

Physician Hospital Joint Ventures & Local Market Factors

AICPA Healthcare Conference

September 18, 2008

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Agenda

- Discuss drivers of collaboration
- Discuss types of collaboration, key features and challenges associated with each
- Examine local historical, demographic, reimbursement and other factors that influence value
- Discuss typical valuation methodologies and the reasons for their use

Reasons for Collaboration

- Physicians are increasingly looking for ways to supplement revenues
- Regulations change and either close old avenues or open new ones
- Need to involve a higher level of clinical expertise in the management of a particular service

Regulatory Hurdles

➤ Stark

- Issue if the service falls into one of the 11 categories of Designated Health Services (DHS)
- Nuclear medicine added 1/1/07
- If a DHS is involved, try to fit into a safe harbor
- No intent requirement, this is a strict liability regulation

Regulatory Hurdles

➤ Stark III

- Effective December 5, 2007
- Eliminates safe harbor for compensation arrangements – this is a two-edged sword
- “Stand in the shoes” provision could have far reaching implications
- New rules regarding block leases for space and equipment

Regulatory Hurdles

- **Stark III – Part Two issued July 31, 2008**
 - Effective October 1, 2008 for the most part
 - Per click leases prohibited for space and equipment – implementation delayed until October 1, 2009
 - Changed the definition of “entity” which for all intents and purposes killed “under arrangements” also delayed until October 1, 2009

Regulatory Hurdles

➤ **Anti-kickback Statute**

- Must ensure that arrangement is not structured in a manner that induces or compensates for referrals
- Criminal statute that can include imprisonment in addition to fines
- Were particularly tricky for per “click” or per procedure compensation arrangements – these are practically impossible to structure given the recent CMS regulations

Regulatory Hurdles

- **Internal Revenue Service (IRS)**
 - Can prompt private inurement or excess benefit issues if the deal is too lucrative to private individuals
 - Not for profit organizations must be cautious about participating in deals that could jeopardize their tax-exempt status

Forms of Collaboration, Key Features and Challenges

Joint Venture – Plain Vanilla

- Key Features
 - Involves transfer of a portion of ownership to another entity
 - Typically use an income approach based on anticipated cash flows of the venture
- Pros
 - Easily understood
 - Tried and true structure
- Cons
 - Generally prohibited for DHS
 - Requires upfront capital and/or debt

Forms of Collaboration, Key Features and Challenges

Leases – Now must be block for the most part

➤ Key Features

- Physicians purchase a specified number of hours or days of access to a specific piece of equipment– must be on a block basis to survive regulatory challenge currently
- Most commonly utilized for imaging equipment and cath labs
- Typically use an income approach based on anticipated cash flows of the venture
 - Estimate total cost to provide service
 - Add fair market return, generally 10% - 20%
 - Divide by relevant block of time

Forms of Collaboration, Key Features and Challenges

Leases – Block continued

- Pros
 - No upfront capital required
 - Appealing if there is not enough volume to support full-time
- Cons
 - Difficult to structure from a regulatory standpoint
 - Fairly easy for competitors to duplicate

Forms of Collaboration, Key Features and Challenges

Management Agreements

➤ Key Features

- Current movement toward management services with a quality incentive
- Typically use a blend of income and market approaches
 - Hourly rate analysis for administrative portion – no safe harbor here now
 - Either cost to replace or fixed fee calculated as a percent of revenue like P4P for the quality portion

Forms of Collaboration, Key Features and Challenges

Management Agreements – continued

- Pros
 - No change in ownership
 - No upfront capital involved
 - Allows physicians formal input into operations
- Cons
 - Upside reward to physicians is minimal
 - Doesn't generally accomplish the most significant objective – to increase revenue stream
 - Quality based compensation is controversial

Forms of Collaboration, Key Features and Challenges

“Under Arrangements”

- Key Features
 - Limited to rural facilities or non-referral sources such as radiologists – the rest will need to be unwound
 - Entire service line or department management was outsourced – both upside and downside risk assumed
 - Historically involved outpatient surgery, imaging or cath labs
 - Hospital remained the provider of care so reimbursement was hospital based

Forms of Collaboration, Key Features and Challenges

“Under Arrangements”

- Key Features - cont.
 - Used either a market or income based approach to develop a fee schedule
 - Market approach using the Medicare fee schedule as the starting point
 - Could supplement the market approach with other arrangements in the market if available
 - Income approach using historical or projected costs plus a fair market return

Forms of Collaboration, Key Features and Challenges

“Under Arrangements” – continued

➤ Pros

- Allowed collaboration while protecting hospital based reimbursement
- Facilitated greater clinical knowledge base into operations
- Could promote better quality outcomes
- Monetized assets for hospital
- Freed up hospital management time

Forms of Collaboration, Key Features and Challenges

“Under Arrangements” – continued

➤ Cons

- Very challenging to develop model and balance goals of participants with regulatory challenges
- Unproven model - risk of a regulatory body prohibiting its creation in the near future – done effective October 1, 2009
- Generally equipment was sold to the managing party so unwinding may be difficult

Conclusions on Type of Model

- Analysis is a very “facts and circumstances” decision
- Risk tolerance of the hospital and the physicians must be understood – both financial and regulatory risk
- Competent legal counsel experienced in these types of healthcare ventures must be engaged
- Seek an OIG opinion if in doubt – it will strengthen your case if the transaction gets challenged down the road

Conclusions on Type of Model

- Regulations change so frequently – ensure that “unwind” provisions are addressed in the operating agreement

Remember – if it sounds too good to be true – it probably is or will soon be deemed so!

Healthcare Market Structure And Its Implication For Valuation [and Location] Of Privately Held Provider Entities*

OR

If It Works In Miami, It May Not Work In Boston But It Might
Work In Dallas!!

Mark O. Dietrich. CPA/ABV

**Business Valuation Review, Summer, 2008, Peer Reviewed*

Importance

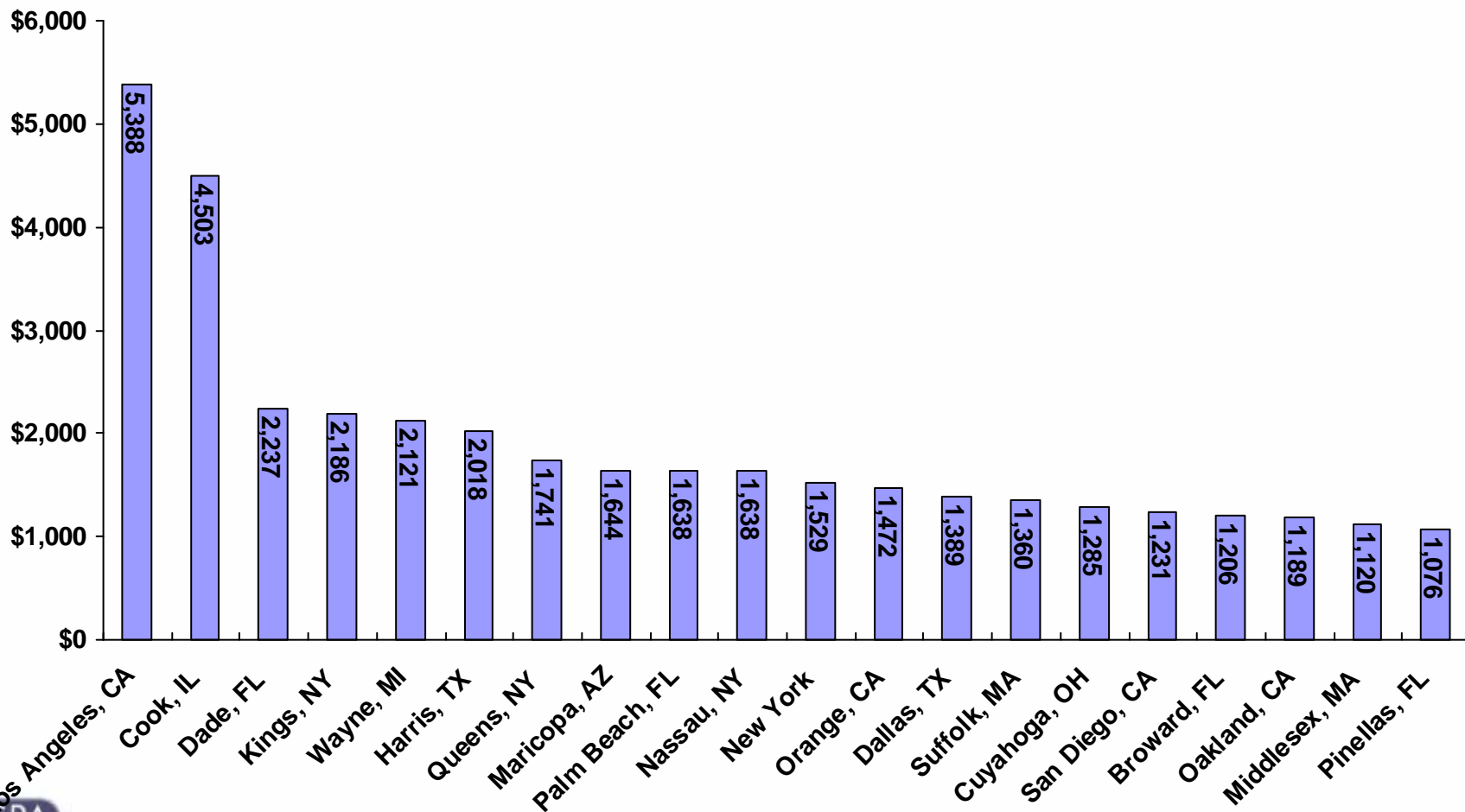
- Healthcare Industry strategies tend to originate in one area and spread to others: Managed Care & Integrated Delivery Systems started on the West Coast, for example. Sort of an “Old Economy” version of Viral Marketing.
- Although Strategies, like Viruses, may be successful at their origin point, they are not always successful everywhere!
- In the Business of Healthcare, specific Market Conditions suggest whether a Strategy can be replicated, much the same way that Environmental Conditions affect the ability of a Virus to replicate and spread.

The Factors

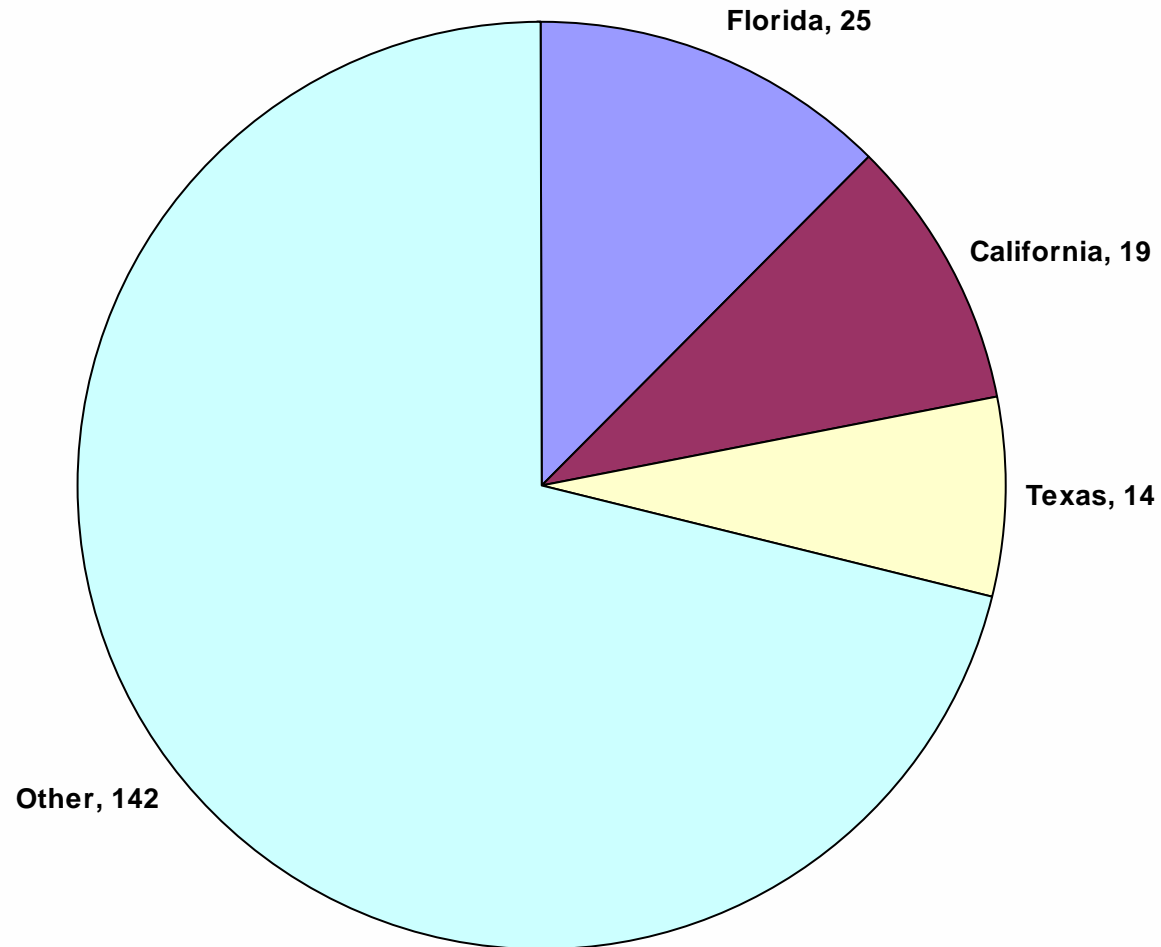
- High Medicare Spending
- Presence and market strength of **Blue Cross** plans
- Overall Health Insurer Concentration
- Degree of market strength of local **Nonprofit Health Insurers** versus **For-profit Health Insurers**,
- The degree of market strength of local **Nonprofit Hospitals** versus **For-profit Hospitals**
- Certificate of Need laws and
- Other local demographic and economic factors.

High Medicare Spending

20 Largest Counties for 2005 Medicare Spending (\$Billions)



of Top 200 Counties for Part A & B Total Spending



Market Strength Of Blue Cross Plans & Overall Health Insurer Concentration

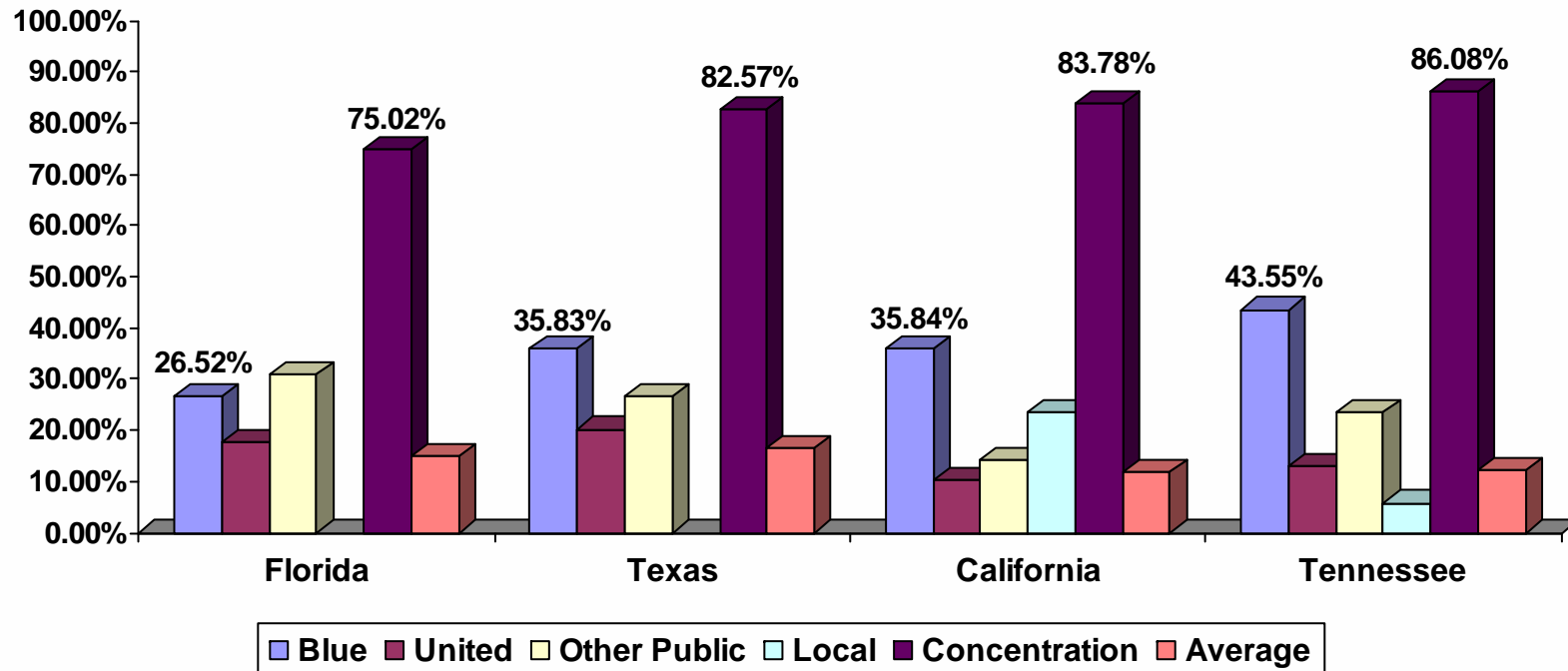
Market Concentration is defined here as the total market share of the Blue Plans, Public Health Insurers and large local health insurers

And a Tip of the Hat to JD Epstein!



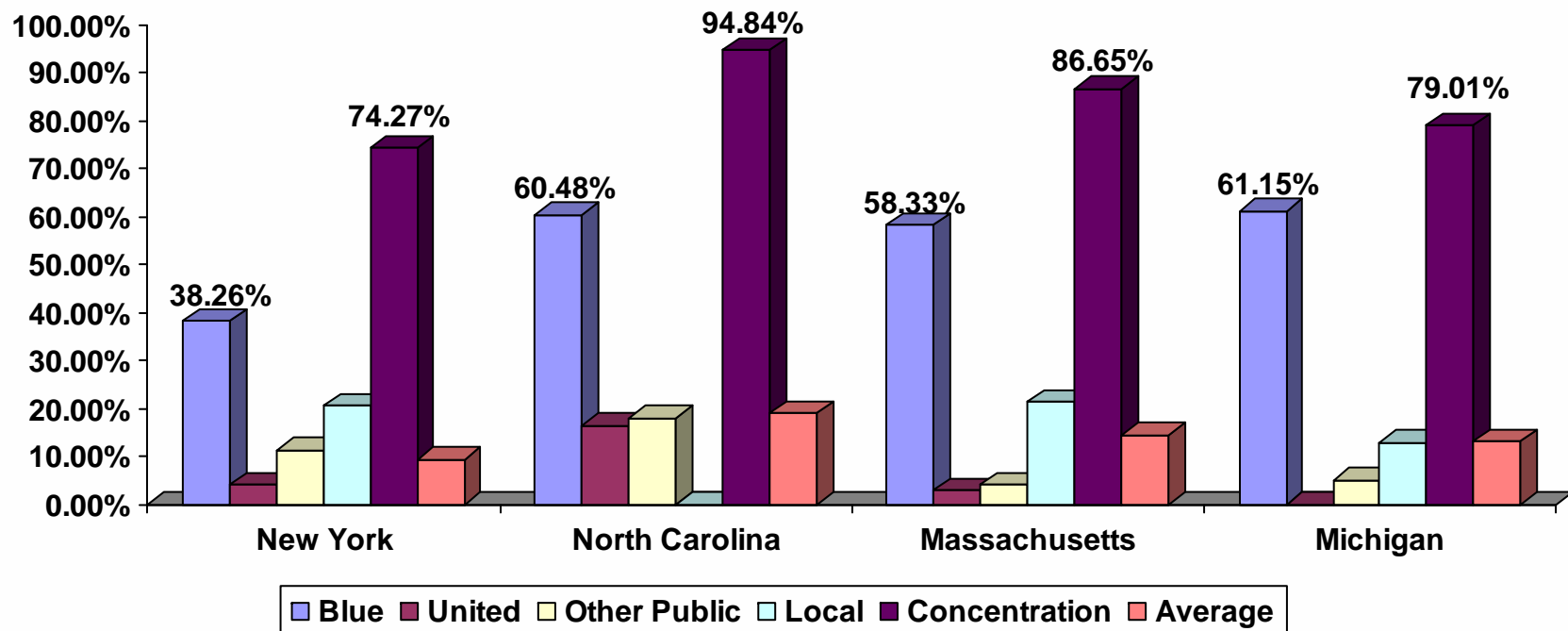
Blue Plans and Monopsony* Concentration

Insurance Market Concentration in States Where For-Profit Providers are Prevalent



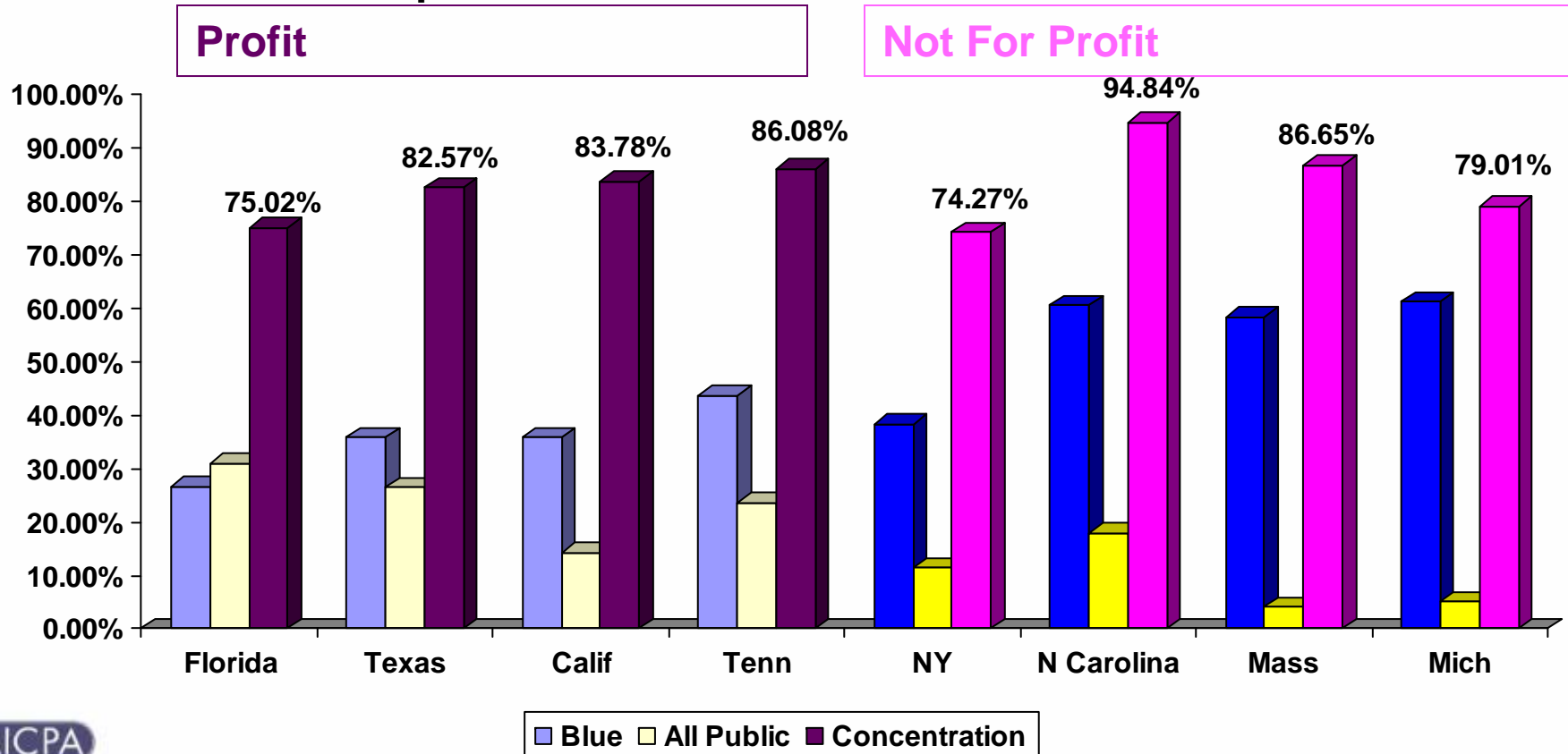
Blue Plans and Monopsony Concentration

Insurance Market Concentration States Where For-Profit Providers are *not* Prevalent



Comparison of Profit & Not For Profit States

Comparative Insurance Market Consolidation

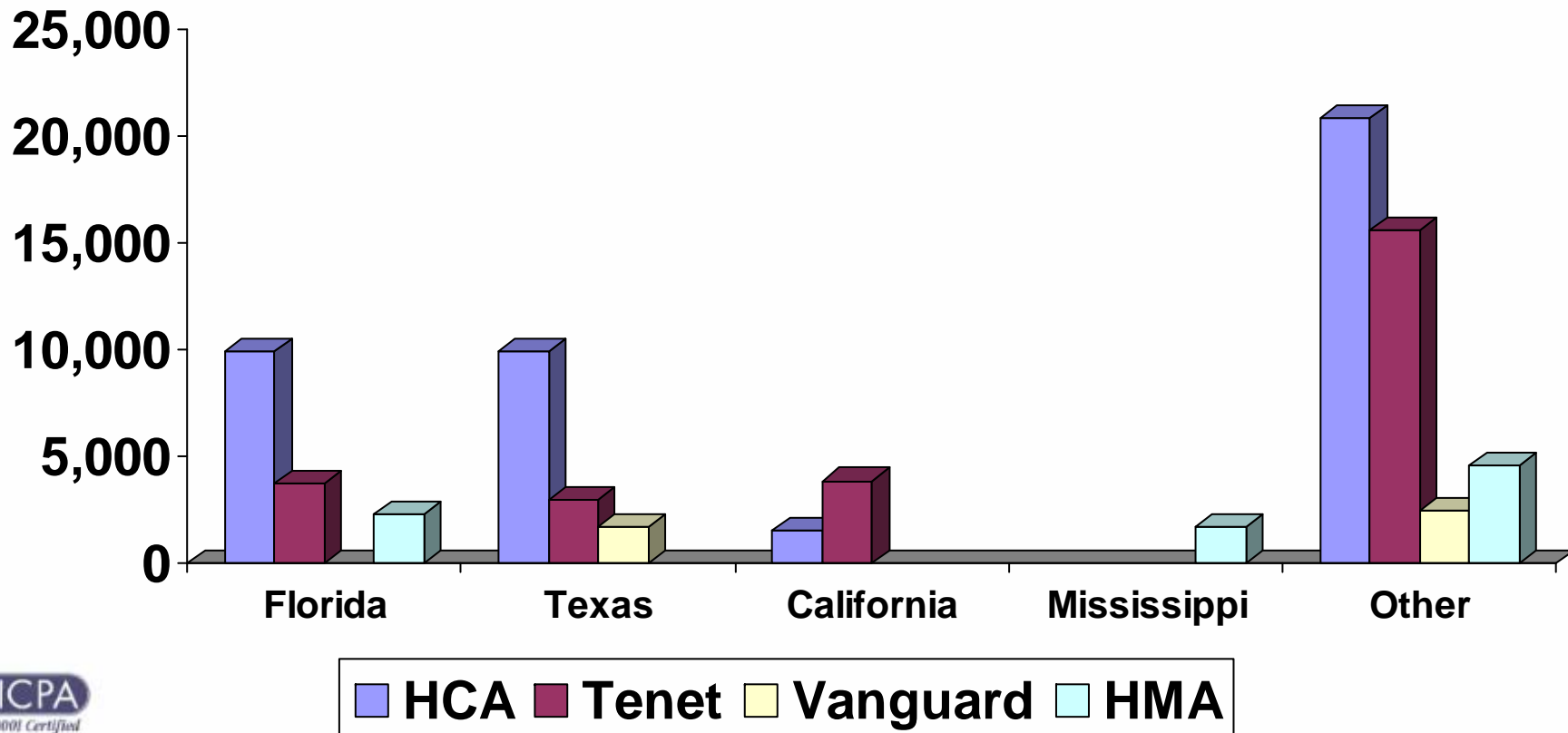


For Profit Hospital States

- Florida
- Texas
- California
- Tennessee
- Others *primarily* south of the Mason-Dixon Line
- Exceptions, of course!

Representative For Profit Hospital Chains

Number of Beds by State



NonProfit Hospital States

- New York
- North Carolina
- Massachusetts
- Michigan
- Illinois
- North Dakota, Iowa
- Exceptions, of course, but less than you would expect!

“Wealthy” Teaching Hospitals

- Harvard-Affiliated Partners Health System in Boston
- Baylor Health Care System in Dallas
- Yale-New Haven Hospital
- New York City: Mt. Sinai Hospital, Beth Israel Medical Center and NYU Medical Center
- The University of Chicago Health System and Northwestern Memorial Hospital and Health System
- Johns Hopkins Hospital and Health System in Baltimore

Query

- When Will a For Profit Hospital Locate in Boston?
- When Pigs Fly!



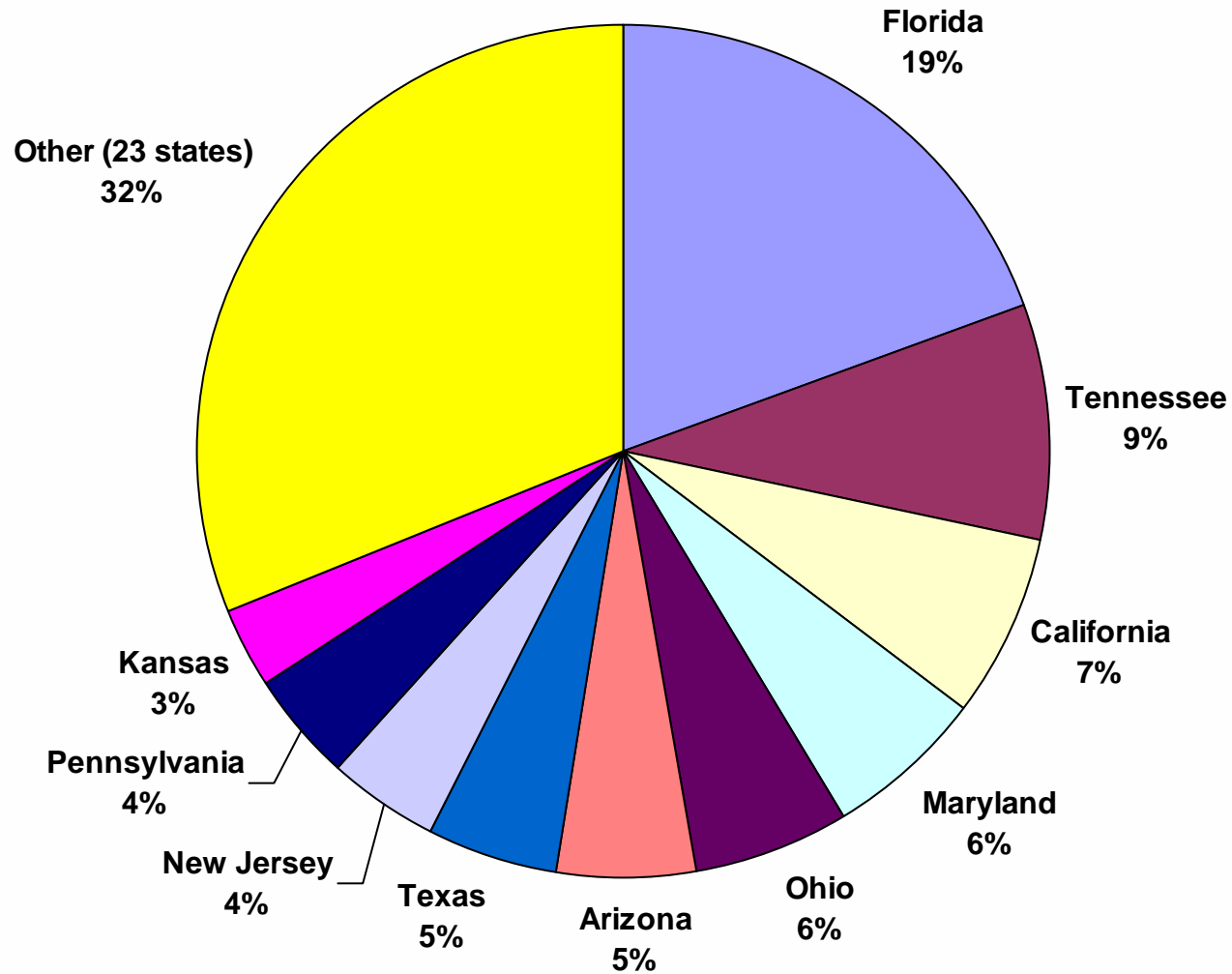
Hospital Market Data

- As Reed Tinsley and I asked in a co-authored article in the December 2006 American Bar Association's *The Health Lawyer*.
 - “What does [out of market] transaction data say or reveal about the value of a hospital with EBITDA of \$1.0 million located in North Carolina? Does it tell a valuator that it could be worth the median [multiple] value of \$5 million or the [average multiple] value of \$7.5 million – the average being 50% greater than the median? Could it be worth [the highest multiple value of] \$18.2 million? Given the Stark regulations requirement that comparable transactions be in a particular market at the time of acquisition, can any of these [out of market] multiples be used?”

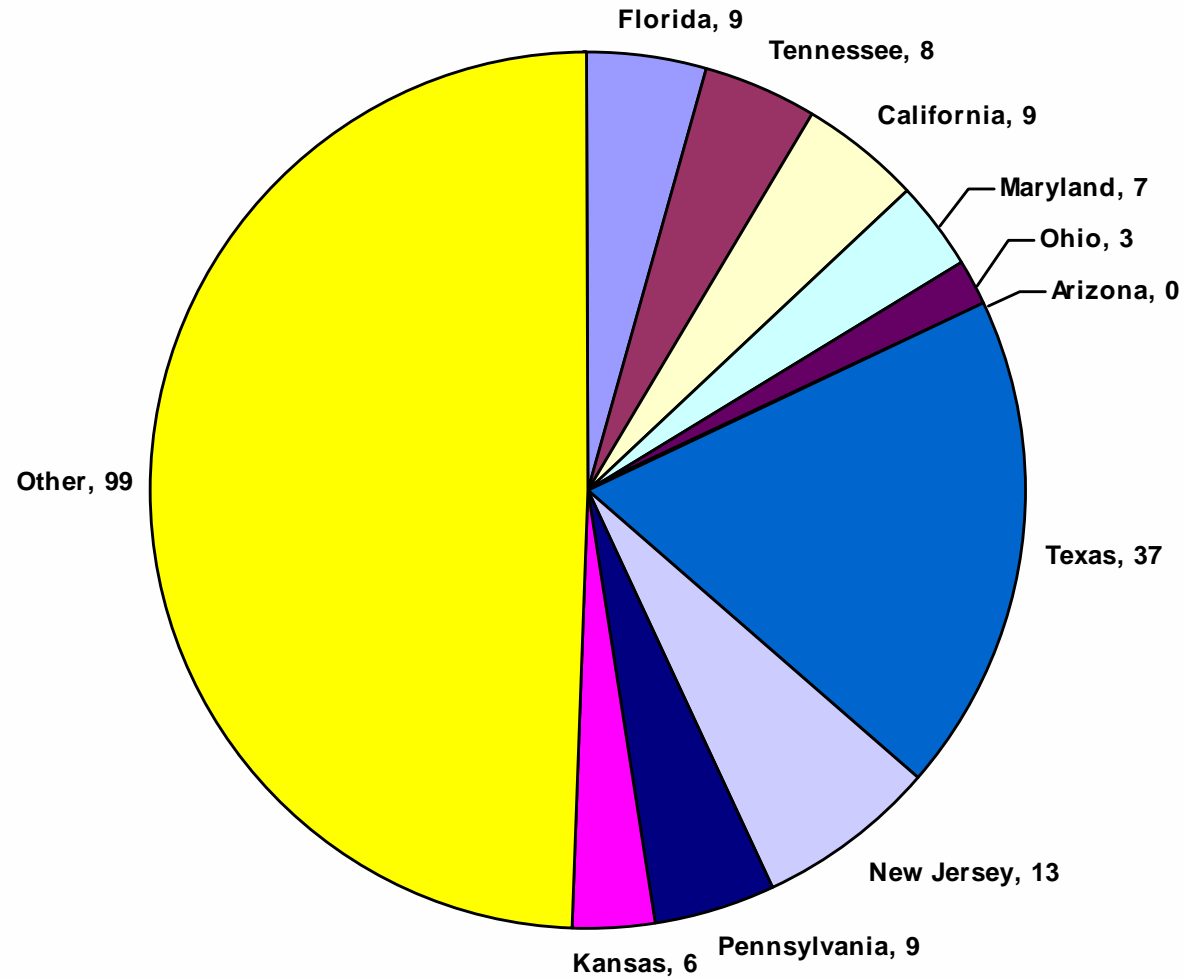
Certificates of Need

- State-issued facility license
- Highly politicized
- **Florida, Texas**, Pennsylvania and **California** do not require a CON for an ASC! (Recognize those **Bold** States?)
- Many of ASC-Consolidator AmSurg's facilities are located in these states!

AMSG ORs by State



of Top 200 Counties for Part B Per Capita Spending



Other Factors

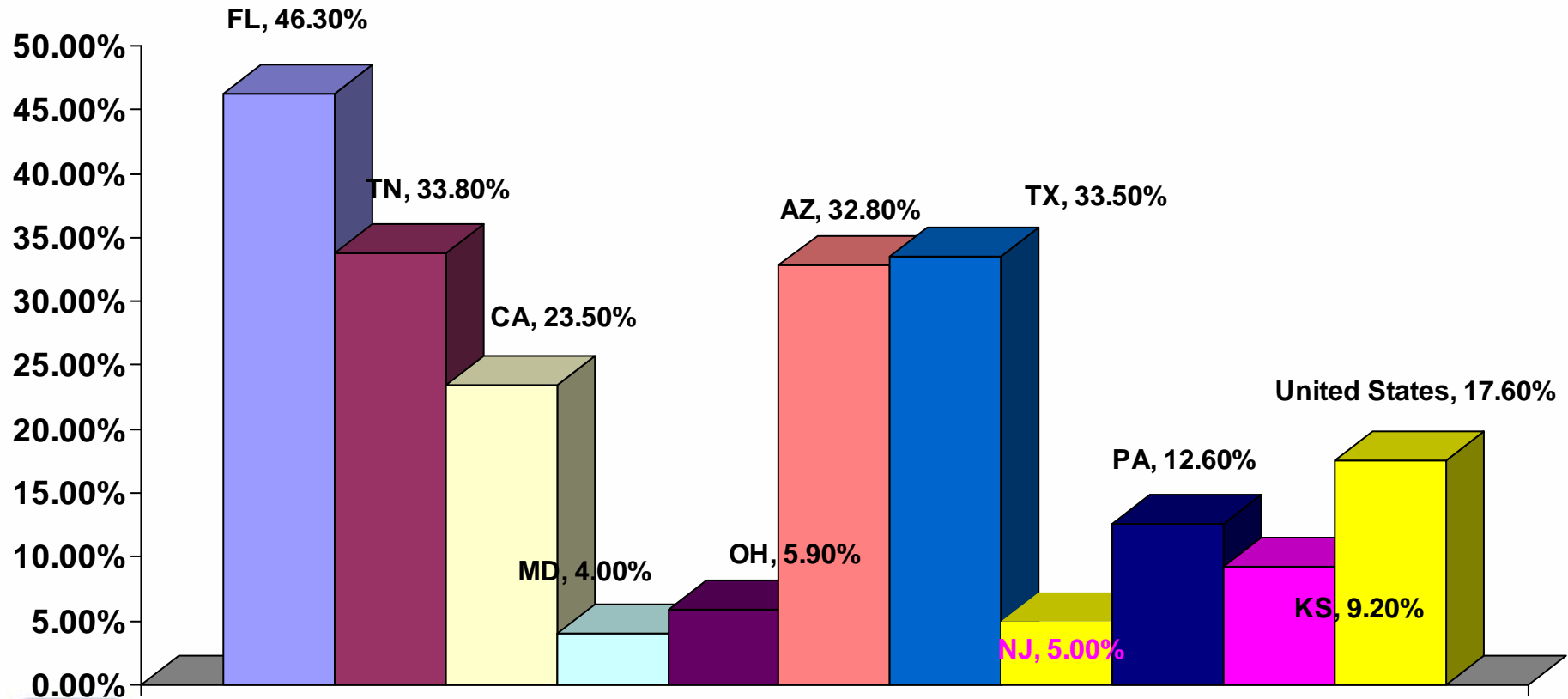
Top 10 AMSG States	For- Profit Beds %	MD Spending%	For- Profit Beds	RANKINGS			
				Total Healthcare Spending	Metropolitan Pop	MD Spending	Per Capita
Florida	34.60%	31.50%	3	4	6	9	19
Tennessee	24.90%	31.40%	10	15	26	10	21
California	17.10%	33.40%	18	1	2	3	44
Maryland	3.00%	28.70%	34	19	7	20	18
Ohio	1.80%	26.80%	39	7	25	35	15
Arizona	21.00%	33.00%	15	21	14	5	50
Texas	34.30%	30.80%	4	3	11	11	45
New Jersey	2.80%	28.20%	35	9	1	27	13
Pennsylvania	8.50%	26.60%	28	5	22	38	11
Kansas	14.40%	31.50%	22	31	35	8	24
United States	14.10%	28.20%	NA	NA	NA	NA	

Explanations of Factors

- For-Profit Beds %: The percentage of all hospitals beds owned by for-profit hospitals
- MD Spending %: The portion of the state's healthcare spending that goes to physician services
- Rankings
- For Profit Beds: The rank based on total for-profit beds, with 1 being highest,
- Total Healthcare Spending: The rank based upon total dollars spent
- Metropolitan Population: The rank based upon the percentage of the states population located in Metropolitan areas (as opposed to rural)
- MD Spending: The rank based upon total dollars spent
- Per Capita: The rank based upon per capita income

Other Factor Impact on AMSG

Prevalence of For Profit Hospitals For AMSG's Major States



Strategy and Value Implications

- Does the Enterprise operate in a market with factors analogous to those where acquirers or for-profits are active?
- If there are no or few for-profit providers in a valuation subject's service area, are those transactions or Guideline Public multiples relevant?
- Can acquirer multiples be adjusted to exclude acquisition growth inherent in public company strategies and values?
- If it worked in Dallas, should I try it in Sioux Falls?

Conclusion

- Don't forget the Stark Regulations limitations on use of out-of-market transactions!
- Use the Checklist provided as part of materials to compare Subject Market to purported Guideline's Market(s)

Take Away

- “For having lived long, I have experienced many instances of being obliged, by better information or fuller consideration, to change opinions, even on important subjects, which I once thought right but found to be otherwise.”
- Benjamin Franklin

CHECKLIST OF FACTORS TO CONSIDER WHEN EVALUATING SIGNIFICANCE OF OUT OF MARKET TRANSACTIONS

Factor	Subject Market	Comparable Market	Data Source(s)
Economic & Demographic Factors			
Medicare Part A Spending total & per capita			http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp#TopOfPage http://www.statehealthfacts.org/
Medicare Part B Spending total & per capita			As above
Pending or anticipated per unit revenue changes			www.medpac.gov , Centers for Medicare & Medicaid generally
Hospital spending per capita and in total			http://www.statehealthfacts.org/
Physician spending per capita and in total			http://www.statehealthfacts.org/
Per capita income levels of population			http://www.statehealthfacts.org/
Age distribution of population			http://www.statehealthfacts.org/
The concentration of the population in urban versus rural areas			http://www.statehealthfacts.org/
In rural areas, the extent and quality of road systems enabling access to healthcare providers; barriers to access such as bridges or ferries from peninsula or island communities			
Health insurance coverage statistics, including coverage by Medicaid			http://www.statehealthfacts.org/
Presence of Medicare Advantage plans			http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/
Medicaid spending and crisis status (Medicaid is typically the single largest line item in a state budget)			http://www.statehealthfacts.org/
Health Insurer factors			
Identity and Market Share of health insurers; in large states, regional market concentration should be considered along with state-wide data; HMO penetration versus indemnity and other types of health insurance should also			http://www.statehealthfacts.org/ , Lehman Brothers analysis, SEC filings, State Insurance Commissioner

be considered			
Whether or not Insurers use Network Fee Schedules or Individually Negotiated Fee Schedules			
Utilization Factors			
Hospital length of stay			http://www.statehealthfacts.org/
Hospital days per 1000			http://www.statehealthfacts.org/
Hospital cost per day			http://www.statehealthfacts.org/
Imaging per capita, rate of increase			www.medpac.gov
Inpatient v. Outpatient Surgery			http://www.statehealthfacts.org/
Market Competition Factors			
Presence of publicly held provider entities			SEC filings
Competing for-profit local providers			
Competing not for profit providers			
The percentage of all hospitals beds owned by for-profit hospitals			http://www.statehealthfacts.org/
The rank by state based on total for-profit beds			http://www.statehealthfacts.org/
Presence of Integrated Hospital Systems			
Presence of Integrated Delivery Systems with physician networks			
Potential economies of scale resulting from multiple locations in terms of costs, negotiating strength, marketing, etc.			
Whether or not Insurers use Network Fee Schedules or Individually Negotiated Fee Schedules (<i>again</i>)			
Intensity of market competition for acquisitions			SEC filings
Impact of acquisition growth on stock price			
Legal Factors			
For physician practices, enforceability of noncompete laws including judicial precedent			
Certificate of Need laws for various provider entities			http://www.ncsl.org/programs/health/cert-need.htm
Federal Regulatory Status			http://www.cms.hhs.gov/home/regsguidance.asp
Anti Kickback			

Stark Laws False Claims Act CMS Administrative Sanctions Enforcement Trends, e.g., Big Pharma is current target			
State Regulatory Status			
Political Factors			
Lobby strength of state Hospital Association, Medical Society, Imaging, ASC, Chiropractic, etc.			
Board Representation on Provider Entities, particularly Exempt Hospitals and Teaching Hospitals			