PHYSICIAN-HOSPITAL ALIGNMENT STRATEGIES

Practice Acquisition and Physician Employment Arrangements
TUESDAY, MAY 24, 2011
PHYSICIAN-HOSPITAL ALIGNMENT STRATEGIES
Practice Acquisitions and Physician Employment Arrangements

May 24, 2011
12:00 p.m. CST

Web Participants: For Audio Access Dial 866.253.6505
Conference ID: 1526480
Presentation may be printed via Foley.com/HPA4
Housekeeping

- Today's program will last approximately 3 hours and will include one 10-minute break at 1:30 p.m. Central time.

- We encourage you to ask questions during our interactive Question and Answer session. For those of you participating in our offices, your Foley office host will assist you in asking your question. For those participating via web conference, simply click “Q&A” on the menu bar and type your question. Please indicate to whom your question is directed. If time does not allow for us to answer your question, we will follow up with you to address it.

- To print today’s handout materials, our web participants are encouraged to go to Foley.com/HPA4 to print a PDF.

- Additionally, should web participants require audio assistance please press *0.
Today’s Speakers

• C. Frederick Geilfuss II, Partner, Foley & Lardner LLP

• Sean T. Hartzell, Senior Manager, ECG Management

• Victoria Poindexter, Managing Director, Morgan Keegan/Shattuck Hammond Healthcare

• Richard K. Rifenbark, Senior Counsel, Foley & Lardner LLP
Today’s Speakers

• Richard F. Seiden, Partner, Foley & Lardner LLP
• Adria Warren, Senior Counsel, Foley & Lardner LLP
• Troy Wells, President, Arkansas Health Group
• David V. White, Executive Director, Pinnacle Healthcare Consulting
Current Trends of Hospital Purchases of Physician Practices

Victoria Poindexter
Managing Director
Morgan Keegan/Shattuck Hammond Healthcare
Discussion Topics

1. Drivers of Provider Integration/Practice Acquisition Activity
2. Review of Recent Provider Integration Activity
Drivers of Provider Integration Activity

- Hospitals and physicians are facing an increasingly complex and difficult operating environment...

- Economic Conditions and Healthcare Reform
- Valuation and M&A Trends
- Capital Requirements and Access
- Reimbursement and Payor Mix
- Utilization / Demand
- Financial Performance
Economic Conditions

- The depressed economy has had a significant, negative effect on hospitals and physicians
  - Lower utilization – reduced inpatient admissions, elective procedures and non-urgent physician visits – combined with reduced reimbursement rates
    - Provider Medicare revenue grew at the slowest rate in 6 years during the 12 months ended February
  - Payor mix deterioration – more Medicaid and self-pay, higher receivables and bad debt expense
  - Previous expense cuts have left little opportunity to improve non-clinical operational efficiency
    - Hospital operating margins increased from 1.8% in 2008 to 2.4% in 2010 despite slower revenue growth
Economic Outlook

- Projected slow economic recovery and large federal and state budget deficits cannot tolerate escalating healthcare costs
  - Medicare and Medicaid represent balancing items in federal and state budgets
- Yet demographic and other trends point to an increase in demand for healthcare
  - Aging baby boomers, increased consumer sophistication, technological advancements
- Reimbursement levels will continue to fall
Message to Providers...

“Our deficit-reduction plan is simple, but it will require a great deal of money.”
Other Significant Trends

- Add to the economic challenges:
  - Physician shortages
    - Demographics, reduced income potential, malpractice risk, fewer participating in governmental programs
  - Changing physician lifestyle preferences
    - 46% of physicians surveyed expressed interest in employment\(^1\)
  - Increased care management and reporting requirements
    - New capabilities and functions
  - Capital investment requirements
    - IT and equipment

\(^1\) “Physician Alignment in an Era of Change,” HealthLeaders Media/Intelligence, September 2010
Healthcare Reform

The ACA is anticipated to further increase the challenges...

- Hospitals will see increases of 11.9% from 2011 through 2020, vs. 27% if paid full market basket\(^{(1)}\)
- Future for physician rates uncertain — sustainable growth formula would reduce fees by 28% by 2020

### Objectives

- Greater number of insured
- Better prevention / improved outcomes
- Lower reimbursement
- Incentives for higher quality/lower cost
- Incentives for collaboration — hospital/physician/provider/payor partnerships
- Incentives for use of IT capabilities

### Legislation

- 2010-11: Medicare payment reductions; physician-owned hospital prohibition
- 2012: Accountable Care Organizations and alternative payment methods established; Medicare Advantage payments aligned with FFS
- 2013: Value-based purchasing for hospitals; reduction in readmission payments
- 2014: Medicaid and Commercial eligibility expansion; DSH payment reductions begin
- 2015: Reduced payment for hospital-acquired conditions; value-based purchasing for physicians

\(^{(1)}\) Congressional Budget Office, August 2010, Fact Sheet
Healthcare Reform – Much uncertainty remains...

"Can a rising tide lift a boat that has a huge hole in the bottom?"
Greater collaboration among hospitals and physicians will be critical in order to “Do More with Less”

**Hospitals**
- Scale and efficiency critical to survival
- Must possess strong market share position/patient access
- Must have cooperation of physicians
- Pluralistic medical staff still necessary

**Physicians**
- Reduced reimbursement from ALL payors and decline in profitability
- Greater proportion of revenues tied to P4P vs. FFS programs
- Capability to coordinate care and outcomes – create ACOs
- Recruitment and retention challenges
- Increased interest in physician employment model
- Significant capital investment requirements
- Heightened regulatory demands
- Declining revenue from ancillaries – imaging/ASCs
- Increased cost of managing private practice/practice overhead
- Loss of autonomy and control over practice
- Continued malpractice insurance needs/concerns
- Generational and gender shift in physicians
- Reduced reimbursement from ALL payors and decline in profitability
- Greater proportion of revenues tied to P4P vs. FFS programs
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- Continued malpractice insurance needs/concerns
- Generational and gender shift in physicians
Evolution of Hospital-Physician Alignment

The outlook for providers has restored the balance of power between hospitals and physicians...

- Independent medical staff, employment of only hospital-based physicians; cost-plus reimbursement, incentives aligned to generate volume

- Hospitals begin to acquire primary care practices – compete with for-profit PPMCs and overpay for practices, negotiate employment contracts without productivity or cost reduction incentives

- Hospitals enter into JVs and new alignment vehicles with specialists in order to retain revenue and market position

- Industry pressures and environmental factors present intense challenges and align interests of hospitals and physicians

Introduction of DRGs; creation of HMOs

Hospitals begin to divest of physician practices and health plans as compensation declines, specialists begin to compete for ancillary service revenues and require payment for hospital services

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Recent Integration Activity

The recent surge in integration activity reflects the recognition by many hospitals and physicians that collaboration is the key to survival...

- Not a one-size fits all approach — still a market- and hospital-specific decision
- A number of different models continue to be necessary and are being utilized

High

- Purchase of physician practice and employment of physicians
- Joint venture
- Co-management company
- Leasing of space, equipment, staff
- Directorships, stipends and management contracts

Low
Practice Acquisition Overview

- Practice purchase/physician employment is the model most often utilized today
  - Objectives: maximize reimbursement/income through care management and protect market share
  - Vast majority of hospitals employ a very small % of their physicians
    - 61% of hospital leaders plan to acquire medical groups within 12-36 months; 71% received an increase in requests for employment (1)
    - PCPs most in demand, followed by cardiologists, orthopedists, general surgeons and hospitalists (1)
  - Transaction often involves the purchase of the medical group’s interest in a specialty hospital or ASC
    - From 46 in 2002, 277 physician-owned hospitals today

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(1) “Physician Alignment in an Era of Change,” HealthLeaders Media/Intelligence, September 2010
The volume of publicly-announced acquisitions has increased significantly since 2009 — yet this is likely only a minority of those completed...
_Practice Acquisition Trends_

- While the universe of transactions is somewhat limited, the objectives of each acquiring group are identifiable...

### 2010 - 2011 YTD Acquisition Detail

<table>
<thead>
<tr>
<th>Acquirer</th>
<th>Avg. Physicians per Group</th>
<th>Anesthes.</th>
<th>Cardiology</th>
<th>Emer. Medicine</th>
<th>Internal Med.</th>
<th>Multi-Specialty</th>
<th>Pediatrics/ Neonat.</th>
<th>Primary Care</th>
<th>Other(1)</th>
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</thead>
<tbody>
<tr>
<td>Hospital/ Health System</td>
<td>49</td>
<td>-</td>
<td>18</td>
<td>1</td>
<td>-</td>
<td>10</td>
<td>-</td>
<td>1</td>
<td>4</td>
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<tr>
<td>Publicly Traded PPM</td>
<td>15</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>10</td>
<td>3</td>
<td>12</td>
<td>-</td>
<td>5</td>
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<tr>
<td>Private Clinic/ Physician Group</td>
<td>69</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>PE Firm/Other</td>
<td>362</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>7</strong></td>
<td><strong>21</strong></td>
<td><strong>6</strong></td>
<td><strong>12</strong></td>
<td><strong>16</strong></td>
<td><strong>12</strong></td>
<td><strong>3</strong></td>
<td><strong>14</strong></td>
<td></td>
</tr>
</tbody>
</table>

(1) Includes Geriatrics, Urogynecology, Sleep Diagnostics, Oncology and Radiology
Practice Acquisition Trends

- Publicly-traded Physician Practice Management Companies (“PPMs”) reported the majority of transactions...

- The PPMs are trading well and have significant acquisition currency — P/E range of 12–32

- Valuations driven by earnings growth – PPMs expected to aggressively pursue accretive acquisitions

-- Last Six Months Stock Performance (% Change)(1)  

--- (1) Sector stock performance weighted according to market capitalization; Data as of May 16, 2011

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## Overview of Publicly Traded PPMs

<table>
<thead>
<tr>
<th>Company</th>
<th>Primary Specialties</th>
<th>LTM Rev. ($ in mm)</th>
<th>Market Cap. ($ in mm)</th>
<th># of Clinics/Hospitals Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integramed America</td>
<td>Fertility care, Vein disease</td>
<td>$250</td>
<td>$121</td>
<td>176</td>
</tr>
<tr>
<td>Emergency Medical Services Corp.</td>
<td>Emergency medicine, Internal medicine, Radiology, Anesthesia</td>
<td>$2,941</td>
<td>$2,827</td>
<td>&gt;500</td>
</tr>
<tr>
<td>MEDNAX</td>
<td>Neonatology, Maternal-fetal care, Pediatrics, Anesthesia</td>
<td>$1,451</td>
<td>$3,600</td>
<td>&gt;280</td>
</tr>
<tr>
<td>Continucare Corp.</td>
<td>Primary care</td>
<td>$324</td>
<td>$302</td>
<td>20</td>
</tr>
<tr>
<td>IPC The Hospitalist Company</td>
<td>Internal medicine</td>
<td>$389</td>
<td>$839</td>
<td>&gt;700</td>
</tr>
<tr>
<td>Team Health Holdings</td>
<td>Emergency medicine, Anesthesia, Pediatrics</td>
<td>$2,759</td>
<td>$1,447</td>
<td>&gt;600</td>
</tr>
</tbody>
</table>
Publicly traded PPMs are primarily interested in small, single specialty practices where their management services and expertise can quickly improve cash flow

- Focus on pediatrics and internal medicine is not surprising – majority of acquisitions made by MEDNAX, a provider of neonatal and pediatric physicians, and IPC The Hospitalist Company
- Also several acquisitions of Anesthesiology and ER groups by Emergency Medical Services and Team Health

The difference in focus among PPMs and hospitals/health systems suggests there should be less competition (than in the 1990s) for deals
Practice Acquisition Trends

- Private equity firms have shown renewed interest in the physician practice sector after a period of inactivity...
  - Targeting large practices with high earnings potential
    - Clayton, Dubilier & Rice – $3.2B pending acquisition of Emergency Medical Services = >1x Revenue and almost 11x EBITDA
    - Moelis Capital Partners – acquisition of NAPA Management Services Corporation, a 700+ provider group
    - Highlander Partners, Flexpoint Ford – acquisition of 300-member, internal medicine group Eagle Hospital Partners
  - PE firms should not represent competition to hospitals given their objectives – consolidation of large groups, enhance financial performance and exit in 5-7 years
Smaller physician groups continue to join **clinics and larger physician groups**, but the relative number of these transactions is declining

- Some physicians prefer to retain their independence from the hospital but are looking for opportunities to share overhead and investment requirements
  - American Anesthesiology (NC) – Acquisition of 23-physician Greensboro Anesthesia Physicians (NC) (valued at $50M)
  - Emory Specialty Associates (GA) – Purchase of 3-physician Georgia-Heart Care
  - Hill Physicians Medical Group (CA) – Acquisition of 120-member Physicians Integrated Medical Group (CA)
  - MedicalEdge Healthcare Group (TX) – Acquisition of 10-physician Arlington Cancer Center (TX)
Practice Acquisition Trends

- **Hospitals and health systems** are generally targeting moderate sized practices, either multi-specialty or cardiology groups
  - Texas Health Resources (TX) – Acquisition of MedicalEdge Healthcare Group (TX), a multi-specialty practice with 420 providers
  - St. Joseph Mercy Health System (MI) – Strategic merger with IHA (MI), a multi-specialty, 156-physician group practice
  - St. Joseph’s Hospital Health Center (NY) – Acquisition of North Medical P.C., the largest private multi-specialty group in central New York (more than 450 professional and support staff)
  - Froedtert Health (WI) – Acquisition of several ProHealth Care Medical Associates (WI) clinics and 42.5% interest in ambulatory surgery center; included 90 multi-specialty providers
Practice Acquisition Trends

- Avanti Health (CA) – Acquisition of Coast Plaza Doctors Hospital (CA), a 117-bed **multi-specialty**, physician-owned hospital
- Catholic Health Initiatives (CO) – Acquisition of Nebraska Heart Hospital, a 63-bed, physician-owned **cardiology** hospital, and the Nebraska Heart Institute, a 30-physician **cardiology** group practice
- Memorial Health Care System (TN) – Acquisition of The Chattanooga Heart Institute (TN), the region’s largest **cardiology** group (23 physicians)
- HCA (TN) – Acquisition of Galichia Heart Hospital (KS), an 82-bed physician-owned **cardiology** hospital
Key Transaction Provisions

- While the structure and terms of today’s transactions are highly market- and provider-specific, in general they are more conservative than those of 1990s vintage deals...
  - Valuation and Purchase Consideration
    - Heightened concern about violating Stark and anti-kickback provisions through premium upfront valuations and/or valuations based on potential value to the hospital
    - Practice valuations today are more often based on their current and tangible assets (cash, A/R, equipment, supplies, facilities) and earnings from ancillary facilities/services
    - Fewer hospitals are paying for significant goodwill
    - Fair market, incentive-based salaries are often utilized to provide consideration upside
    - Trend towards asset purchases in order to limit the liabilities transferred to the acquirer, or holdbacks to cover breaches
Key Transaction Provisions

– Compensation Structure and Employment Agreements
  ■ Accountability is the basis for physician compensation today
  ■ Salaries are generally structured to include base and bonus components
    – Guaranteed for no more than 3 years
    – Bonus mechanics vary by transaction but are primarily tied to productivity, clinical efficiency and patient satisfaction measures
  ■ Non-competes are generally required in both purchase agreement and employment agreement
    – Details considered include term, geography covered, services covered, enforceability, etc

– Governance
  ■ Hospitals are providing physicians the opportunity to share leadership – at the board level and among senior management – in recognition of their ability to influence necessary change
Hospital-Physician Alignment – Will it work this time?

“Only time will tell whether this merger makes sense or not.”

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About Morgan Keegan...

- **Morgan Keegan Healthcare Investment Banking** (formerly Shattuck Hammond Partners) is one of the largest healthcare investment banking groups on the “Street,” with over 40 professionals operating out of offices in New York, San Francisco, Atlanta, Chicago and Nashville.

- 27-year history of providing client-focused, partner-level investment banking and advisory services for public, private and not-for-profit healthcare organizations across the country, with a focus on growth companies.

- Lead advisor on transactions in the healthcare industry totaling over $38 billion in asset value, including over $12 billion in M&A, $15 billion in Capital Markets, $7 billion in Real Estate transactions and $4 billion in derivatives.

- **Morgan Keegan** has over 340 investment bankers in more than 30 offices across the country have closed nearly 270 deals over the past 5 years, representing $52 billion.

- 27 senior equity research analysts covering approximately 300 companies, including 4 healthcare analysts covering more than 30 companies.

- Healthcare Services Analyst achieved Wall Street Journal Best on the Street Analyst Survey four times.

- Healthcare Information Technology Analyst designated by Financial Times/StarMine 2009 as Number 1 stock picker and Number 3 earnings estimator.

- Leading full-service brokerage and investment banking firm with $1.3 billion in revenues and over $74 billion in customer assets; 83% increase in revenues since 2001.

Morgan Keegan
Morgan Keegan & Company, Inc.
Members ﾂINRA, SIPC
Structuring the Transaction and Legal Issues

Richard K. Rifenbark, Senior Counsel, Foley & Lardner LLP and Adria Warren, Senior Counsel, Foley & Lardner LLP
Session Overview

- Federal and state regulatory implications
- Structuring options
Regulatory Issues

- Select Federal Issues
  - Federal Anti-Kickback Statute (AKS)
  - Physician Self-Referral Law (Stark)
  - False Claims Act (FCA)
  - Civil Monetary Penalty Law (CMPL)
  - Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Regulatory Issues

- Select State Law Issues
  - State anti-kickback statutes
  - State Stark laws
  - Corporate practice of medicine prohibitions
  - Fee splitting
  - Clinic/facility licensure
  - Covenants not to compete
  - Certificate of need
  - State privacy/security laws
Anti-Kickback Statute

- Federal criminal statute, also civil penalties
- Prohibits the knowing and willful payment or receipt of remuneration to induce referrals of items and services covered by a federal health care program
- Covers all types of arrangements & individuals
- Safe harbors
  - Provide immunity for certain arrangements
  - Not required
Anti-Kickback Statute

- Potential penalties for AKS violations
  - Up to $25,000 per offense
  - Up to five years imprisonment per offense
  - Mandatory exclusion from federal health programs
  - Civil monetary penalties
  - Liability under the FCA
Anti-Kickback Statute

- AKS practice acquisition safe harbors
  - Practitioner-to-practitioner safe harbor
  - Practitioner-to-other entity (hospital) safe harbor
    - Practice acquired is located in a HPSA
    - Sale is completed within three years
    - Seller not in a position to refer after sale completion
    - Purchaser must use diligent and good faith efforts to recruit a successor within one year to take over the practice
  - Most practice acquisitions are not safe harbored
- Bona fide employment exception and safe harbor
Anti-Kickback Statute

- If not structured to comply with the acquisition safe harbor, the operative question is whether the purchase price is a disguised kickback from the buyer (overpayment) or seller (underpayment) to induce post-deal referrals.

- Importance of valuation – to help negate an adverse inference of improper intent, the parties should obtain an independent appraisal of fair market value.
  - To the extent that a payment exceeds FMV, it can be inferred that the excess amount over FMV is intended as payment for the referral of health-program business. U.S. v. Lipkis, 770 F.2d 1447, 1449 (9th Cir. 1985)
Anti-Kickback Statute

- “Fair market value” means 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. Usually, the fair market price is the price at which *bona fide* sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in *bona fide* service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.
- OIG Advisory Opinions not available for FMV
Anty-Kickback Statute

- OIG views with suspicion payments for intangibles that reflect or relate to past or future referrals or are affected by the expectation or guarantee of a certain volume of business between the parties, such as payments for:
  - Goodwill
  - Value of an ongoing business unit
  - Covenant not to complete
  - Exclusive dealing arrangements
  - Patient lists
  - Patient records

See OIG Letter to IRS (December 22, 1992); Letter to the American Hospital Association (November 2, 1993); OIG Advisory Opinion 09-09
Stark Law

- Civil statute, covers only physician relationships
- Prohibits a physician from making referrals for certain “designated health services” (or DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship, unless an exception applies
- DHS includes, among other things, all inpatient and outpatient hospital services
- “Financial relationships” include both ownership and compensation relationships
- Intent is irrelevant
- Exceptions are required (if a financial relationship exists with a physician referring DHS)
Stark Law

- Penalties for Stark violations
  - Payment denial/recoupment by Medicare and Medicaid
  - Civil monetary penalties up to $15,000 per prohibited service/billing
  - Circumvention schemes face civil monetary penalties of up to $100,000 per incident
  - Exclusion from Medicare/Medicaid participation
  - Liability under the FCA
Stark Law

- Acquisitions of physician practices create a financial relationship that will prohibit referrals to the hospital buyer unless a Stark exception applies
- Strict liability—an exception must be met!
- The principal compensation exception for practice acquisitions is Stark’s “isolated transactions” exception
Isolated transactions exception requirements

- Aggregate payments fixed in advance (no earn outs)
- Amount of remuneration is consistent with the FMV of the transaction
  - Similar to valuation issues under the AKS if seller will continue to be in a position to refer
- Remuneration cannot take into account (directly or indirectly) the volume or value of any referrals by the referring physician or other business generated between the parties
- Remuneration must be commercially reasonably even absent any referrals
- No other transactions occur for six months, except Stark excepted transactions and commercially reasonable post closing adjustments
- Installment sales are permitted if integral to the transaction and the payments are guaranteed even if buyer defaults
Stark Law

- Associated transactions (e.g., employment, consulting, lease agreements) must also meet a Stark exception.

- Potential exceptions include:
  - Employment
    - Identifiable services
    - FMV and commercially reasonable
    - Does not take into account the volume or value of referrals
  - Personal services
  - Fair market value
  - Space rental or equipment rental
  - Indirect compensation

- All based on fair market value
False Claims Act

Among other things, the FCA makes it illegal for any person to:
- Knowingly present a false or fraudulent claim for payment or approval by the Government or Government contractors or grantees that receive federal funds
- Knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the Government

AKS: Section 6402(f)(1) of the Patient Protection and Affordability Act expressly states that a claim for items or services resulting from an AKS violation constitutes a false claim under the FCA

Stark: Failure to repay money received through Stark violations may also trigger FCA liability
False Claims Act

- Penalties: A civil monetary penalty of not less than $5,500 and not more than $11,000 per claim; treble damages; reasonable attorney’s fees

- Private citizens, called “relators” or whistleblowers, may bring FCA actions in the name of the Government and receive up to 30% of any settlement
Corporate Practice of Medicine

- Some states prohibit lay entities from employing physicians – this is often referred to as the prohibition on the corporate practice of medicine (CPOM)
  - “Corporations and other artificial legal entities shall have no professional rights, privileges, or powers. However, the Division of Licensing may in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made by any such institution, foundation, or clinic.” Cal. Business and Professions Code Section 2400.

- Rationale for CPOM: Protect independent judgment of physicians from profit motives of corporations
- The CPOM restricts the ability of hospitals to employ physicians following a medical practice acquisition
Corporate Practice of Medicine

- Penalties for violating the doctrine include:
  - Enforcement action by state AG
  - Enforcement action by applicable professional board
  - Debarment of the professional
  - Civil, criminal penalties, injunctive relief
Structuring Options

- Asset Purchase
  -- Employment Model
  -- Professional Services Arrangements (PSA)
  -- Management Services (MSO) Model
  -- Real Estate Component
- Stock Purchase/Merger
Typical Transaction Structures
Asset Purchase/Employment Model

- Health Care System
  - Hospital
  - Clinic
- Physician Practice
  - Assets
  - Employees

Transfer of Employees
Typical Transaction Structures

**Asset Purchase/Employment Model**

- Assets of Physician Practice are purchased by Health System Clinic
- Purchase price set at fair market value
- Physician employees, along with clinical and non-clinical staff become employees of Health System Clinic
- Physician employees are compensated at fair market value in Stark Law compliant employment arrangements
Typical Transaction Structures

Asset Purchase/PSA Arrangement

- Health Care System
  - Hospital
  - Clinic

- Physician Clinic
  - Asset Sale
  - PSA Compensation
  - Professional Services
  - Employees
Typical Transaction Structures
Asset Purchase/PSA Arrangement

- Assets of Physician Practice are purchased by Health System Clinic at fair market value
- Clinical and non-clinical staff become employees of Health System Clinic
- Health System Clinic bills for physician services
- Physicians remain employed by Physician Practice and enter into a long-term professional services arrangement to provide professional medical services to Health System Clinic for FMV compensation
- Physician Practice can also enter into a Management Agreement, with a separate management fee
- In a tax-exempt system, Clinic may be operated as 501(c)(3) organization
- The PSA Arrangement may also be entered into with a Foundation affiliate of the Health System
Typical Transaction Structures
Asset Purchase/PSA Arrangement

- Physician relieved of burden of capital investment and administration of Physician Practice
- PSA compensation can be structured utilizing various compensation methods
- Model works well in states with strict corporate practice of medicine standards
Typical Transaction Structures
Management Services Organization

- Health Care System
  - Hospital
  - MSO
- Physician Practice
  - Assets
  - Management Services
Typical Transaction Structures
Management Services Organization

- Physician Practice remains independent
- MSO acquires tangible assets
- MSO provides turn-key management services to Physician Practice
  - Equipment
  - Billing
  - Collections
  - Accounting
Typical Transaction Structures
Management Services Organization

- Purchase price limited to value of hard assets
- Physicians relieved of burdens of:
  - Capital investment
  - Administration of practice
- Physician practice remains at risk for reimbursement and physician compensation
- MSO services must be provided at FMV
Typical Transaction Structures

Asset Purchase

- Real Estate Component
  -- Often, physicians hold practice real property in a separate entity
  -- Transactions often structured to allow lease of real property to Health System
  -- Current leases may be renegotiated to obtain more favorable terms
  -- FMV lease valuations are advisable
Typical Transaction Structures

Stock Sale/Merger

Health Care System

Physician Practice → Clinic

Hospital

Physician Group Subsidiary

OR

Physician Group Division(s)/Employees

Merger/Stock Sale
Typical Transaction Structures
Stock Sale/Merger

- Can be used in non-corporate practice of medicine states
- Acquiror assumes all liability of the Physician Practice
Transaction Issues

- Purchase Price
  - Fair market value
  - Consideration of tax consequences

- Physician compensation must also meet regulatory safe harbor

- Regulatory approvals

- Due diligence and documentation
Case Study of a Practice Acquisition

C. Frederick Geilfuss II, Partner, Foley & Lardner LLP
and
Troy Wells, President, Arkansas Health Group
WHY AFFILIATE?

- Hospital Perspective
- Physician Perspective
- Theoretical vs. Real
ISSUES TO RESOLVE UPFRONT

- Define Expectations
  - Integration issues matter
- Consistency
- Be Decisive
- Build Trust
- History/Experience/Importance of Precedent
- Critical Initial Decisions
- Setting Your Team
STRUCTURE OF TRANSACTION

- Stock Purchase vs. Asset Purchase
- An Upfront Issue To Resolve
STRUCTURE OF TRANSACTION

- Stock Purchase
  - Take All Assets (Receivables, Cash) and Liabilities (Lawsuits), Assume Licenses, Permits, Provider Numbers
  - Take Unknown Liabilities – Malpractice Claims, Other Lawsuits, Medicare Repayments, False Claims Penalties
  - If Desire To Operate Tax Exempt: Taxable Gain To Be Recognized
  - Contracts May Not Require Consent (But Check)
STRUCTURE OF TRANSACTION (cont.)

- **Asset Purchase Transaction**
  - Purchase Identified Assets – Tangible and Intangible
  - Assume Identified Liabilities (and leave risk of others)
  - New Provider Number
  - Contracts Being Assigned
WHAT TO VALUE?

- Income, Cost, Market
- Date of Valuation
- Discounted Cash Flow (Adjust for Debt and Cash)
WHAT TO VALUE? (cont.)

- Value Assets Purchased
  - Tangible Assets – FFE, Supplies, Real Estate
  - AR: Don’t Include, Pay Advance Against Collection (w/o Acquiring) or Acquire
  - Intangible Assets
    - Non-Compete of Seller or Physician
    - Assembled Work Force
    - Software
    - Leasehold Equity
    - Name
    - Medical Records
  - Others
GOVERNANCE

- Clinical Autonomy

- Physician Compensation Decisions

- Potential Committees
  - Management
  - Clinical Services
  - Operations
PHYSICIAN EMPLOYMENT AGREEMENT

- Term

- Non-Compete
  - Geography vs. Other employer

- Other Provisions
  - Tied to affiliation agreement
PHYSICIAN COMPENSATION

Setting Initial Compensation
- Use of Prior W-2 Income
- Surveys

Signing Bonus

Retention Payments/Commitments To Stay

Group Retention Payments
PHYSICIAN COMPENSATION (cont.)

- Production Based Compensation
  - Base
  - WRVU and Percent Of Collections
  - Pool Approach

- Incentives for Quality

- Incentives for Other Initiatives

- Outside Income – Research Medical Directorships, IP, Expert Witness Testimony
NON-PHYSICIAN EMPLOYMENT

- Agree To Hire?
- Compensation
- Benefits – Comparison
- PTO (Vacation and Sick Pay)
- Onboarding: Criminal Check, Drug Testing
- WARN Act Issues
MANAGED CARE ISSUES

- What Do Agreements Provide
- What if Seller and Buyer Both Have Contracts
- Assignment Provisions
- Credentialing
ASSIGNMENT AND ASSUMPTION OF OTHER AGREEMENTS

- Required Consent: Asset vs. Stock Deals
- Medical Director Agreements
- Recruitment Arrangements
- Competitively Sensitive Agreements
- Space Leases – Estoppels
- Equipment Leases
REPRESENTATIONS, WARRANTIES AND INDEMNIFICATION

- Stock vs. Asset Differences
- Representation on Authority
- Representation on Legal Compliance
- Representation on Title
- Survival
- Liabilities Not Assumed
- Basket; Cap
PHYSICIAN-HOSPITAL ALIGNMENT STRATEGIES

Practice Acquisitions and Physician Employment Arrangements

May 24, 2011

We Will Return in 10 Minutes
Challenges in Valuing Physician Practices

David V. White, Executive Director, The Pinnacle Group
Transactions Accelerating

- Declining reimbursement.

- Technology and administrative pressures.

- Provider integration – changes in provider organizations.

- Quality of life/ career focus.

- Competition – “If your not doing it, your competitor may have an advantage”. 
Valuation Process Milestones

Initial Discussions/ Project Engagement and Planning - decision of attorney client privilege, key contacts and hospital engagement vs. joint engagement.

Asset Valuation – tangible assets, intangible assets as appropriate, etc.

Conduct Management Interview and Discuss Forecasts

Presentation of Draft Report

Issue Final Signed Report

Confidentiality Agreements

Term Sheet / LOI/ Data Request

3-6 weeks +

Presentation of Draft Report

Comments/ Discussion on Draft Report

Note – “Scope Creep and Tangential Issues Never Materialize” 😊
Information/ Due Diligence
(Wish List Items)

- Financial statements for each entity/division (income statement, balance sheet and cash flow statement) for the last 5 years. Also include most recent year-to-date financial statements/reports, if any, and for the same period in the prior year.

- Accounts receivable reports for each entity (most current, A/R subcategorized by financial class, i.e., self-pay, Medicare, BC/BS, etc.)

- Depreciation schedules.

- Provider compensation and benefits detail.

- Lease agreement(s) – equipment, technology and real estate.

- Budgets and financial projections for current year and beyond, if available.

- Documentation of notes payable, term loans or other outstanding indebtedness with amortization schedules, if any.

- Previous valuation reports or purchase price on ownership interests.

- Additional details on – physical plant, accessibility, managed care contracts, vendor arrangements, employees, payor mix, referring physicians, business development/ marketing, patient origin, superbill, procedure productivity by provider, etc.
Management Interview (themes) - Risk Assessment

- History on the Group (e.g. culture, significant events). Timing of key personnel entering / leaving the Group.
- Market and competition.
- Workforce issues – partners, administration and others.
- Capital improvement needs.
- Growth forecasts.
- New services which may impact revenue and costs going forward.
- Operational discussions – efficiency, workflow, technology (EHR), etc.
- Risks as perceived by the Group (could include but not be limited to payors, other practices, unsustainable operating costs, bad leases on space/equipment, etc.).

NOTE – Ask open ended questions and let the Group talk about themselves.
Trends on the Deal

- What is being bought or sold?
  - Specific tangible assets – majority consideration
    - Hard assets (itemization of furniture, equipment and analysis of supplies on hand)
  - Certain identifiable intangible assets – organizational decision
    - Medical records (active patient records within previous 2/3 years – not including deceased patients)
    - Assembled workforce (those positions that have been trained and will transition to new employment)
  - Leasehold improvements - case by case basis
  - Practice goodwill – trend across the country is not to consider
  - Leveraged income streams
    - Ancillaries – “it depends”
    - Employed providers (physician associates and midlevel providers) – no consideration
  - Liabilities and accounts receivable – no consideration, typically stay within practice entity
  - Patents and other intellectual property – case by case basis

- Note – most clients are focusing on compensation going forward and trying to minimize the cost and exposure to risk on the practice valuation.
Valuation Standards

Standard of Value - FMV

- ASA - “the price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arm’s length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both have reasonable knowledge of the relevant facts.” (American Society of Appraisers, Business Valuation Standards, 2010/2011)

- Stark / Anti-Kickback - “the value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use)...” (42 USC 1395nn (h)(3) - Limitation on Certain Physician Referrals)

  “...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 ... where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.” (42 CFR Section 411.351) Standard of Value – FMV

Premise of Value – Going Concern vs. Liquidation
Valuation Approaches - Cost

- **When to use**
  - Medical practice acquisitions
  - Low margin and unprofitable healthcare entities
  - Asset intensive entities (e.g., Hospitals, Diagnostic Imaging)

- **Common asset categories - tangible**
  - Accounts receivable
  - Inventory
  - Other current assets
  - Liabilities
  - Fixed assets
    - Leasehold improvements

- **Common asset categories – intangible (trends on organizational positions)**
  - Assembled workforce
  - Medical records
  - Non-compete agreements
  - Patient relationships – “Is the hospital paying for all the work we have done to help them in the past?”
  - Goodwill - trends and implications
Valuation Approaches - Income

- **When (NOT) to use**
  - Many medical practice acquisitions
  - Low margin and unprofitable healthcare entities

- **When to use**
  - Profitable going concern entities - ASC, Dialysis, Imaging
  - Discussion on ancillary business lines

- **Identifying factors that contribute to risk**
  - Reimbursement - payor mix
  - Volume – competition and demographics
  - Expenses
    - Suppliers – drugs and medical supplies
    - Capital expenditures
    - Workforce

- **Cash flow considerations**
  - Physician compensation
  - Management services/ revenue cycle
  - Medical director services
  - Real estate issues
  - Global billing – professional vs. technical (ancillary) revenue

- **Auditing and Coding (revenue vs. compliance risk)**
Valuation Approaches - Market

- **When to Use** – When you can identify good comparables; however, it is often difficult to find truly good comparables.
  - Public Companies
    - Too big
    - Too diversified
  - M&A Transactions
    - Pricing data not disclosed
    - Data unreliable
  - Issues to consider – leverage, cost structure, payor differences, productivity, etc.

- **When is it more appropriate to apply**
  - Cardiac catheterization labs
  - Ambulatory surgery centers
  - Dialysis centers
  - Hospitals/ LTAC’s / SNF’s

- **Possible Sources** – Pratts Stats, Levin Associates.
Reconciliation

- Review outcomes of the approaches.
- Consider the goodness of fit of each approach.
- Evaluate the correlation of the approaches.
- “Considered and included” vs. “considered and not selected”.
- Weighting.
Crossroads/ Considerations

"Stay with me now, people, because in step C, things get a bit delicate."
Transaction Lagniappe

- Data integrity.
- Revenue sources and sustainability.
- Owner emotions.
- Urban myths.
Closing Thoughts

- Consistency.
- Be cautious on paying now and in the future.
- Coordinate with other elements of the broader transaction.
Structuring Performance-Based Compensation to Align with a Payment System in Transition

Sean T. Hartzell, Senior Manager, ECG Management Consultants, Inc.
Today, we will discuss structuring post-transaction physician compensation arrangements.

I. Physician Employment Market and Trends
II. Emerging Compensation Models
III. Compensation Discussions/Negotiations
IV. Case Studies
I. Physician Employment Market and Trends
Driving Forces Behind Hospitals Employing Physicians

The pace of practice acquisition is accelerating.

- **Reimbursement Cuts** – Reimbursement cuts in key areas, such as imaging, ancillary testing, and drug administration, are resulting in declining incomes for physicians in independent practices (or longer work hours and stagnant incomes).

- **Lack of Capital** – The need for capital to fund investments in electronic health records (EHRs) is significant.

- **Physician Preference** – In recent years, physicians emerging from residency or fellowship programs have generally not been as interested in the traditional private practice partnership model.

- **Reform** – Looming payment reform, such as bundled payments for specific conditions or episodes of care, will link physicians and hospitals financially in the future.

- **Importance of Demonstrating Quality** – The need to demonstrate clinical quality across the continuum of care requires a tighter affiliation between hospitals and physicians.
## I. Physician Employment Market and Trends
### Hospital Employment – History

<table>
<thead>
<tr>
<th>Early 1990s</th>
<th>Mid-1990s</th>
<th>Late 1990s</th>
<th>Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding Frenzy</td>
<td>Panic/Chaos</td>
<td>Restructure/Divestiture</td>
<td>Network Maturity</td>
</tr>
<tr>
<td>“We must have physicians to compete for contracts!”</td>
<td>“What happened to capitation? Why are we losing so much money?”</td>
<td>“You figure this out, or we will close the doors.”</td>
<td>“We had better grow this thing if we expect to have a medical staff.”</td>
</tr>
</tbody>
</table>

### Key Drivers

- Managed Care and Capitation
- Bad Employment Contracts
- Fight or Flight
- Physician Shortages

### Range of Expected Loss Per Physician

- "Zero, if we get enough contracts!"
- $100,000 – $200,000
- $80,000 – $100,000
- $20,000 – $40,000
I. Physician Employment Market and Trends

Lessons Learned

Between the lessons learned from past experience and changes in the market, hospitals are smarter about physician employment today.

- **No Purchase of Goodwill** – Hospitals are only buying hard assets at their appraised value.
- **No Practice-Purchase Bidding Wars** – There are seldom bidding wars for physician practices, which historically inflated practice prices.
- **No High Guaranteed Salaries** – High guaranteed salaries weaken productivity incentives and can be very costly for hospitals.
- **Connection Between Productivity and Compensation** – A significant amount (at least 50%) of physician compensation should be productivity-based.
- **Financial Engineering to Obtain the Highest and Best Reimbursement** – Provider-based billing opportunities can significantly enhance revenue from employed physicians.
I. Physician Employment Market and Trends

Implications of Physician Employment by Nonprofit Entities

- **Fair Market Value Compensation** – Physician compensation must adhere to fair market value principles, as required by the IRS and Stark law. Noncompliance could potentially result in financial penalties, exclusion from Medicare/Medicaid, or revocation of tax-exempt status.

- **IRS Form 990** – Nonprofit organizations must submit this form annually. This form requires the disclosure of compensation amounts for the top five earners in the organization, and it is publicly available.

- **Physician Risk and Reward** – Both are typically reduced under hospital-based employment.

- **Distribution of Ancillary Profits** – Ancillary profits are much more tightly regulated for physicians employed by hospitals.

- **Physician Recruitment** – Hospitals have much greater latitude in supporting physician recruitment for hospital-employed physicians.

- **Referrals** – A hospital can require its employed physicians to refer to the employing hospital, except in cases in which they are prohibited by regulation (patient choice, physician judgment, payor determination).

- **Governance** – Physicians cannot form the majority of the hospital board or the committee that determines physician compensation. However, they can influence governance through the medical staff, physician advisory councils, etc.
I. Physician Employment Market and Trends

Impact on Provider Compensation Plans

Production-driven plans will need to evolve to reflect changing economics, but there is a reluctance to get too far ahead of reimbursement changes.

2010

- Productivity based on FFS.
- Incentive bonuses for quality and service.

2015 +

- Incentives for evidence-based medicine, outcomes, cost control, patient satisfaction, and teamwork.
- Global payments.

Organizations should consider developing a compensation plan strategy to push PCPs and other specialties toward global payments in a stepwise process that limits significant disruption.
I. Physician Employment Market and Trends

Compensation Plan Types and Metrics

In the next few years, we expect a shift in compensation models to better align incentives with value-based care that will reward a combination of physician production, resource management, and, ultimately, health outcomes.

Percentage of Physicians by Compensation Plan Type

Primary Performance Metrics for Variable Compensation

Source: ECG conducts regional provider compensation and production surveys in the Northwest and Midwest. These surveys include data from 63 provider organizations, representing 7,458 providers within 58 physician subspecialties and eight midlevel provider specialties.

The increase in the insured population, coupled with the physician shortage, will require compensation plans to maintain production-based components.
Over the past 4 years, hospitals have dramatically increased their ownership of physician practices.

2007 MGMA Physician Practice Ownership

2010 MGMA Physician Practice Ownership

As this trend continues, more and more existing physicians will find it difficult to continue in private practice.


In this new environment, compensation models must focus on more than just productivity.

Broadly, we believe that there are three fundamental approaches to designing a compensation plan that recognizes these new realities:

- **Metric-Driven** – Measure and pay for all the variables that drive the new definition of performance.
- **Salary-Driven** – Pay a base salary (with limited ranges) and rely on group culture and peer pressure to drive the desired behavior.
- **Balanced** – Pay a base salary that covers the most difficult-to-measure portions of physician effort, coupled with explicit incentives for easier-to-measure metrics.

With upcoming payment changes that may fundamentally alter the way provider organizations obtain reimbursement, it is important that provider compensation plans can adjust to these new incentives/revenue streams.
## II. Emerging Compensation Models

### Overview of Typical Plan Components

**The basic structure of a compensation plan must match organizational goals to achieve clear and definable incentives.**

<table>
<thead>
<tr>
<th>Typical Plan Goals</th>
<th>Incentive</th>
<th>Performance Metrics</th>
<th>Ease of Measurement/ Availability of Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reward a high level of clinical activity that will result in increased revenues and/or improved patient access.</td>
<td>Work Effort</td>
<td>Charges, net revenues, RVUs, panel size, visits/encounters, and office hours/availability.</td>
<td>High</td>
</tr>
<tr>
<td>Encourage cost-effective and clinically appropriate care.</td>
<td>Medical Management/ Quality</td>
<td>HEDIS indicators, inpatient days per thousand population, ambulatory visits per thousand population, and selective utilization rates (e.g., ER visits, MRIs).</td>
<td>Medium</td>
</tr>
<tr>
<td>Acknowledge a patient-oriented focus and the importance of patient satisfaction to enrollment growth.</td>
<td>Patient Satisfaction</td>
<td>Patient satisfaction surveys, patient complaints and compliments, and panel retention.</td>
<td>Medium</td>
</tr>
<tr>
<td>Reward the performance of nonclinical activities that benefit the organization.</td>
<td>Group Citizenship</td>
<td>Governance participation, committee participation, peer review, specific work group outcomes, and staff surveys.</td>
<td>Low</td>
</tr>
</tbody>
</table>
II. Emerging Compensation Models

Example Targets

A compensation model that incorporates service-related bonuses could potentially utilize the following metrics:

<table>
<thead>
<tr>
<th>Potential Metrics</th>
<th>Example Targets</th>
</tr>
</thead>
</table>
| Clinical Quality                  | • Adherence to selected Physician Quality Reporting Initiative (PQRI) quality guidelines.  
                                  | • Achievement of three unique quality metrics as approved by the service line governance committee. |
| Practice Operations               | • Participation in at least three service line committees.                       
                                  | • Active involvement in supply chain improvement initiatives.                   |
| Patient Satisfaction Scores       | • Achievement of predetermined patient satisfaction scores (e.g., internal benchmarks; indicators from the Press Ganey Associates, Inc., survey). |
| Financial Indicators/Practice Performance | • Cost reductions in excess of target each year.                                  
                                  | • Revenue gains of 5% each year.                                                |
| Outreach/Referral Relationships   | • At least 12 hours per month provided to community outreach in designated key areas.  
                                  | • Market share gains of 2.5% each year.                                         |
| Access                            | • Time to third available appointment within predetermined time period.           |
| Program Development               | • Achievement of program targets related to clinical research and/or program development (e.g., percutaneous valve program).  
                                  | • At least 16 hours per month provided to clinical research initiatives.         |
III. Compensation Discussions/Negotiations

Compensation Pool Funding and Distribution

Both the funding and distribution of future physician compensation need to be addressed during the acquisition process.

Compensation Pool Funding
• Will the compensation pool remain the same or grow?
• Will a compensation pool floor be established?
• How will the compensation pool be funded (e.g., percentage of collections, rate per WRVU)?
• Will new funding components be added (e.g., quality, retention)?
• For how long will this compensation pool funding methodology exist?
• Will there be any operating expenses that need to be covered other than physician compensation?

Compensation Pool Distribution
• Who will be eligible for pool distributions?
• How will the pool be distributed to physicians (e.g., even split, productivity, quality)?
• Will all physicians receive compensation using the same model/methodology?
III. Compensation Discussions/Negotiations

Key Employment Terms

In addition to the compensation pool funding and distribution, it is important to finalize other key contractual terms during the negotiations.

Key terms include:

• Length of initial contract and renewal process.
• Termination provisions.
• Adherence to established policies and quality standards.
• Practice restrictions and noncompetition/non-solicitation provisions.
• Utilization of facilities and other providers.
• Fair market value testing and potential reconciliation.
• Leadership responsibilities.

There are numerous other terms that may be standard to the acquiring organization or customized based on the situation.
### III. Compensation Discussions/Negotiations

**Contract Types**

A thorough examination of existing physician agreements (shareholder, partner, employee, associate, etc.) is a critical first step in developing a successful transition path.

The realities within the targeted medical group may require the hospital to create several contractual vehicles related to physician employment.

#### Example

<table>
<thead>
<tr>
<th>Contract Type</th>
<th>Pre-Transaction Employed Physician Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate</td>
<td>Pre-Associate</td>
</tr>
<tr>
<td>5-Year Guarantee</td>
<td>Initial</td>
</tr>
<tr>
<td>Continuation</td>
<td>Initial</td>
</tr>
<tr>
<td>2-Year New Hire</td>
<td>Initial</td>
</tr>
<tr>
<td>1-Year Contract(^1)</td>
<td>Initial</td>
</tr>
<tr>
<td>3-Year Evergreen</td>
<td>Thereafter</td>
</tr>
</tbody>
</table>

\(^1\) At the employer’s discretion, a pre-associate may be offered a 1-year contract or a series of 1-year contracts.
### III. Compensation Discussions/Negotiations

**Physician Division Policies**

Employed physicians may need to abide by policies already established within the acquiring organization.

<table>
<thead>
<tr>
<th>Policy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call Coverage</td>
<td>Addresses how employed physicians will participate in unassigned patient call coverage.</td>
</tr>
<tr>
<td>Completion of Medical Records</td>
<td>Identifies allowable time frames for employed physicians to complete patient medical records.</td>
</tr>
<tr>
<td>Work Expectations and Physician FTE Definition</td>
<td>Describes the minimum amount of time a physician will need to work to be considered a full- or part-time employee.</td>
</tr>
<tr>
<td>Board Certification</td>
<td>Identifies requirements for ensuring that employed physicians achieve or maintain certification within their designated specialty(ies).</td>
</tr>
<tr>
<td>Confidentiality and Conflicts of Interest</td>
<td>Describes types of information that must remain confidential and situations in which physicians should refrain from engaging.</td>
</tr>
<tr>
<td>Patient Scheduling</td>
<td>Describes how and what types of patients for which physicians need to provide access.</td>
</tr>
<tr>
<td>Charity-Care Documentation</td>
<td>Ensures that physicians document all instances in which charity care is provided.</td>
</tr>
<tr>
<td>Independent Review Process</td>
<td>Describes a review process in the event that an employed physician alleges undue intrusion into his/her practice of medicine.</td>
</tr>
<tr>
<td>Corrective Action</td>
<td>Identifies options at the hospital’s disposal should a physician be found in violation of the employment contract.</td>
</tr>
<tr>
<td>Compensation and Expense Reimbursement</td>
<td>Identifies how physicians will be compensated and what physician business expenses will be reimbursed.</td>
</tr>
</tbody>
</table>
IV. Case Studies
Large Multispecialty Group

In certain situations, it is wise to modify as few compensation elements as possible.

<table>
<thead>
<tr>
<th>Item/Key Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transaction</td>
<td>Large Midwest hospital purchased a 320-physician multispecialty medical group.</td>
</tr>
<tr>
<td>Compensation Funding</td>
<td>Whereas the group funded the physician compensation pool through collections, the hospital developed a specialty-specific funding rate per WRVU for clinical performance.</td>
</tr>
<tr>
<td>Compensation Distribution</td>
<td>The hospital agreed to maintain the current compensation pool distribution methodologies, which included specialty-specific methodologies (e.g., guaranteed salaries, collections-based, WRVU-based, pooling)</td>
</tr>
<tr>
<td>Contract Length</td>
<td>The hospital developed individual employment contracts that mimicked the group’s pre-transaction contracts for non-shareholders and a 5-year contract for shareholders. All contracts will convert to an evergreen contract after the initial period.</td>
</tr>
<tr>
<td>Termination</td>
<td>• A physician can be terminated by the hospital for cause after appropriate notice and cure period.</td>
</tr>
<tr>
<td></td>
<td>• Additionally, the hospital can terminate a physician in the event that the physician is prohibited from or restricted in the practice of medicine or in the case of unethical conduct.</td>
</tr>
<tr>
<td>Practice Restriction</td>
<td>Practice restrictions will remain the same as that found within the group’s pre-transaction shareholder and employee agreements.</td>
</tr>
</tbody>
</table>
## IV. Case Studies
### Single-Specialty Group

*Compensation constructs can be developed that mimic the economics of private practice.*

<table>
<thead>
<tr>
<th>Item/Key Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transaction</td>
<td>Mid-sized Mid-Atlantic health system purchased a single-specialty oncology group with 10 to 12 physicians.</td>
</tr>
<tr>
<td>Compensation Funding</td>
<td>Whereas the group funded the physician compensation pool through collections, the hospital developed a single funding rate per WRVU for clinical performance. This rate incorporated a certain level of budgeted clinical operating expense.</td>
</tr>
</tbody>
</table>
| Compensation Distribution | The group was responsible for paying actual clinical operating expenses out of the funded pool. The remaining funds were distributed in the following manner:  
• A portion of the compensation pool was split evenly across all physicians.  
• A portion of the compensation pool was split based on each physician’s individual productivity.  
• A portion of the compensation pool was split based on each physician attaining quality and patient satisfaction metrics. |
| Contract Length        | The system created an initial 5-year contract for each physician with evergreen provisions.                                                                                                                    |
| Practice Restriction   | For 2 years post-employment, the physicians agreed to not be employed by a hospital or health system within the acquiring organization’s primary or secondary service areas.                                       |
Questions?
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C. Frederick Geilfuss II is a partner with Foley & Lardner LLP and is a member of the firm's Health Care Industry Team. Mr. Geilfuss is co-chair of the Health Care Industry Team Business and Transactions Work Group. He counsels health systems, hospitals, medical clinics, rehabilitation agencies, nursing homes, and other health care providers on general operational concerns, regulatory and business matters. He has many years of experience in health care acquisitions, integrated delivery service issues, managed care contracting, defense of providers against government enforcement actions, finance, real estate, administrative and medical staff issues, physician recruitment, fraud and abuse matters, and other health law issues. Mr. Geilfuss has been recognized as one of the nation's outstanding health care transaction lawyers by Nightingale's Health Care News. He also has received a Lilly Award for his service on behalf of the mentally ill.

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Troy Wells has eleven years of combined administrative, operational, clinical, billing and business development healthcare experience. He has a Bachelor’s degree in Microbiology and a Master’s degree in Health Services Administration. He is an associate of the American College of Healthcare Executives and a member of Calvary Baptist Church.

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David White is a partner in the Pinnacle Group and founding member of Pinnacle Healthcare Consulting. His professional focus has been geared towards building stronger provider relationships and identifying shared business opportunities for healthcare businesses. He has extensive experience in the areas of new business development, health services valuation and financial analysis, healthcare market research, medical staff partnership planning and physician practice management consulting. During the past four years, he has managed over three hundred fair market value analyses. Mr. White has assisted health systems, community hospitals, rural hospitals, specialty health service providers, single and multi-specialty medical groups across the country. He has worked with national health plans regarding provider contracting and medical management issues.