

Hospital/Physician Affiliation Trends

December 6, 2011



Hospital Strategies in 2011

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- Jim Rolfe Biography
- Jen Johnson, CFA Biography

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I. Introduction

VMG Background

- ❑ VMG Health solely provides transaction advisory and valuation services in the healthcare industry
- ❑ Offices located in Dallas, Texas and Nashville, Tennessee
- ❑ Services include
 - Business Valuation
 - Transaction Advisory Services
 - Joint Venture Relationship Development
 - Professional Services Valuations
 - Tangible Asset Appraisals
 - Financial Reporting Valuations (ASC 805 & ASC 350)
 - Real Estate Appraisals
- ❑ Routine transaction advisory services have involved
 - Hospitals
 - Diagnostic Imaging Centers
 - Radiation Therapy/Cancer Centers
 - Rehabilitation Hospitals
 - Dialysis Facilities
 - Cath Labs
 - Physician Organizations
 - Ambulatory Surgery Centers (“ASCs”)
 - Urgent Care Centers
 - Physical Therapy
 - Medical Transport
 - Home Health Agencies

VMG Health performs over 600 valuations per year throughout the United States and abroad

VMG Health currently employs over 50 professionals

VMG – Client List

Hospital Systems and Hospitals



Specialty Hospitals



ASC Companies



Jim Rolfe

- ❑ Managing Director of Transaction Services for VMG
- ❑ Previously a Vice President of Acquisition and Development for Community Health Systems (“CHS”), the second largest healthcare system in the country
- ❑ 50 transactions over the past five years (Buy-side, Sell-side, and Joint Ventures)
 - Hospitals
 - Outpatient Facilities (ASC, Imaging Centers, Labs, etc.)
 - Physician Practices
 - Home Health Agencies
 - Post Acute Facilities
- ❑ \$2.2 Billion in transactions over the past five years
- ❑ 18 whole hospital syndications with physicians

Jen Johnson, CFA

- ❑ Partner
- ❑ Previously with KPMG's litigation department
- ❑ Former Finance professor from the University of North Texas
- ❑ Published multiple times related to physician compensation and fair market value

*Healthcare Financial Management
Compliance Today
American Health Lawyers Weekly
Hospital Review*



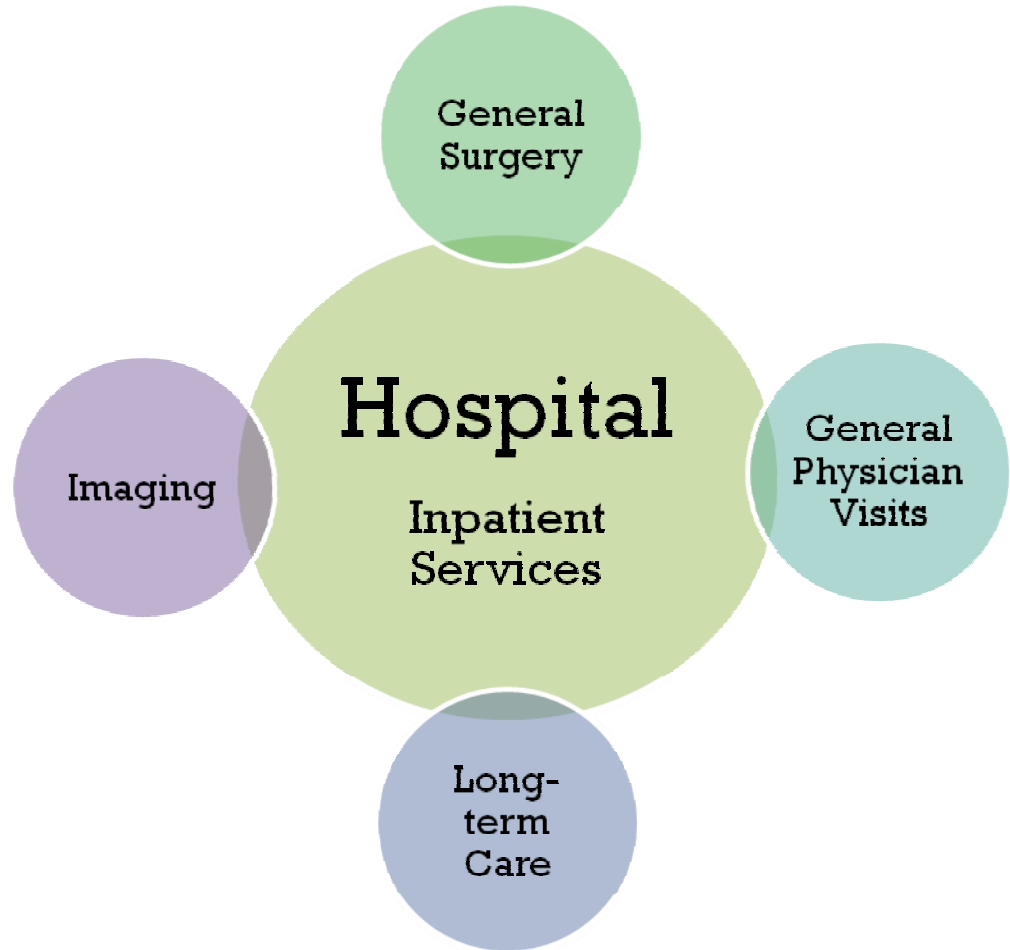
- ❑ Provides professional service valuations in the following areas
 - On-call Agreements
 - Medical Directorships
 - Pay-For-Performance Arrangements & Quality Initiatives
 - Physician Employment & Independent Contractor Arrangements
 - Management and Co-Management Agreements
 - Leasing and Joint Venture Relationships

II. Hospital Market

Hospital Trends

Hospitals in the 1980s *The Bundled Hospital*

- ❑ Cost Based Reimbursement
- ❑ One-stop shop for healthcare

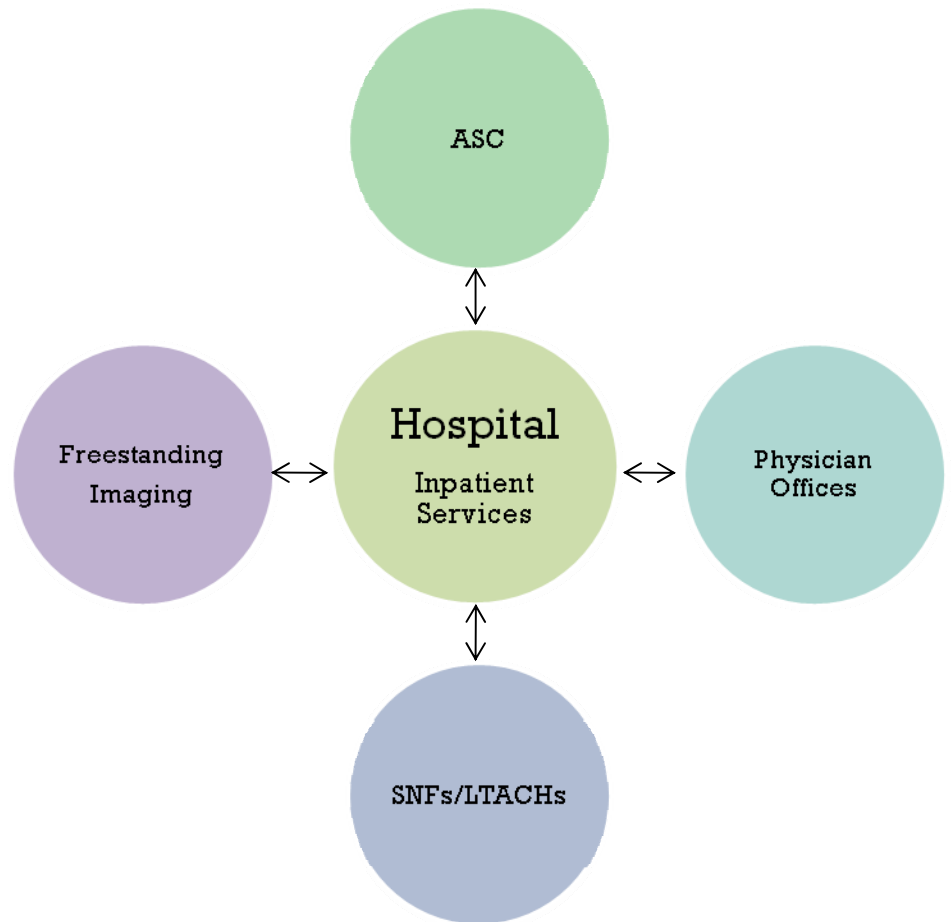


Hospital Trends

Hospitals from 1990s to 2000s

The Un-Bundled Hospital

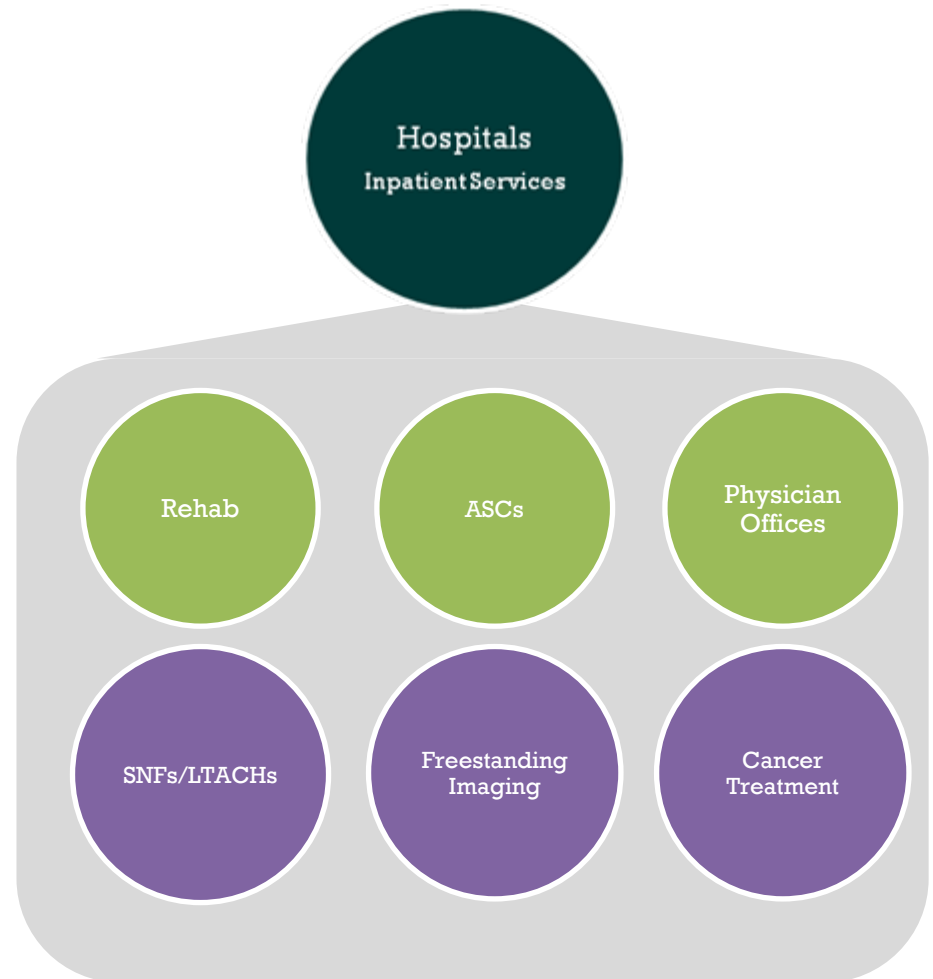
- ❑ Migration of inpatient services to outpatient services
- ❑ Freestanding centers proliferate
- ❑ Fee schedule based reimbursement



Hospital Trends

The Future of Hospitals *The Integrated Hospital*

- ❑ Hospitals will be connected financially and clinically with outpatient services
- ❑ Outpatient services will be integrated with other outpatient services
- ❑ Quality based reimbursement
- ❑ Financial Incentives connected to patient outcomes



Why the Shift from Inpatient to Outpatient?

- ❑ Reimbursement changes
 - Transition from a cost basis to a fee-for-service schedule.

- ❑ Advances in medicine and technology
 - Increasing number of surgical and non-surgical procedures can be done within 23 hour time frame

- ❑ Capacity and service issues
 - OR times and capacity constraints

- ❑ Control of the patient

- ❑ Change in the consumer (patient) sentiments
 - Patient believes increasing costs of healthcare warrant increased quality and accessibility

- ❑ Economic benefits
 - Once CMS regarded ASCs as viable, CMS started reimbursing ASCs at a higher rate

What are Hospital CEO's dealing with?

□ Governmental Issues

- Affordable Care Act
- Accountable Care Organizations (“ACO”)
- Bundle Payments, Episode-Based Payments
- Pay-for-Performance – Quality
- Cuts in CMS payments and DSH
- Obama Care – every American insured

□ Economic Issues

- Unemployment
- Credit and access to capital
- Shortage of physicians
- Shortage of clinical staff

□ Operational Issues

- Decline in I/P and O/P admissions
- Out flow of service lines
- Uncompensated care
- Recruitment and retention of physicians
- Labor pressures
- Managed care leverage
- Intense competition
- Decrease in margins

Hospitals Viability

What can a hospital do?

- ❑ Develop an Integrated Delivery Network (“IDN”)
 - Acquire/Merge Hospitals
 - Acquire Practices
 - Acquire Ancillaries
 - Align or employ physicians

What are Hospital Leaders saying?

“We have a very active acquisition pipeline. The future growth of our company will come from acquisitions.”
Gary Newsome, CEO of HMA

“Not only are we seeing a growing pipeline for acquisitions of hospitals, but in physician practices, surgery centers and other ancillary practices, as well.”
Richard Bracken, CEO of HCA

“We're going to stay very active on the acquisition side and have to stay active in order to be competitive in deals. So, we have the cash available and are fully available to finance acquisitions.”

Jeff Sherman, CFO of Lifepoint

“Nearly 74% of hospital leaders planned to increase physician employment within in the next 12 to 36 months.”
2010 Health Leaders Survey

III. Hospital Acquisitions

Hospital Acquisitions

Historical Hospital Transactions

- ❑ \$74.3 Billion in transaction between 2000 and 2009
- ❑ HCA LBO \$33 Billion
- ❑ CHS purchase of Triad Hospitals \$6.8 billion
- ❑ Excluding HCA, Triad Hospitals, and Quorum: \$34.5 billion in transactions between 2000 and 2009. Average of \$58 million per facility
- ❑ Future transactions will fall into two distinct categories: Healthy and Troubled
- ❑ Healthy hospitals Trade on EBITDA Multiples (6-8x) or Revenue Multiples (.8-1.2x)
- ❑ Troubled hospitals typically trade on Revenue Multiples (.3-.6x)

IV. Ancillary Service Acquisitions

Ancillary Service Acquisitions

Three Legislative Actions are Impacting Physician-owned Ancillary Services

Patient Protection and Affordable Care Act (2010)

- Requires written notification to patients for ancillary services
- Must provide a list of other ancillary providers in the area
- Implemented immediately upon enactment
- Applies to all Stark in-office services

Medicare Improvements for Patients and Providers Act (2008)

- Advanced imaging services must be accredited by an HHS approved accreditation agency
- But be accredited by 1/1/2012

Deficit Reduction Act

- Reduced outpatient imaging reimbursement by as much as 30%

Ancillary Service Acquisitions

Reimbursement Risk Impacts Sustainability and Value

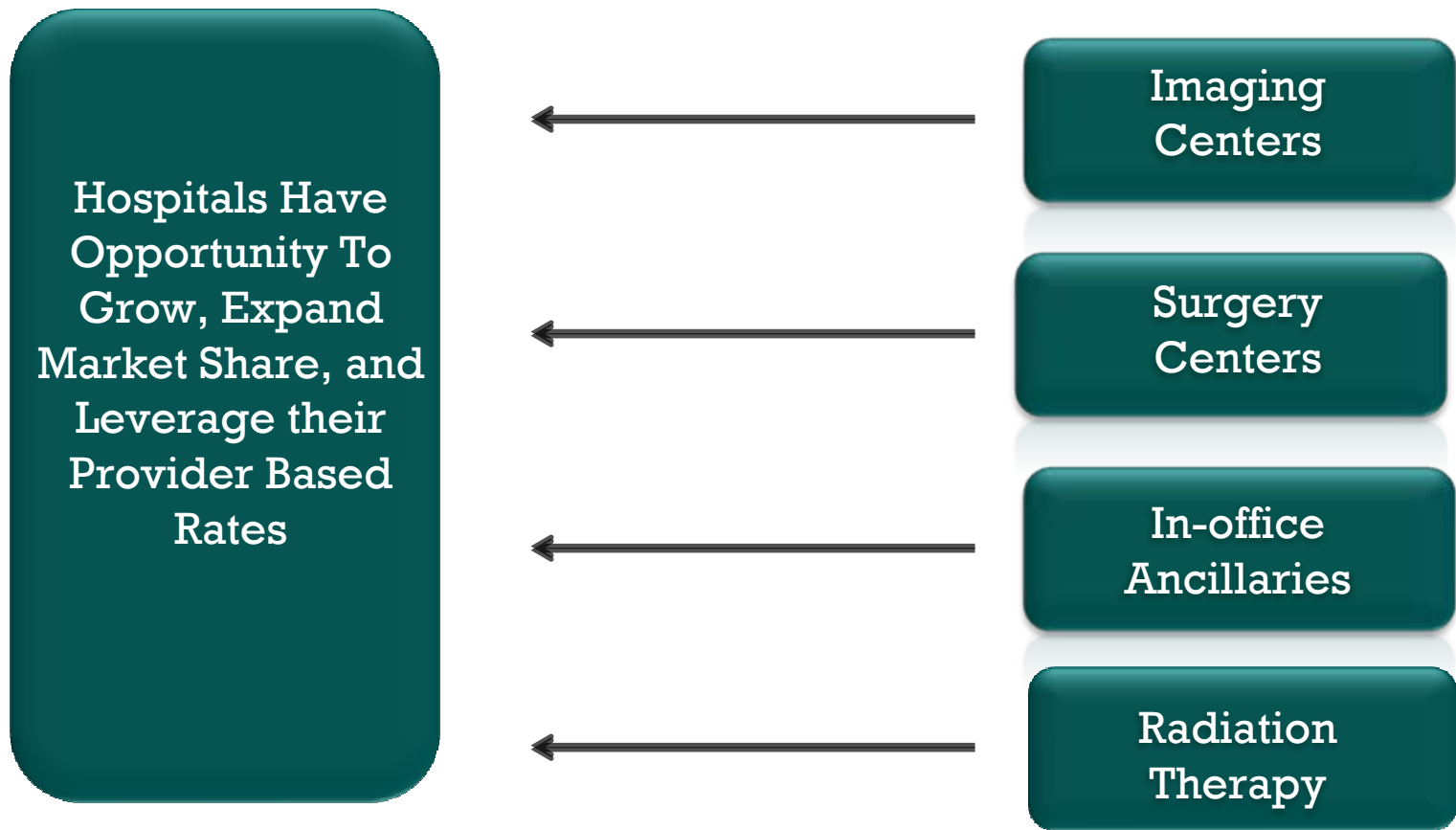
- ❑ *Imaging*: Lower reimbursement, accreditation, utilization requirements
- ❑ *Surgery Centers*: Out of Network and struggling centers
- ❑ *Radiation Therapy and Medical Oncology*: reimbursement pressure on advance imaging
- ❑ *In-office Ancillaries*: declining reimbursement for Nuclear Studies and PET

Why Do Hospitals Pursue these Transactions:

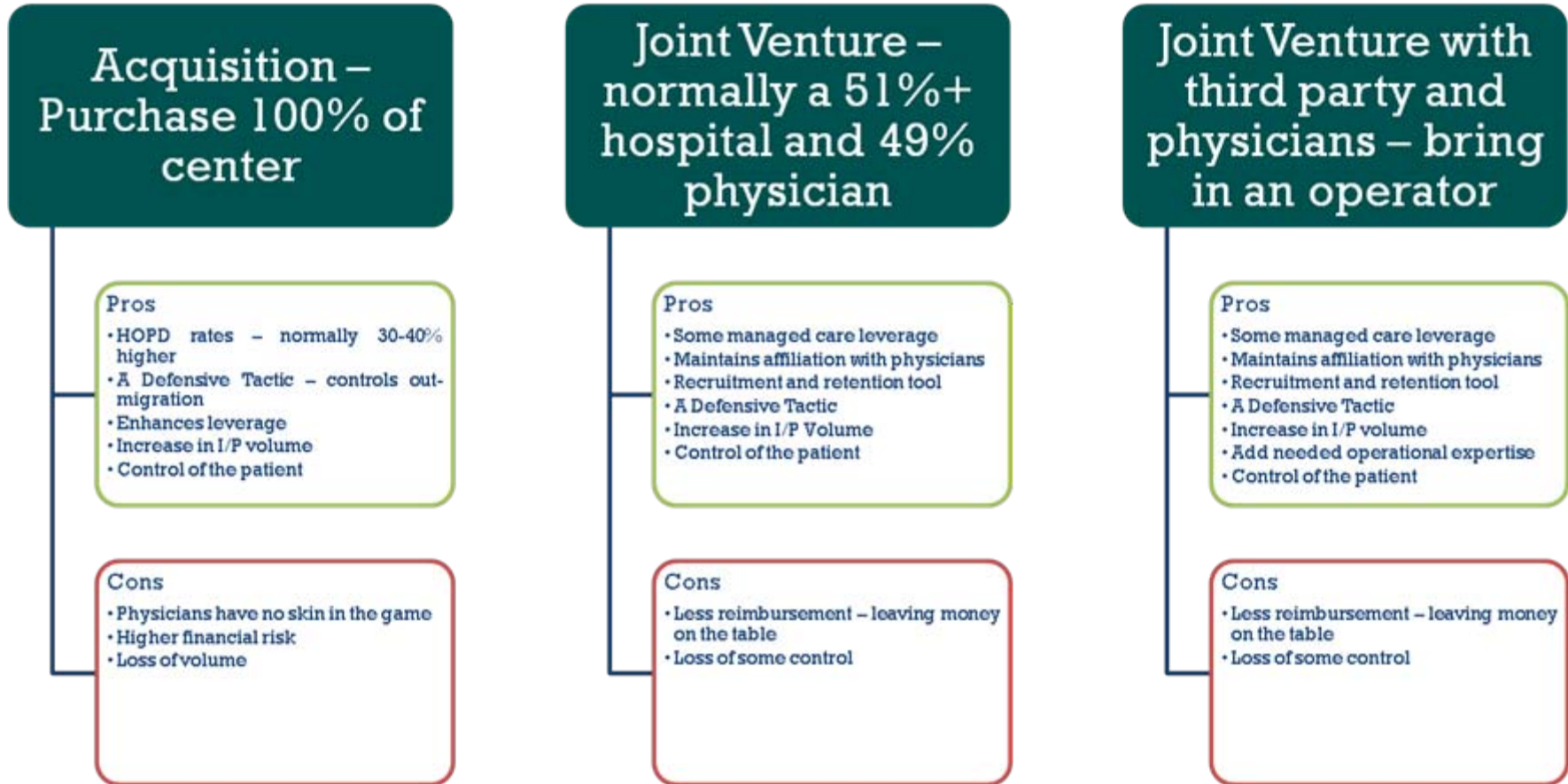
- ❑ Valuations of ancillary services that are at risk are relatively low
- ❑ Hospitals can apply their higher HOPD rates
- ❑ Acquiring ancillary services meets a strategic desire to expand into an integrated network and to prepare for future Accountable Care contracting

Ancillary Service Acquisitions

Hospitals are Integrating Ancillary Services Back into their Networks



Ancillary Service Acquisitions



Others: Lease or real property affiliations

Ancillary Service Acquisitions

Valuation Issues

Fair Market Value of an Ancillary Business

- Ancillary service valuations require the consideration of an income approach, a market approach, and a cost approach
- Cost approach generally represents a floor and is disregarded if income and market approach are higher
- Market approach can be hard to apply, especially given market changes
- Values can be low if the facility is struggling.
- EDITDA multiples can be anywhere from 3x-7x.
- Rules of thumb are dangerous in valuations.
- A valuation cannot incorporate factors attributable directly to the buyer (ie. better contract rates).

V. Physician Practice Acquisitions

Physician Practice Acquisitions

Why are Physician Practice Acquisitions happening?

- Greater desire/need to become employed
- General anxiety among physicians about the future
- High costs of private practice (malpractice, etc.)
- Scheduled cuts in Medicare Physician Fee Schedule
- Structures for integrated models and new payment plans
- Reimbursement cuts in specific specialties (Cardiology)
- Cuts in technical fees related to in-office ancillary services

Physician Practice Acquisitions

Example: The Impact on Cardiology

Professional cuts range from 10-40% over four years



Ancillary (Nuclear studies) cut by 40%



Elimination of consultation codes



60% of surveyed Cardiology practices plan staff layoffs

46% of surveyed Cardiology practices plan to eliminate service lines

17% of surveyed Cardiology practices will stop accepting Medicare

39% of surveyed Cardiology practices are considering integration (sale and employment) into a hospital system

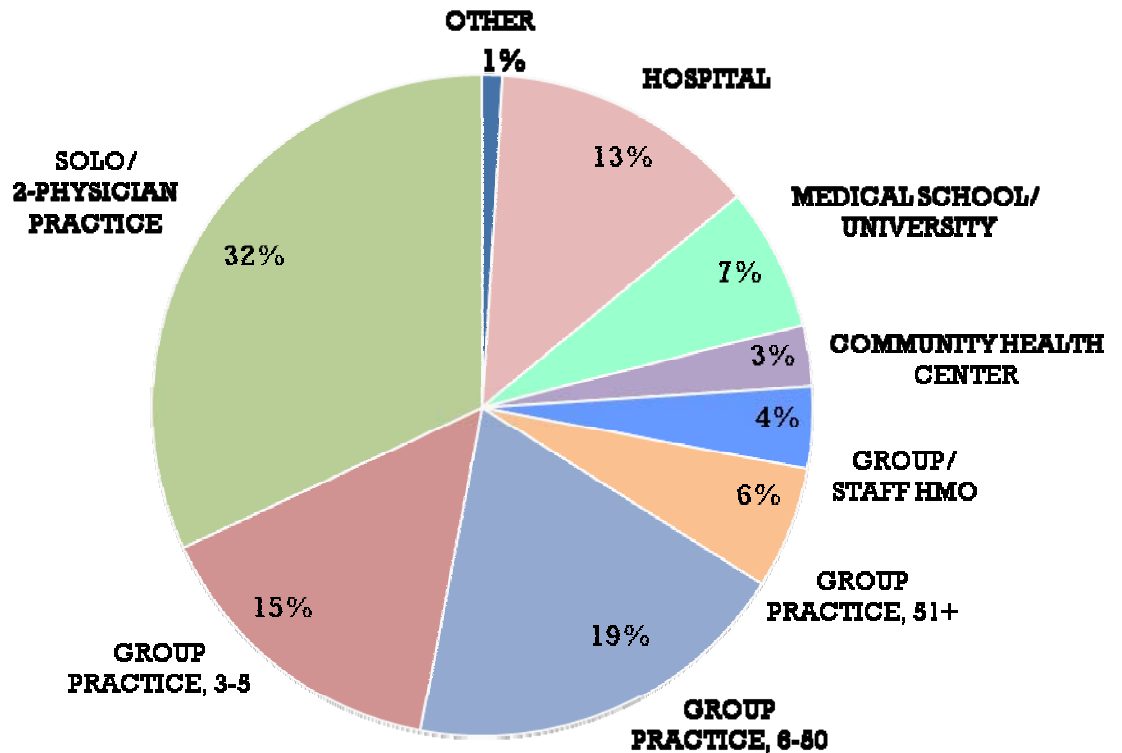
(American Academy of Cardiology)

Physician Practice- Practice Type

United States Physicians by Practice Type in 2005

72% of physicians were independent

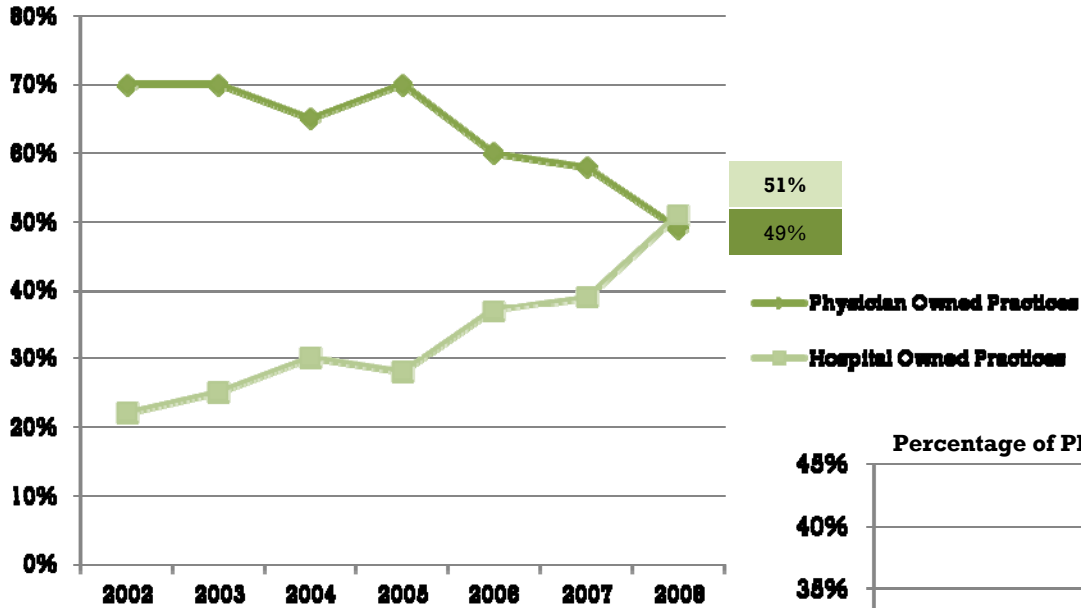
- Nearly one-third of physicians worked in solo or two-physician practices
- 15.0% of physicians worked in groups of three to five physicians
- 19.0% of physicians worked in practices of six to 50 physicians
- The number physicians surveyed who work at a hospital was 13%



(Center for Studying Health System Change)

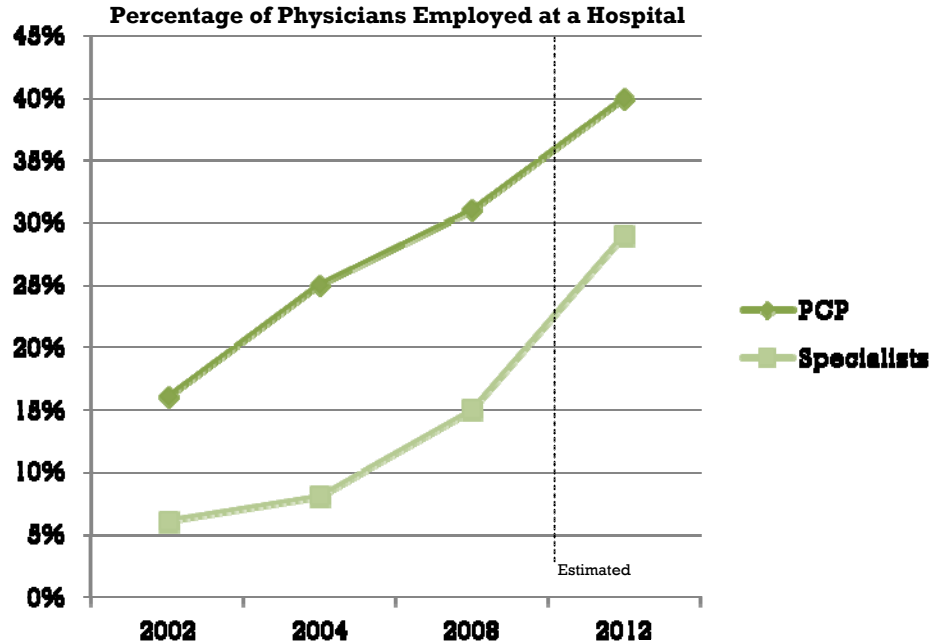
Physician Practice

Physician Practices by Ownership



There has been a significant increase in Hospital acquisitions of Physician Practices

Hospitals are acquiring both primary care physicians ("PCP") and specialists



(MGMA)

Physician Practice Acquisitions

Two Valuation Issues

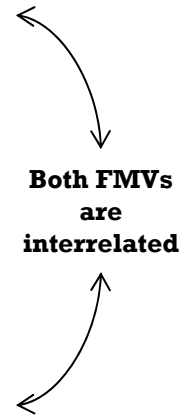
Fair Market Value of the Practice

- A practice typically has little intangible value
- To have a higher FMV, practice must have earnings exceeding physician compensation

Fair Market Value Compensation

- Compensation must be set at FMV
- Compensation should consider practice value

Both FMVs are interrelated



- Valuation process is subject to manipulation/faulty approaches
- Faulty valuations are not a defense for hospitals against penalties

Professional Service Agreements

Why the Growth in Physician Alignment?

Association of American Medical Colleges work force projections indicate the U.S. will have a shortage of 91,500 physicians by 2020.

❑ Non-economic Reasons

- Security – healthcare reform, changing reimbursement
- Quality of Life – older and younger physicians, on average, working less hours

❑ Economic Reasons

- Increased compensation: post employment or contracted arrangement
- Better hospital-based reimbursement
- Replace potential loss of ancillary earnings
- Investment requirements for information technology
- Participate in risk-based contracting, ACOs, quality initiatives
- Integration trend

Physician Service Agreements

May be a result of joint ventures, acquisitions, employment or new independent contractor arrangements

- Administrative Services
- Call Coverage
- Co-management (fixed + variable)
- Management
- ACO models
- Professional/technical splits
- Development
- Billing and Collection
- Leasing Arrangements
- All of the above

Valuation Starting Point

- ❑ Agreement Terms must be understood and are sometimes unclear at valuation stage, define:
 - What services will be provided?
 - How parties will be compensated?
 - Valuation should match the agreement
- ❑ No published standards for physician compensation valuations
- ❑ Appraisal firm should understand
 - Healthcare regulations
 - Valuation principles
- ❑ Regulatory Guidance
 - Fair Market Value
 - Data considerations
- ❑ Business valuation standards - a good place to start

Fair Market Value Definition

- ❑ Based on the anti kickback statute, and other healthcare regulations and guidelines, any transaction between hospitals and physicians must be at Fair Market Value.
- ❑ IRS definition - *“the amount at which property would change hands between a willing seller and a willing buyer when the former is not under any compulsion to buy and the latter is not under any compulsion to sell and when both have reasonable knowledge of the relevant facts.”*
- ❑ Provides a conclusion which should not reflect consideration for value or volume of referrals.
- ❑ Rely upon generally accepted valuation theory – consider multiple valuation methodologies and approaches: cost, market and income approach

Matching Analysis to Agreement Services

- ❑ It is now likely a combination of several valuations will be required for one agreement, choose the right data/analysis to reflect each of the services
- ❑ Multiple, objective surveys suggested
- ❑ Data should not reflect referral relationships
 - Medical Director data
 - On-Call data
 - Competing Hospitals – Extra Caution
- ❑ Management and Billing – cost to replicate when not typical
- ❑ Quality – utilize P4P comparables (found in several types of arrangements)
 - Stick to regulatory guidance when it comes to paying for quality
 - More on this later in presentation

Clinical Compensation Analysis

- ❑ Historical Compensation drawbacks
- ❑ Income Approach challenges and relevance
- ❑ Cost-Market Approach – benchmark productivity

Common Misuse of Survey Data - \$/WRVU

EP Cardiology Example – Median \$/WRVU

- MGMA 90th Reported Compensation= \$777,461
- MGMA Median Reported \$/WRVU = \$45.85
- MGMA 90th Reported WRVUs = 21,230
- Calculated Compensation = \$973,283 (25% above 90th)

Always plug in your proposed compensation to expected production to calculate expected compensation

EP Cardiology Example – 90th \$/WRVU

- MGMA 90th Reported Compensation= \$777,461
- MGMA 90th Reported compensation/WRVU = \$74.24
- MGMA 90th Reported WRVUs = 21,230
- Calculated Compensation = \$1,576,190 (103% above 90th)

Tuomey Case Lessons

- ❑ Do not pay fulltime benefits/malpractice premiums for part-time services
- ❑ Physicians paid above the 75th percentile of market data should demonstrate productivity consistent with other physicians in this percentile
- ❑ Understand arrangements where the provider is not making money
- ❑ Compensation for administrative duties should be based on significant duties
- ❑ Valuation methodology is as important as total compensation
- ❑ Creative arrangements need to be carefully constructed, the government suggests getting an OIG Opinion
- ❑ No opinion shopping, carefully choose your valuation firm

Paying For Quality

- ❑ Hospitals critical success factors – shifting towards quality of clinical performance
- ❑ In late 2003, CMS and Premier Inc. launched the Hospital Quality Incentive Demonstration (HQID) for over 250 hospitals offering financial incentives for the top 20% of hospitals.
- ❑ Congress authorized the development and implementation of a value-based purchasing (VBP) program to replace the RHQDAPU program which reports quality (the precursor).
 - Performance (Incentives) would be based on either improving historical performance or attaining superior outcomes compared with national benchmarks.
 - Proposed ACOs include similar guidelines
- ❑ Numerous third party payors provide P4P payments to hospitals and physicians
- ❑ Executive compensation may soon be tied to quality outcomes!

Results of Quality Initiatives

- ❑ Hospital Quality Incentive Demonstration (HQID) - Raised overall quality by an average of 17% over its first four years with total payments in excess of \$36.6 million and majority of hospitals improved their quality of care across the board
- ❑ In 2008, the Robert Wood Johnson Foundation and California HealthCare Foundation reported results of a national program that tested the use of financial incentives to improve the quality of health care.
 - Tested seven projects across the nation that adjusted compensation based on performance scores – hospitals and physicians.
 - Among the notable findings from the program were that:
 - Financial incentives motivate change
 - Alignment with physicians is a critical activity for quality outcomes
 - Public reporting is a strong catalyst for providers to improve care
- ❑ Less favorable findings and why

Regulatory Guidance

OIG & CMS guidelines provide a solid foundation regarding structuring quality care arrangements:

- Quality measures should be clearly and separately identified
- Quality measures should utilize an objective methodology verifiable by credible medical evidence
- Quality measures should be reasonably related to the hospital's practice and consider patient population
- Do not consider the value or volume of referrals. Consider an incentive program offered to all applicable providers
- Incentive payments should consider the hospital's historical baseline data and target levels developed by national benchmarks
- Thresholds should exist where no payment will accrue and should be updated annually based on new baseline data.
- Hospitals should monitor the incentive program to protect against the increase in patient fees and the reduction in patient care
- Incentive payments should be set at FMV

PSA Valuation Take Aways

- ❑ Understand agreement Terms
 - What are the services?
 - How is the compensation stated in the agreement (valuation should match)?
- ❑ Consider all facts and circumstances
- ❑ Rely upon appropriate data
- ❑ Use multiple valuation methodologies
- ❑ Commercially Reasonable
 - Facility needs – overlap of services?
 - Operational assessment
 - Understand total hours

Compliance Infrastructure Tip

Establish Internal Thresholds

1

Calculators by specialty type and service

2

Third party opinion on individual arrangements falling outside calculator

- Internal Compensation Calculators are based on systematic and unbiased overall guidelines which eliminate the user's ability to include its results
 - Each indication of value considers the specialty and reflects the service provided by the physician.
 - Utilizes multiple, objective national surveys reflecting clinical compensation and administration compensation and medical director compensation by specialty.
 - Each indication delineates between employed and independent contractor agreements.

VMG Health Contact

Jim Rolfe

Managing Director of
Transaction Advisory

rolfe@vmghealth.com

214-369-4888

Jen Johnson

Partner

jenj@vmghealth.com

214-369-4888