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Monetary Decisions in Radiology Practice: Valuing Your Practice and  
Assessing Future Financial Trends

*Kevin McDonough, CFA*  
*Senior Manager*  
*VMG Health, LLC*

*Jonathan Helm, AVA*  
*Manager*  
*VMG Health, LLC*

# Overview (A Primer on Valuation)



- I. *Practice Acquisitions – A Look Back in History*
- II. *Practice Acquisitions – Current Observations & Trends*
- III. *Valuation 101: Practices & Ancillary Services*
- IV. *Trends in Imaging Center Valuations*
- V. *What Determines Value for Imaging Centers?*

# Practice Acquisitions – Past & Present

# Physician Transaction History



## *Physician Acquisition & Employment – A Look Back in History*

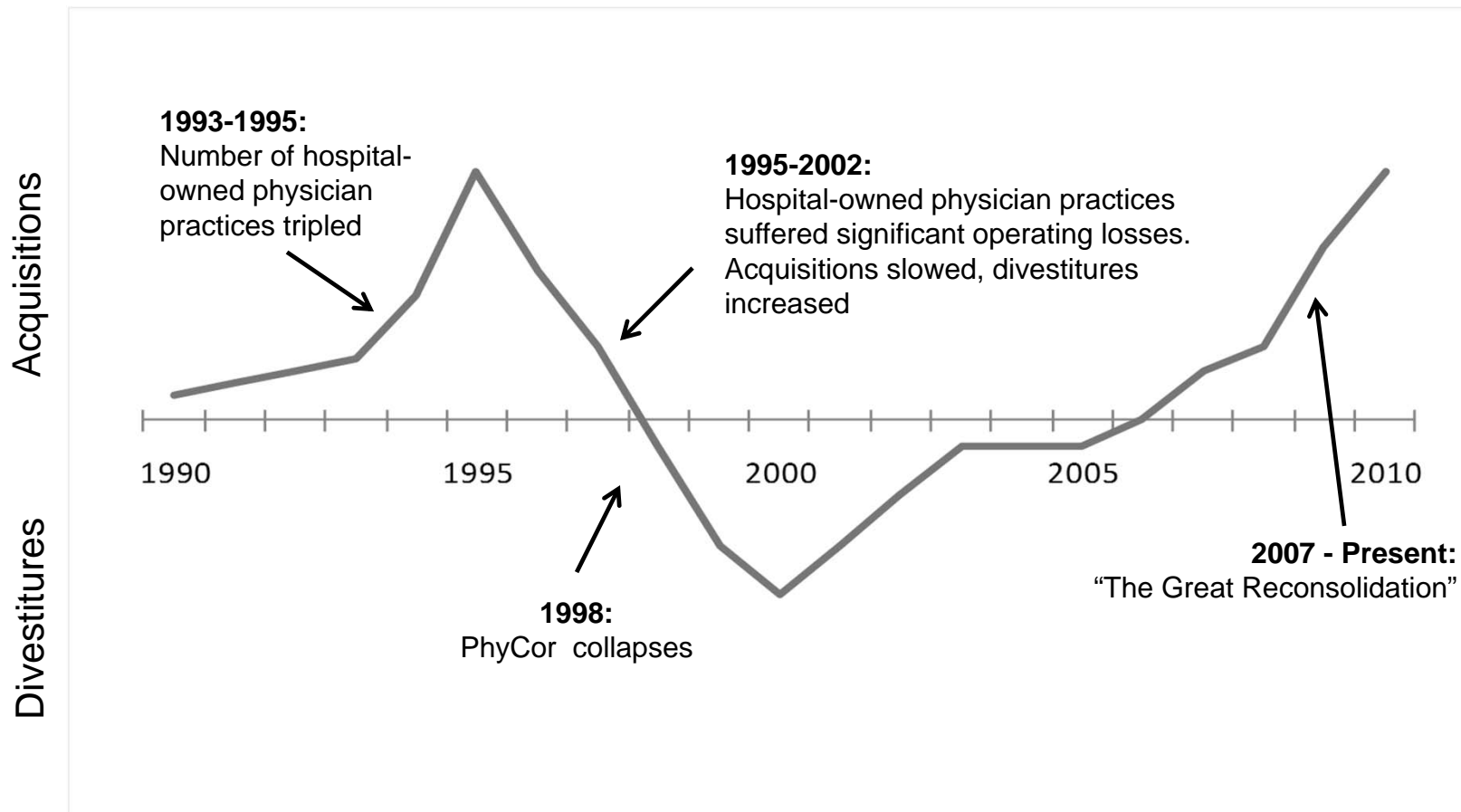
- *Physician Practice Management Companies (PPMCs)*
  - *PhyCor (1998)*
  - *Typically purchased equipment, A/R, real estate*
  - *Provided management services for fee (% of revenue)*
  - *Physicians were not employees*
  
- *Hospitals Defensive Response: Integrated Delivery Network (IDN)*
  - *Hospital-owned*
  - *Typically purchased equipment, A/R, real estate, goodwill*
  - *Physician was gatekeeper*
  - *Ancillary services often included*
  - *Physicians were employed*

# Physician Transaction History

- ❑ *The PPMC / IDN Bust – late 1990s / early 2000s*
  
- ❑ *Physicians frustrated with how hospitals managed practices*
  - *Hospital's lack of experience in billing for physician services*
  - *Grew too large too quickly*
  - *Lack of Physician involvement in decision-making*
  
- ❑ *Hospitals frustrated with Physicians' lack of motivation and declining productivity*
  - *Prices paid for practices were too high to earn adequate ROI*
  - *Often caused by guaranteeing Physician salaries with no recourse*
  - *Resulted in significant losses to hospitals*
  
- ❑ *Many PPMCs / IDNs dissolved and physicians re-entered private practice*

# Physician Transaction History

## Physician Practice Transaction Timeline



# Physician Transaction History



## *2007 to Present: The Great Reconsolidation*

### *Driving Forces for Physicians:*

- Physician desire to be shielded from market forces*
- Reimbursement cuts – in some cases these have been drastic*
- Increasing costs – particularly malpractice*
- Increased in costly IT requirements (EMR)*
- Reaction to Healthcare Reform*
- Shifting physician demographics*
- Shifting desire for work/life balance*

# Physician Transaction History



## *2007 to Present: The Great Reconsolidation*

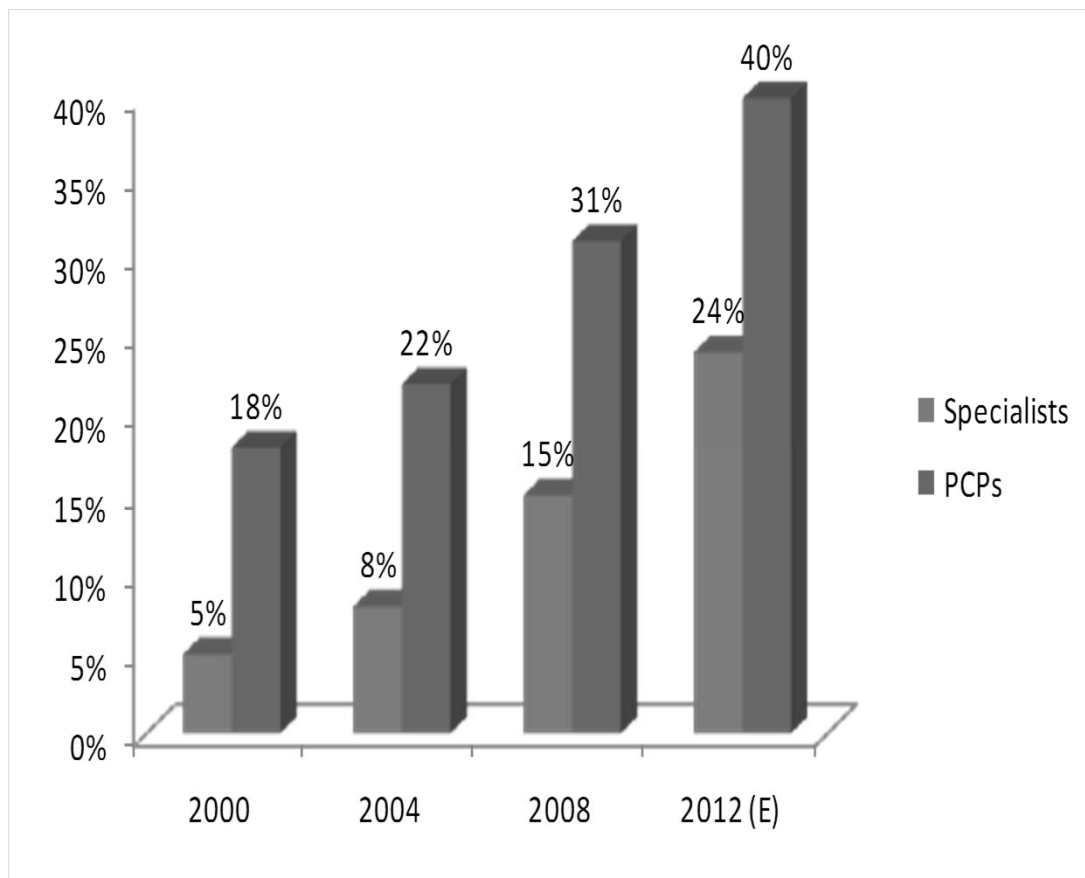
### *Driving Forces for Hospitals:*

- Herd Mentality*
- Secure/expand referral network – defensive strategy*
- Advantageous reimbursement – particularly for ancillaries (imaging)*
- Addressing staffing shortages*
- Need for call coverage*
- Healthcare Reform – ACOs*
- Need to improve and exhibit quality of care*

# Physician Transaction History

## *Hospital Employed Physicians on the Rise...*

**Current and Projected Hospital Employment**



*Since 2000:*

- *Employed PCPs has Doubled*
- *However Employed Specialists has increased 5-fold*

# **Fair Market Value from a Regulatory Perspective**

## *Regulatory Overview*

- ❑ *Fair Market Value (“FMV”) – the only premise of value to meet the Anti-Kickback Statute and Private Inurement Regulations*
- ❑ *FMV – both for-profit and not-for-profit health care providers that accept payments from government programs (Medicare / Medicaid) must be careful that exchanges between them and other providers are at FMV.*
- ❑ *Definition*
  - *The price, expressed in terms of cash equivalents, at which a property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arms length in an open and unrestricted market, when neither is under compulsion to buy nor to sell, and when both have reasonable knowledge of the relevant facts*
  - *FMV can consider revenue increases or cost savings to the Practice that any hypothetical willing buyer would be able to influence but not specific downstream referrals the Practice drives to a health system*

## *Regulatory Overview*

- ❑ *Stark Law*
  - *Prohibits physicians from referring a patient to an entity with which the physician (or an immediate family member) has a financial relationship, when the referral is for the furnishing of certain designated health services (DHS).*
- ❑ *Anti-Kickback Statute*
  - *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.*
- ❑ *Private Inurement*
  - *Deals with Tax-exempt entities providing excess benefits to non tax-exempt individuals or entities*

# Valuation Approach

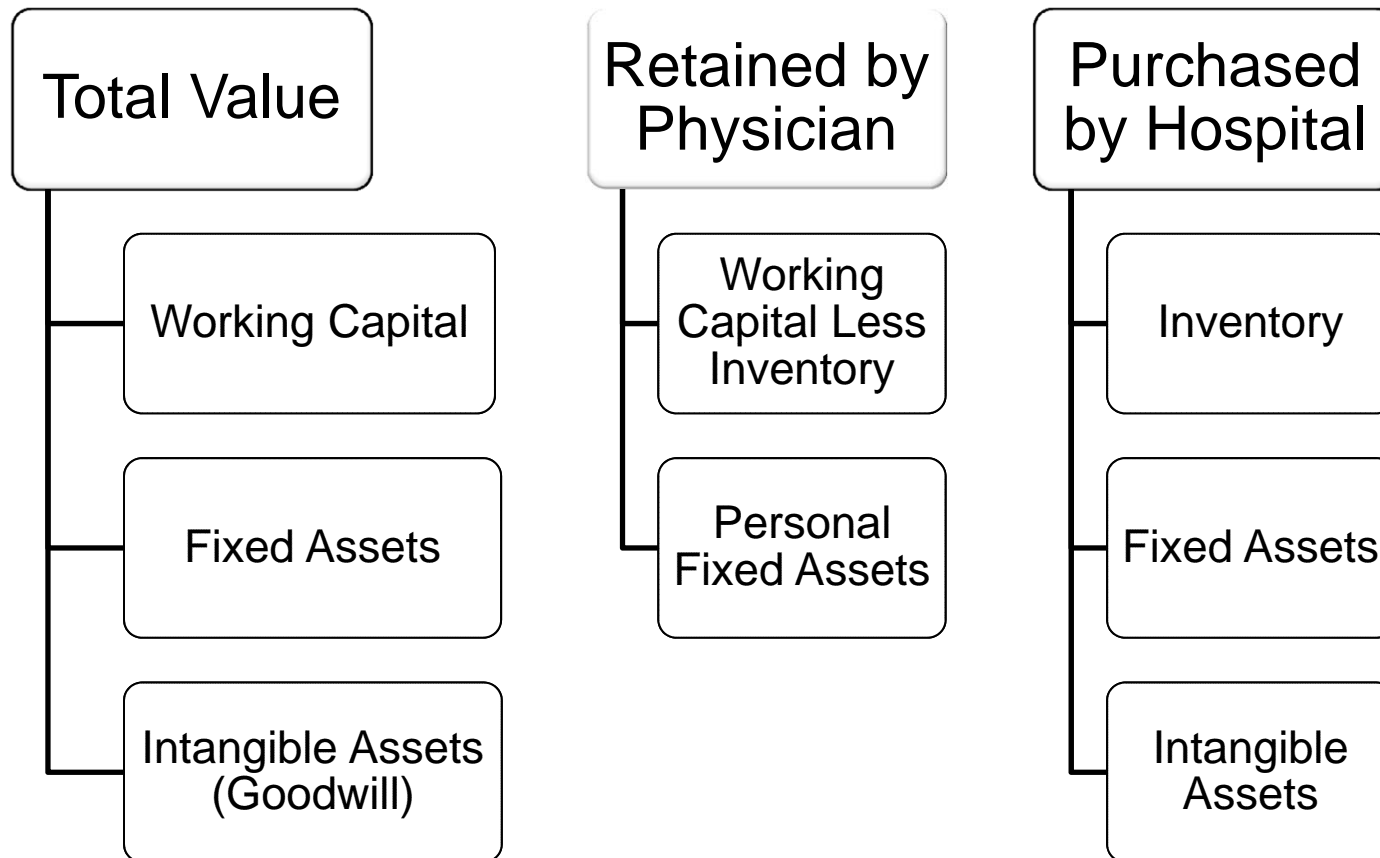
## *Fair Market Value vs. Strategic Value*

- ❑ *Investment Value or Strategic Value*
  - *Premise of value used everyday in merger and acquisitions which are not required to meet Fair Market Value standards*
  - *Definition – The price, at which a property would exchange hands between a specific buyer and able seller; it is the value of a property to a particular investor*
- ❑ *Examples of FMV / Investment Value*
  - *Investment Value:*
    - ❑ *Adjusting the reimbursement rates for the sellers to Hospital-based (Provider-based)*
    - ❑ *Adjusting the cost structure to account for efficiencies or economies of scale that only a specific buyer could realize*
  - *Fair Market Value:*
    - ❑ *Adjusting reimbursement rates up to freestanding market averages*
    - ❑ *Adjusting the cost structure to reflect market norms for similar businesses*

# Valuation Primer - Practices

# Valuation Primer

## Components of Value...



*There are three accepted business valuation methods...*

- Income Approach*
  - *Discounted Cash Flow Method*
  
- Asset (Cost Approach)*
  - *Tangible Assets*
  - *Intangible Assets*
  
- Market Approach*
  - *Guideline Public Company Method*
  - *Similar Transactions Method*

# Valuation Primer

## Valuation – Three Approaches

<i>Primary Approach By Type of Business</i>	<i>Professional Practice (Pro Fee)</i>	<i>Imaging Center (Tech Fee)</i>
<b>Income Approach</b> <i>Discounted Cash Flow Method</i>	←	←
<b>Cost Approach</b> <i>Tangible Assets</i> <i>Intangible Assets</i>	←	×
<b>Market Approach</b> <i>Guideline Public Company Method</i> <i>Similar Transactions Method</i>	×	←

## *Two Separate Components of a Hospital Transaction*

- ❑ *Upfront Value for your Professional Practice and/or Ancillaries*
  - *Hospital Acquires Professional Practice (uncommon in radiology)*
  - *Hospital Acquires Rad-owned Imaging Center (very common)*
  
- ❑ *Ongoing Value related to your Compensation / Professional Arrangement*
  - *Direct Employment (uncommon)*
  - *Exclusive Read Agreements*
  - *Practice Lease Arrangements*
  - *Co-Management Agreements*

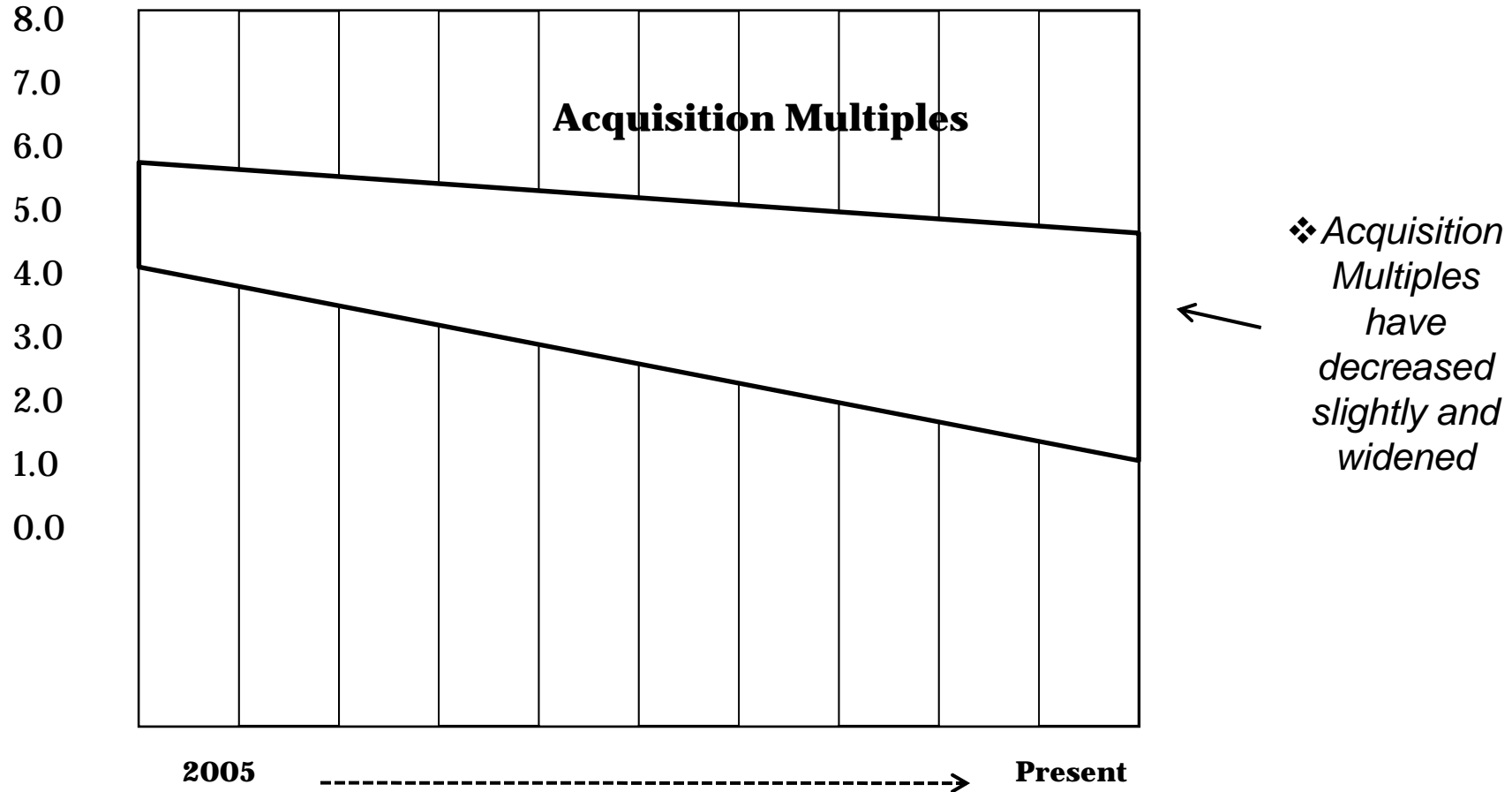
## *Practice Valuation versus Ancillary Services (imaging centers)*

- ❑ *Professional Practice Valuation = Not Very Lucrative*
  - *Hospital will buy Fixed Assets – very little intangible value*
  - *Acquisition Value versus Ongoing Comp Structure*
  
- ❑ *Ancillary (Imaging Center) Valuation = Can be Quite Lucrative*
  - *Physician is giving up Income Stream*
  - *Buyer will compensate Physician for this Lost Income Stream*
  - *Many Imaging Centers are still Quite Profitable*
  - *Acquisition Market is Quite Active*

# Valuation Primer – Imaging Centers

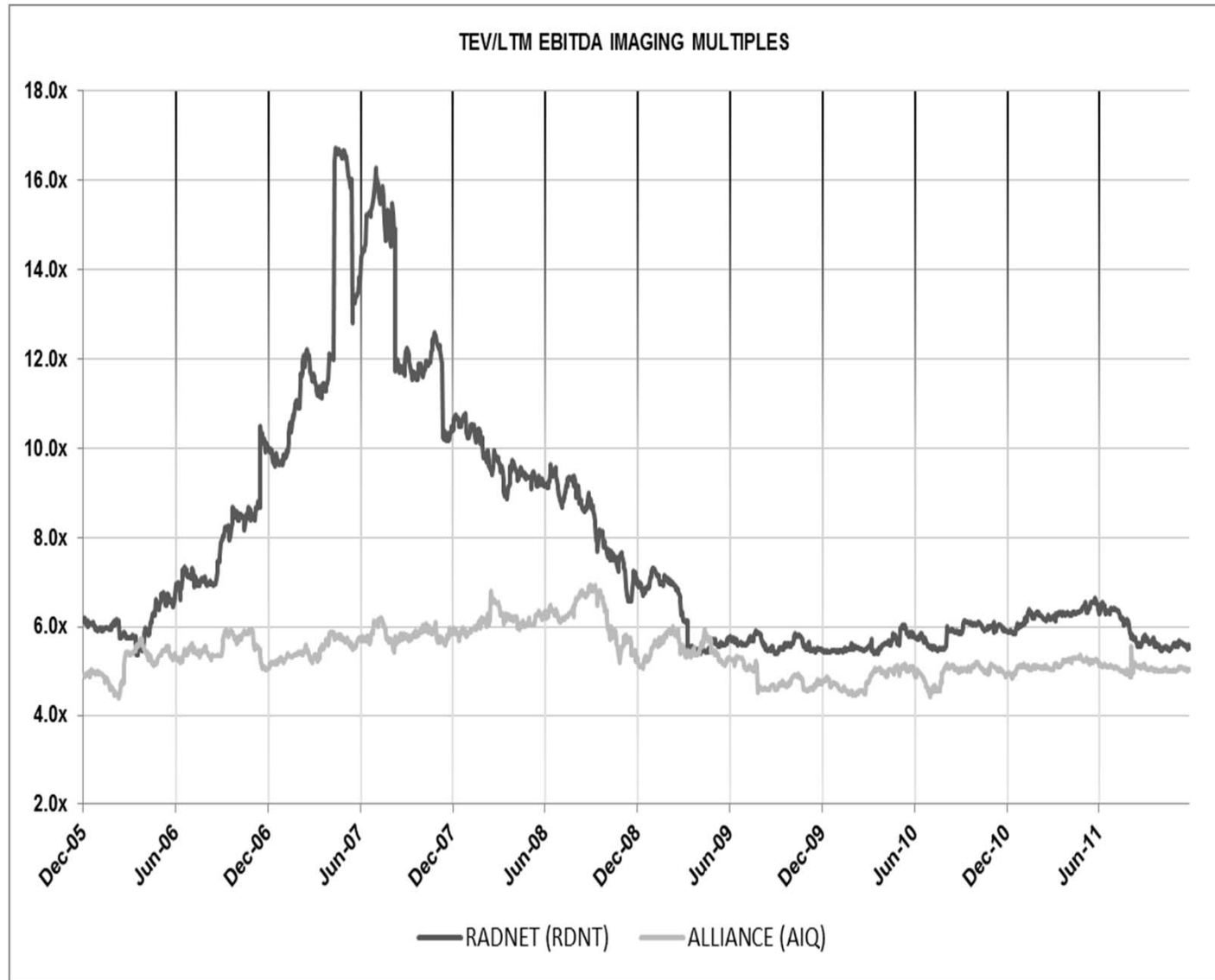
# Valuing Imaging Centers

## Imaging Valuation Trends as Multiple of EBITDA



- ❖ *Key Takeaway - All Imaging Centers are Not Created Equal with Respect to Valuation Multiples*

# Valuing Imaging Centers



*Publicly Traded  
Imaging Stocks  
provide Insight  
into Valuation*

# Valuing Imaging Centers

## *What Makes an Imaging Center More / Less Valuable??*

### *Market Risk Factors*

- *Existence of Certificate of Need* ↑
- *High Level of Competition for Imaging* ↓
- *Favorable Patient Demographics* ↑
- *High Historical Population Growth* ↑
- *High Geographic Cost Impact* ↓

# Valuing Imaging Centers

## *What Makes an Imaging Center More / Less Valuable??*

### *Financial / Operational Risk*

- *High Historical Profitability* ↑
- *Ability to Sustain / Grow Profitability* ↑
- *High Level of Debt Obligation* ↓

# Valuing Imaging Centers

## *What Makes an Imaging Center More / Less Valuable??*

### *Fixed Capital / Equipment Risk*

- *Reliance on Old Equipment / Outdated Technology* ↓
- *Physical Plant in Poor Condition* ↓
- *Equipment Capacity Concerns* ↓
- *Excellent Location (Patient / Physician Convenience)* ↑

# Valuing Imaging Centers

## *What Makes an Imaging Center More / Less Valuable??*

### *Referring Physician Risk*

- *Reliance upon a Single or Few Major Referral Sources* ↓
- *Ability to Show Growth in # of Referring Physicians* ↑
- *Major Referral Sources expanding Practice* ↑
- *Local Hospital Employing Referring Physicians* ↓

# Valuing Imaging Centers

## *What Makes an Imaging Center More / Less Valuable??*

### *Managed Care / Reimbursement Risk*

- *High Concentration of Revenue from Single Payor* ↓
- *Low Reliance upon Medicare / Medicaid* ↑
- *Ability to Show Historical Growth in Reimbursement* ↑

## Presentation Overview

- Fair Market Value Definition Overview
- Physician Services Valuation – Overview of Process
- Common agreement structures & valuation techniques
  - Direct Employment Agreements
  - Practice Lease Agreements
  - Co-Management (payment for quality) Agreements

## Fair Market Value Definition

- Traditional IRS Definition:

*“Fair market value (FMV) is the price that property would sell for on the open market. It is the price that would be agreed on between a willing buyer and a willing seller, with neither being required to act, and both having reasonable knowledge of the relevant facts.”*

- Fair market value has a more extensive definition for healthcare transactions and service agreements.

## Fair Market Value Definition (cont'd)

- Stark Definition:

*“The value in arm's-length transactions, consistent with the general market value. ‘General market value’ means the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement.”*

## Physician Services Valuation

- There are no published standards for physician compensation valuation.
- Most valuers start with traditional business valuation approaches.
- Three general valuation approaches:
  - *Cost Approach*
  - *Market Approach*
  - *Income Approach*

## Physician Services Valuation (cont'd)

- Valuator must understand health care industry regulations and guidance and how they apply to fair market value.
- For example - Stark Law guidance:
  - *Use multiple, objective market compensation surveys:*
    - ❖ Common clinical compensation surveys include:
    - ❖ MGMA – Physician Compensation & Production Survey
    - ❖ AMGA – Medical Group Compensation & Financial Survey
    - ❖ Sullivan Cotter & Associates – Physician Compensation & Productivity Survey
    - ❖ Reliance on one survey may not be enough . . . .
  - *Beware of market data including referral relationships.*

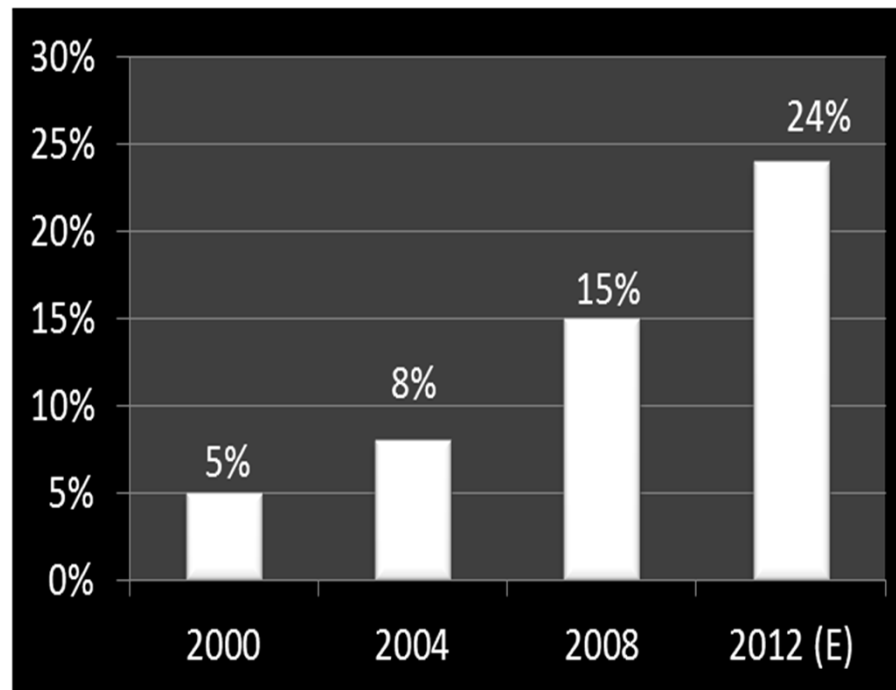
## Physician Services Valuation (cont'd)

- Understand the market data
  - *Numerous challenges with published survey data*
  - *Ensure data reflects similar services (clinical vs. admin)*
  
- Understand the subject agreement terms:
  - *What services will be provided?*
  - *How parties will be compensated?*
  - *Who is at risk?*
  - *Valuation should always match the agreement.*

## Physician Employment Agreements

- Increasing number of physicians being employed by hospitals.

*Percentage of "Active" Specialists Employed by Hospitals*



Source: Health Care Advisory Board 2008 Survey on Physician Employment Trends

## Physician Employment Agreements (cont'd)

- Drivers for physician employment include (from the physician's perspective):
  - *Reimbursement uncertainty*
  - *Frustrations with practice management*
  - *Increasing malpractice and other operating costs*
  - *Work-life balance*
  - *Income stability*
- Agreements may include a bundle of services (clinical, medical director, call coverage, etc.).

## Physician Employment Agreements (cont'd)

- Compensation model structures vary widely across the market:
  - *Fixed salary model*
  - *Revenue minus expense model*
  - *Percentage of collections model*
  - *Compensation per work RVU model*
  - *Hourly rate or fixed stipend (medical director services)*
  
- Compensation is set at a fair market value level - how is this compensation level determined?

## Physician Employment Agreements (cont'd)

- Clinical compensation valuation approaches include:
  - *Cost-Market Approach*
    - ❖ Cost to employ a physician based on market data (common surveys include MGMA, AMGA, and SCA)
    - ❖ Simple to understand and explain
    - ❖ Benchmarking exercise (professional collections, work RVUs)
    - ❖ Ensure benchmarking data is “apples to apples”
  - *Income Approach*
    - ❖ Considers the specific economics of a physician’s practice
    - ❖ Considers payor mix, actual reimbursement, & expense profile

## Physician Employment Agreements (cont'd)

- Medical Director compensation valuation approaches include:
  - *Cost Approach*
    - ❖ Considers published clinical compensation data
    - ❖ Position requirements (physician & specialty)
    - ❖ No productivity measurements
    - ❖ Drawback: Clinical compensation data not a perfect match to the services provided
  
  - *Market Approach*
    - ❖ Based on comparable data for medical director positions
    - ❖ Drawback: Source data includes referral relationships
    - ❖ Don't forget to factor in physician experience . . .

## Practice Lease Agreements

- AKA “Synthetic” employment agreements – general characteristics include:
  - *Physicians retain ownership of the practice*
  - *Asset acquisition may occur (ancillary services)*
  - *Independent contractor arrangement with a hospital*
  - *Hospital bills / collects for physician services and retains revenues*
  - *Hospital pays compensation on a productivity basis (percentage of collections is common)*
  - *Practice decides how to distribute compensation internally*
  - *Practice operating expenses may be assumed by the hospital or the practice.*

## Practice Lease Agreements (cont'd)

- Drivers of this model include (from the physician's perspective):
  - *Physicians retain autonomy, management of practice, and flexibility on internal compensation distribution*
  - *Protection from volatile reimbursement*
  
- How is the payment to the physicians determined? Typical valuation approaches include:
  - *Similar approaches as discussed under direct employment*
    - ❖ *Cost-Market Approach*
    - ❖ *Income Approach*

## Practice Lease Agreements (cont'd)

- Important questions to ask:
  - *Are all practice services included?*
  - *Who is responsible for operating expenses (hospital or practice)?*
  - *Does the payment within the agreement contemplate both physician compensation AND operating expenses assumed?*
  - *Are any other services being provided (i.e., medical directorships)?*

## Co-Management Agreements – Evolution

- Hospital 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 to improve the quality of health care*
  - *Includes financial incentives for the top 20% of hospitals.*
  - *Top 10 percent receive an incentive payment of 2% of reimbursement*
- Hospital Inpatient Quality Reporting (Hospital IQR) program was put into place during this period.

## Co-Management Agreements – Evolution

- Congress authorized the development and implementation of a value-based purchasing (VBP) program to replace the Hospital IQR program which reports quality (the precursor).
  - *Performance (Incentives) would be based on either improving historical performance or attaining superior outcomes compared with national benchmarks.*
  - *The VBP program is currently being tested*
- Numerous third party payors provide P4P payments to hospitals and physicians.

## Co-Management Agreements – 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.

## Co-Management Agreements – Structure

- Structure and terms of the arrangement should be clearly defined before valuing compensation.
- Common compensation structures for co-management agreements:
  - *Fixed Fee*
    - ❖ Time dedicated to meetings designed to improve the overall quality of care for a specific service line.
    - ❖ FMV based on cost to engage a physician to provide similar services (clinical and administrative survey data)
    - ❖ May include medical directorships and non-physician services (billing, administration, etc.)

## Co-Management Agreements – Structure

- Common compensation structures for co-management agreements:
  - *Variable Fee*
    - ❖ Quality targets are outlined and incentive payments are provided for those responsible for implementing best practices to achieve the predefined targets.
    - ❖ Must understand historical, superior quality and improvement
    - ❖ Carefully calculate incentive compensation pool – Tiered structure
  - *Variable fees for quality are sometimes included in physician employment agreements as a percentage of base compensation.*

## Co-Management Agreements – Challenges

- Common co-management service lines: orthopedic surgery, cardiology, ASC ->HOPD
  - *Patient satisfaction, Infection Rates, Readmission, Mortality, etc.*
  - *Many P4P observed metrics are specialty specific...*
  
- The challenge is predicting what will be incentivized and identifying support for the quality payments.
  - *Look to current PQRI measures (<http://www.cms.gov/PQRS/> )*
  - *Track what credible radiology organizations are measuring*
  - *Identify metrics third party payors are relying upon in radiology*