IMPACT ON VALUATION: TRENDS IN TRANSACTIONS AND PHYSICIAN ALIGNMENT

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DIRECTOR

OCTOBER 17TH, 2017
TRANSACTIONS AND PARTICIPANTS
## Transactions and Participants

Overall Deal Volume Has Remained Steady

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Healthcare</td>
<td>17</td>
<td>16</td>
<td>21</td>
<td>35</td>
<td>41</td>
<td>-6%</td>
<td>31%</td>
<td>67%</td>
<td>17%</td>
</tr>
<tr>
<td>Home Health &amp; Hospice</td>
<td>35</td>
<td>35</td>
<td>65</td>
<td>41</td>
<td>55</td>
<td>0%</td>
<td>86%</td>
<td>-37%</td>
<td>34%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>107</td>
<td>84</td>
<td>79</td>
<td>101</td>
<td>90</td>
<td>-21%</td>
<td>-6%</td>
<td>28%</td>
<td>-11%</td>
</tr>
<tr>
<td>Laboratories, MRI &amp; Dialysis</td>
<td>47</td>
<td>36</td>
<td>32</td>
<td>51</td>
<td>41</td>
<td>-23%</td>
<td>-11%</td>
<td>59%</td>
<td>-20%</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>188</td>
<td>225</td>
<td>288</td>
<td>354</td>
<td>337</td>
<td>20%</td>
<td>28%</td>
<td>23%</td>
<td>-5%</td>
</tr>
<tr>
<td>Managed Care</td>
<td>28</td>
<td>15</td>
<td>22</td>
<td>41</td>
<td>21</td>
<td>-46%</td>
<td>47%</td>
<td>86%</td>
<td>-49%</td>
</tr>
<tr>
<td>Physician Medical Groups</td>
<td>70</td>
<td>65</td>
<td>58</td>
<td>78</td>
<td>119</td>
<td>-7%</td>
<td>-11%</td>
<td>34%</td>
<td>53%</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>18</td>
<td>17</td>
<td>19</td>
<td>28</td>
<td>40</td>
<td>-6%</td>
<td>12%</td>
<td>47%</td>
<td>43%</td>
</tr>
<tr>
<td>Other Services</td>
<td>125</td>
<td>105</td>
<td>129</td>
<td>174</td>
<td>196</td>
<td>-16%</td>
<td>23%</td>
<td>35%</td>
<td>13%</td>
</tr>
<tr>
<td>Total</td>
<td>635</td>
<td>598</td>
<td>713</td>
<td>903</td>
<td>940</td>
<td>-6%</td>
<td>19%</td>
<td>27%</td>
<td>4%</td>
</tr>
</tbody>
</table>


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**VMG Health**

We Value Healthcare
TRANSACTIONS AND PARTICIPANTS

Health System Consolidations

Source: VMG observations and research
TRANSACTIONS AND PARTICIPANTS

Payor Consolidations

2015-Q3

Announced Q3 2015 - $37B

Finalized August 1, 2015

2015-Q4

Announced Q3 2015 $54B

2016-Q1

CENTENE Corporation

Health Net

Closed Q1 2016

2016-Q2

DOJ blocks:

Announced Q3 2015 $54B

Source: VMG observations and research
TRANSACTIONS AND PARTICIPANTS

Cross Vertical Consolidations & Divestitures

Source: VMG observations and research
Transactions and Participants

Joint Ventures Across Vertical Landscape

- Acute Care
- ASC’s
- Behavioral
- Diagnostic Imaging
- Dialysis
- Lab Services
- Managed Care
- Physical Therapy
- Physician Services
(Re)Entrance of Private Equity Sponsored Practice Management Co’s

- Physician Practices – primary care, specialists, concierge, etc.
  - Health Systems – in market deal/typical “constraints”
  - PE backed “management companies” – PPM 2.0?
  - Technology driven, keeping docs independent

- Examples:
  - ~$420 mm in 3 rounds
  - ~$75 mm / 5 investors

Source: VMG observations and research
## Observations

1. Healthcare reform initiatives (cost/scale) are expensive and still driving strategy (battle for market share), joint ventures are mitigating risk/avenue for moving up value chain.

2. Existing FFS models still dominate, and determine viability.

3. Physician groups are very much in focus - health systems affiliated physician groups are largest part of market.

4. PPM v2.0 and Private Equity are keeping valuations high.

5. Health Systems continue to focus on compliance....
APPLICABLE LAWS AND FAIR MARKET VALUE
**APPLICABLE LAWS**

The healthcare industry is heavily regulated and these regulations help guide the transaction environment.

<table>
<thead>
<tr>
<th>Law</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stark Law</strong> (42 CFR § 411.351)</td>
<td>Prohibits physicians from referring a patient to an entity with which the physician has a financial relationship, when the referral is for the furnishing of certain designated health services (DHS) (e.g., lab, PT, OT, radiology, DME, inpatient services, etc.). Civil Penalty (payment disallowance, exclusion &amp; CMP liability, may be violation of False Claims Act)</td>
</tr>
<tr>
<td><strong>Anti-Kickback Statute</strong> (42 U.S.C. § 1320a-7b)</td>
<td>Prohibits the payment or remuneration in exchange for, or in order to induce, the referral of patients or other businesses which are reimbursed under the Medicare program. Criminal Penalty (remuneration is anything of value)</td>
</tr>
<tr>
<td><strong>Health Care Fraud Statute</strong> (18 U.S.C. § 1347)</td>
<td>Knowingly and willfully execute/attempt a scheme or artifice to: defraud health care benefit program, or obtain by false or fraudulent pretenses property under custody/control of program in connection with delivery or payment for items or services. Criminal Penalty (10 year imprisonment, restitution, fine)</td>
</tr>
</tbody>
</table>
APPLICABLE LAWS

(continued)

False Claims Act
(31 U.S.C. § 3729(a))

- Generally, a false/fraudulent claim/statement made or caused to be made for payment to the United States. Includes conspiracy and “reverse” false claim provisions.
- Claim must be submitted knowingly (actual knowledge, deliberate ignorance, reckless disregard, no specific intent to defraud required)
- Remedies include: automatic treble damages, mandatory $5,000 - $11,000 penalty per false claim, costs, damages not required

Civil Monetary Penalties Law
(42 U.S.C. § 1320a-7a(a))

- Health and Human Services - Office of Inspector General administrative remedy
- Civil Penalty (Permissive exclusion and money damages for specific violations like payment or receipt of illegal kickbacks
APPLICABLE LAWS

Fair Market Value Prominent in Healthcare Settlements

1. Huge surge in Qui Tam suits & material settlements

2. Growth in federal funding for fraud and abuse investigations

3. Yates memo and OIG alerts warn individuals are at risk criminally and financially

Recent attempts by government to expand liability include the following: Yates Memorandum, Parallel Proceeding, Travel Act (18 U.S.C § 1952)
FAIR MARKET VALUE CASE TAKE-AWAYS

FMVs Gone Wrong

1. Services Must Be Provided

2. Do Not Base Pay on Referrals
   *United States ex rel. Drakeford, M.D. v. Tuomey (2013)*

3. Arrangement Must Be Reasonable
   *United States v. Campbell (2011)*

4. Must Reflect Actual Deal

5. Listen to Good Advice
   *United States ex rel. Pogue v. Diabetes Treatment Centers for America (2008)*
## Fair Market Value Case Take-Aways

<table>
<thead>
<tr>
<th>DOs</th>
<th>DON’Ts</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Must consider all facts and circumstances</td>
<td>✗ Inaccurate assumptions are not okay</td>
</tr>
<tr>
<td>✓ Must ensure calculation accuracy</td>
<td>✗ No opinion shopping</td>
</tr>
<tr>
<td>✓ Periodically reevaluate opinions</td>
<td>✗ Do not consider referral volume or value when determining FMV in healthcare setting</td>
</tr>
<tr>
<td>✓ Valuation should match/align with agreement</td>
<td></td>
</tr>
<tr>
<td>✓ Examine economic and operational reasonability of an arrangement (commercially reasonable)</td>
<td></td>
</tr>
</tbody>
</table>
Physician Services Agreements & Other Considerations
PHYSICIAN SERVICES AGREEMENTS & OTHER CONSIDERATIONS

Trending Valuation Topics

1. Commercial Reasonableness

2. Hospital-Owned Physician Practice Losses

3. Stacking Compensation
Initial definition by Centers for Medicare and Medicaid Services:

An arrangement which appears to be “a sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of any potential referrals.” (63 Federal Register 1700 (January 9, 1998)

According to Stark II:

An arrangement will be considered “commercially reasonable” in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential DHS (designated health services) referrals. (69 Federal Register 19093 (March 26, 2004)
PHYSICIAN SERVICES AGREEMENTS & OTHER CONSIDERATIONS

1. Commercial Reasonableness
2. Physician Practice Losses
3. Stacking Compensation

- Pre-cursor to determining FMV
- Arrangement must make business sense absent considering referrals
- Hospital leadership must understand this standard since they will primarily be the individuals who assess CR.

**Sample** considerations:

- *Operational assessment* – *does the community need this service/number of specialists?*
- *Physician requirements* – *are the number of service hours required?*
- *Financial options* – *can equipment be leased from a third party vendor at a better rate than from a physician group?*

- Counsel’s role – did hospital leadership walk through the business considerations?
- Valuation firm role – is the compensation at FMV?
**Economic/Financial Reasonableness**

1. Essential to the operations of the organization?
2. Is there a defined and specific purpose for the subject arrangement?
3. Does the subject arrangement represent a sensible and prudent business arrangement, excluding the consideration of referrals?
4. Have current economic conditions been considered in relation to the subject arrangement?
5. Does the arrangement further the strategic and financial goals of the Organization.

**Operational Reasonableness**

1. Has the Organization’s size, patient population, and patient demand been considered (patient acuity and need warrants services)?
2. Does the arrangement further patient care, patient satisfaction, and overall public benefit?
3. Are there safeguards to reduce and eliminate the possibility of fraud, prohibited referrals, waste, or abuse?
4. Has a written agreement containing material terms of the arrangement been developed?

**Physician/Clinical Requirements**

1. Is a physician required to perform the services?
2. Is a physician of a particular specialty required to perform the services?
3. Does the physician possess the specialized training, qualifications, and experience required to provide the services?
4. Are the duties being requested of the physician under the subject arrangement duplicative with any other duties performed by the Organization’s personnel?
Practice losses have recently been a focal point in several cases and settlements.

VMG clients (hospitals, health systems, and law firms) have varying perspectives on this topic.

Recent settlements noted that hospital/health system employers were losing substantial dollars on physician practices

- United States ex rel. Reilly v. North Broward Hospital District
MGMA financial data for hospital-owned physician practices shows substantial losses are the norm.

The losses appear to be heavier in the non-primary care setting (surgical and non-surgical categories).

<table>
<thead>
<tr>
<th>Specialty</th>
<th>N*</th>
<th>10th</th>
<th>25th</th>
<th>50th</th>
<th>75th</th>
<th>90th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multispecialty</td>
<td>132</td>
<td>$(480,579)</td>
<td>$(325,150)</td>
<td>$(184,918)</td>
<td>$(68,781)</td>
<td>$12,298</td>
</tr>
<tr>
<td>Nonsurgical</td>
<td>525</td>
<td>$(569,265)</td>
<td>$(415,902)</td>
<td>$(249,995)</td>
<td>$(78,529)</td>
<td>$51</td>
</tr>
<tr>
<td>Primary Care</td>
<td>1,002</td>
<td>$(442,560)</td>
<td>$(281,461)</td>
<td>$(162,696)</td>
<td>$(48,413)</td>
<td>$5,531</td>
</tr>
<tr>
<td>Surgical</td>
<td>377</td>
<td>$(733,495)</td>
<td>$(515,155)</td>
<td>$(326,434)</td>
<td>$(179,424)</td>
<td>-</td>
</tr>
</tbody>
</table>

*N reflects the number of groups responding.

Source: Data included in the table is sourced from MGMA’s 2017 Cost & Revenue Survey.
More specialized surgical practices appear to have the largest losses per physician FTE

<table>
<thead>
<tr>
<th>Specialty</th>
<th>N*</th>
<th>10th</th>
<th>25th</th>
<th>50th</th>
<th>75th</th>
<th>90th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>115</td>
<td>(615,561)</td>
<td>(492,893)</td>
<td>(393,753)</td>
<td>(240,891)</td>
<td>(48,587)</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>23</td>
<td>(1,736,216)</td>
<td>(919,390)</td>
<td>(558,723)</td>
<td>(399,204)</td>
<td>(10,898)</td>
</tr>
<tr>
<td>CV Surgery</td>
<td>27</td>
<td>(869,893)</td>
<td>(733,112)</td>
<td>(507,867)</td>
<td>(334,763)</td>
<td>(9,345)</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>69</td>
<td>(766,473)</td>
<td>(541,241)</td>
<td>(363,682)</td>
<td>(211,001)</td>
<td>-</td>
</tr>
<tr>
<td>Urology</td>
<td>25</td>
<td>(879,369)</td>
<td>(549,769)</td>
<td>(433,208)</td>
<td>(155,908)</td>
<td>(79,162)</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>509</td>
<td>(462,624)</td>
<td>(300,174)</td>
<td>(174,222)</td>
<td>(77,785)</td>
<td>1,152</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>157</td>
<td>(403,806)</td>
<td>(268,968)</td>
<td>(173,426)</td>
<td>(107,334)</td>
<td>(9,837)</td>
</tr>
</tbody>
</table>

*N reflects the number of groups responding.

Source: Data included in the table is sourced from MGMA's 2017 Cost & Revenue Survey.
Some practical reasons for hospital-owned physician practice losses may include:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payor Mix Changes</td>
<td>Employed physicians have little control over the payor mix of their patients. They must treat all patients that enter their practice / facility.</td>
</tr>
<tr>
<td>Expense Allocations</td>
<td>Hospitals often must allocate corporate expenses to all affiliated entities. Such expenses may not typically exist in an independent practice setting inflating the expense profile of the practice.</td>
</tr>
<tr>
<td>Post-Transaction Structural Decisions</td>
<td>Post-acquisition, hospitals often relocate in-office ancillaries to outpatient department settings reducing the available revenues for the practice.</td>
</tr>
<tr>
<td>Specialty Specific Causes</td>
<td>Many hospital-based specialties require subsidies as these physicians do not have any control over both payor mix and patient volumes/schedule.</td>
</tr>
</tbody>
</table>
PHYSICIAN SERVICES AGREEMENTS & OTHER CONSIDERATIONS

1. Commercial Reasonableness
   - Administrative Services
   - P4P, Bundled, & ACO Payment models
   - Billing and Collection Management Development

2. Physician Practice Losses
   - Call Coverage
   - PSA Model ($/WRVU + expenses)
   - Medical Director

3. Stacking Compensation
   - Co-management (fixed + variable)
   - Professional/technical splits
   - AMCs Tier 1, 2, 3 (Sunshine Provision)
   - Subsidy
   - Clinical Services
   - Telemedicine Hub to spoke Hub to provider System to Vendor

FMV and commercial reasonableness continues to gain importance in recent settlements.

Pay-for-Performance adds new complexities to “normal” deals.
Physicians can provide a variety of services

- Clinical, Procedural or Consulting Services
- On-Call Availability
- Administrative Services
- Leadership Roles

Compensation should be established in a manner that provides appropriate consideration for the value of each service while not duplicating or overstating the income.

- Is market survey data a basis for establishing compensation? If so, do you know what is and isn’t included in those reported data sources?

- Is the expectation for aggregate hours worked reasonable?
QUESTIONS?

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