgical procedures provided in both settings.

With regard to commercial insurance, many major health insurance carriers have reduced or removed automatic annual rate increases during contract renewals as insurers seek to reduce future cost exposure before the full implementation of PPACA. Automatic annual rate increases in multi-year contracts are trending to the 1 to 2 percent range, while centers negotiating for 3 to 5 percent annual increases are being offered one-time increases or single-year contracts.

Number of Medicare-Certified ASCs



Ambulatory Surgery Centers (cont.)

Drug Shortages and Rising Costs

Drug shortages have become a critical issue for many centers, affecting the pricing and the reliability of available drugs. ASCs, hospitals, and other providers are often paying premium prices for drug availability.

This became a widely-publicized issue in the fall of 2012 with the U.S. meningitis outbreak resulting from fungal growth in steroid injections (a common ASC pain procedure). The contaminated steroid drugs were mixed at compounding pharmacies regulated under state pharmacy boards. Compounding pharmacies mix drugs made by other companies, and therefore, they are not regulated as drug manufacturers by the FDA. In the wake of severe drug shortages, ASCs and hospitals continue to turn to compounding pharmacies and alternative drug providers for lack of better alternatives.

Acquisitions and Joint Ventures

ASC management companies and hospitals are currently the primary acquirers of ASCs. Increasingly, hospital acquisitions of physician practices include one or more related ancillary businesses, such as ASCs.

In instances where physician-owned ASCs are considering multiple potential sale offers, there is a high correlation between the proposed terms of the sale and the seller's assessment of the offers. Sellers looking to sell outright tend to seek maximum monetary value, while sellers seeking joint-venture arrangements gravitate to buyers that they perceive will provide the most synergistic benefit/success to the center post-transaction.

The major ASC chains executed many single-center and multi-center acquisitions in 2011 and 2012. Consolidation in the industry has increased somewhat as Amsurg, USPI, and SCA now collectively operate 576 centers (about 10% of market). Several ASC chain acquisitions occurred in 2011 and 2012, including USPI's acquisition of Titan Health (14 centers), Amsurg's acquisition of National Surgical Care (17 centers), and Graymark's pending acquisition of Foundation Healthcare (21 centers).

Outlook and Considerations for 2013

Though high ASC transaction volume is expected during the next several years, valuations are likely to be negatively impacted by physician employment trends and suppressed earnings growth related to reductions in reimbursement. Hospital employment of physicians is a significant competitive threat to ASCs, and investor recruitment is becoming more difficult for many centers. Health systems are becoming major employers of primary care physicians and surgical specialists. Hospital-employed surgeons are often precluded from holding ownership interests in competing entities, and therefore, they are required to divest ASC and other ancillary service business holdings.

We have also seen a significant shift in behavior by hospitals, as they now increasingly look to expand their existing ownership percentage or acquire ASCs outright. In many cases, the goal is to convert the freestanding ASC into a hospital outpatient department as many hospitals can realize reimbursement in excess of what ASCs receive for the same types of cases.

In the near term, ASC valuations should reflect long-term growth rates consistent with historical case volume and reimbursement growth of the subject ASC. Until there is a change in the inflationary reimbursement increases being paid by Medicare and commercial insurance companies, growth rates utilized for terminal year valuation purposes should be matched to the growth rates observed in the market.

While healthcare reform and ACOs may present new challenges, the benefits of ASCs as effective, low-cost providers of outpatient surgical services, will continue to cultivate demand from payors, providers and patients alike.

Imaging Centers

During 2012, we noted significant acquisition activity for diagnostic imaging centers driven by a number of factors, including reductions in reimbursement, hospital employment of physicians, and reduced volumes of advanced imaging procedures due to preauthorization requirements.

Reimbursement

Reimbursement for outpatient imaging procedures has been highly pressured since the Deficit Reduction Act (DRA) of 2005. Under the DRA, reimbursement for outpatient imaging services is equal to the lesser of the amount provided under the Medicare Physician Fee Schedule (MPFS), or the amount payable to hospitals under the Outpatient Prospective Payment System (OPPS). Additionally, CMS introduced a multiple procedure reduction resulting in reduced technical payments for services furnished during a single session. As a result, the more expensive of the two procedures is paid at the full rate, while the other procedure receives a 50% reduction in the technical component payment.

The 2012 MPFS extended the same 50% multiple procedure reduction to the professional component of the same services and will continue to implement reductions in professional and technical reimbursement for most advanced imaging services. Casting further uncertainty is the outcome of the Sustainable Growth Rate (SGR) formula. In February 2012, Congress reached an agreement to extend the current Medicare physician payment rates to the end of the year. As such, the 27.4% physician payment cut scheduled to take effect on March 1, 2012 was averted and replaced with a payment freeze through the end of the year. Despite the payment freeze, Congress remains unable to agree on a permanent fix to the SGR formula. At the present time, reimbursement and compensation will be uncertain for those physicians with a high Medicare patient population. Under the 2013 final rule, reimbursement for radiology is expected to decline by 3% and reimbursement for diagnostic testing facilities is expected to decline by 7%.

Shrinking Referral Base

As with other ambulatory services, we have observed significant changes in referral patterns resulting in increased uncertainty regarding the sustainability of procedure volumes in diagnostic imaging centers. Hospitals are acquiring primary care physicians and specialists, and, as a result, employed physicians have begun referring their patients to centers or outpatient departments affiliated with their new employer.

Acquisition Activity

From a hospital perspective, the acquisition of imaging centers supports the overall strategy of physician employment and the continuity of care for patients. As hospitals have employed more physicians, their pool of physicians ordering diagnostic tests and procedures has grown. Though hospitals have generally sought to maximize the utilization of existing imaging equipment, in many cases, the demand exceeded capacity or the geography of an acquired practice necessitated additional diagnostic capabilities. This is particularly true in states with strict certificate of need laws. This has created an active acquisition market for imaging centers, including underperforming centers with certificates of need.

It is important to review and analyze the professional interpretation agreement for imaging centers billing on a global basis. In many instances, the radiology practice providing the professional interpretation also owns an equity interest in the technical business. We have observed certain arrangements whereby the practice will provide professional services for below market rates due to the related ownership. Upon the sale of the center, which typically involves only the technical business, the professional interpretation agreement may need to be revised to reflect market rates. Absent this adjustment, the appraised value of the technical business being acquired would be overstated.

Fixed Asset Appraisals

Along with the increase in physician practice acquisition activity, there has been a corresponding increase in the requests for the valuation of tangible assets. Some common challenges and issues we have faced in connection with fixed asset appraisals in the physician practice setting included the following.

Ownership of Equipment

Generally, we found that physician practices' fixed asset listings were often unreliable, either because assets that should have been capitalized were not captured, or disposals were not properly recorded. Because these fixed asset lists were unreliable, a site visit was typically required to verify the assets to be included in the valuation. In certain instances, we observed additional complications with valuing the assets that are on-site as a result of:

- **Operating Leases.** Certain equipment observed during a site visit may have been subject to a lease, rather than ownership. It is oftentimes difficult to distinguish between owned versus leased assets.
- **Assets Placed for Use.** We have observed that some laboratory companies place their own assets on-site at a practice for its use. This is a form of lease arrangement whereby the practice is obliged to pay for reagents from the laboratory company. Such equipment is not owned by the practice and should not be included in a fixed asset appraisal.

Intellectual Property

Overview

During 2011 and 2012, we saw an increased focus on intellectual property ("IP") arrangements by our clients in the life sciences and other healthcare industry sectors. This has been partly driven by reductions in reimbursement and industry consolidation. We observed that clients who have not historically focused on the commercialization of their IP are now seeking opportunities to enhance profits or gain strategic advantages in an increasingly competitive environment.

Intellectual Property (cont.)

Furthermore, industry consolidation and the continued emphasis of fair value accounting have increased the awareness and need for the identification and valuation of intangible assets such as IP.

Trends in Intellectual Property Valuation and Licensing Arrangements

Intellectual property has long been a driving force behind merger and acquisition activity, and with the significant consolidation occurring in the healthcare industry, there has been an increase in the awareness and need for the identification and valuation of IP. In a business combination, accounting standards ASC 820 and ASC 805 require intangible assets to be valued separately from goodwill. This parallels the increasing trend for health care entities to identify and leverage their existing IP through licensing arrangements. These arrangements preserve the ownership rights associated with the IP, but also provide the licensor a means for facilitating growth, maintaining profits, and creating efficiencies that might otherwise not exist.

In the life sciences arena, successful research and development efforts may result in one or more patents that can be licensed or incorporated into a commercialized product such as a drug or device. However, even unsuccessful development efforts may result in valuable know-how or datasets that can be further commercialized through licensing, including co-development arrangements that leverage prior efforts of multiple parties to increase the probability of a successful product.

Though licensing is far more common in the life sciences, we are also seeing hospitals, physician practices, and other healthcare providers enter into licensing arrangements for their IP. Intellectual assets that may have commercial value include trade names, trademarks, certificates of need, non-competes, clinical data and know-how (*e.g.*, trade-secrets, procedural protocols).

Intellectual Property (cont.)

Other Considerations

The regulatory environment within healthcare generally requires more care and analysis when licensing or acquiring IP than in other industries. This is particularly true for arrangements involving physicians who are in a position to refer, but regulatory constraints are also present within tax-exempt organizations and life sciences companies subject to the Physician Payment Sunshine Act. This act requires any drug, device, or medical supply manufacturer operating in the United States to report all physician payments and benefits. These benefits include, but are not limited to, research funding, profit distribution, consulting fees, royalties, and licensing fees.

Outlook

With the expectation of continued reimbursement pressures and industry consolidation in 2013 and beyond, we believe there will be continued focus on IP transactions in the coming years. Paired with heightened regulatory oversight and scrutiny of these deals, it will be more important than ever to ensure payments under these arrangements are legally compliant.

Life Sciences Compensation Arrangements

Trends in Compensation of Healthcare Professionals

The proposed Physician Payment Sunshine Act¹¹ is driving considerable activity within the life sciences industry. By requiring life sciences companies, including manufacturers of drugs, devices, biological or medical supplies, to record and report certain payments or transfers of value¹² to physicians and teaching hospitals, CMS is striving to promote transparency and reduce the potential for conflicts of interest that HCPs or teaching hospitals might face as a result of their relationships with manufacturers.

¹¹ Section 6002 of PPACA

¹² Payments under \$10 are excluded only if the aggregate amount paid to a healthcare provider (“HCP”) is under \$100 annually.

Life Sciences Compensation (cont.)

Multi-functional aggregate spend systems used, in part, to track HCP payments across the enterprise, are rapidly being implemented at many of the global companies that dominate the sector. Similarly, small and mid-sized medical device and pharmaceutical companies are beginning to examine the compensation arrangements they have with speakers, consultants, advisory board members and researchers/clinical investigators.

Compliance departments throughout the industry are developing policies and procedures for standardizing their relationships with physicians and allied health professionals. In fact, the impact of FMV in establishing compensation rates for HCPs is becoming a popular subject at industry conferences and meetings. There appears to be growing consensus that, in an age of increasing transparency, life sciences companies will need FMV-compliant compensation plans that are well-defined and consistently applied across the enterprise. During the past 18 months, we have seen a significant increase in FMV analyses from pharmaceutical and medical device companies. Demand for key opinion leader (KOL) analyses, which focus on work performed by the most highly influential physicians and allied health professionals, are also increasing. Furthermore, as markets tighten, there appears to be an increasing level of competitiveness associated with securing the services of certain highly qualified healthcare providers/researchers. This competitiveness may be a contributing factor to the significant variation we have seen in these types of compensation arrangements.

While establishing appropriate FMV compensation ranges in the U.S. for HCPs and KOLs is a challenge to life sciences companies, we have seen growing demand for the determination of such rates in the many countries in which global firms operate.



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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.