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# Resource Guide





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# Avoiding the “New Normal” Trap: Maintaining the Integrity of Fair Market Value and the Compliance Process Through the Pandemic

**Joe Aguilar, MBA, MPH, MSN, CVA**

Partner | HMS Valuation Partners

[joe.Aguilar@HMSValue.com](mailto:joe.Aguilar@HMSValue.com)

**Natalie Bell, MBA, CVA**

Director | HMS Valuation Partners

[natalie.Bell@HMSValue.com](mailto:natalie.Bell@HMSValue.com)

**Wade Blundell, ASA, CVA**

Partner | HMS Valuation Partners

[wade.Blundell@HMSValue.com](mailto:wade.Blundell@HMSValue.com)

**Rob Holland, MBA, MPH, CVA**

Director | HMS Valuation Partners

[rob.Holland@HMSValue.com](mailto:rob.Holland@HMSValue.com)

**Mike Vetter, MBA, CVA**

Director | HMS Valuation Partners

[mike.Vetter@HMSValue.com](mailto:mike.Vetter@HMSValue.com)

The coronavirus (COVID-19) pandemic has required us to adapt quickly to changes such as wearing masks, social distancing, virtual learning, and working remotely. The healthcare industry is experiencing this same shift from what was “normal.” Physicians and health systems have had to ride the waves of what has been a sea change in the way healthcare gets done. Hospitals are having to plan for the surge of positive COVID-19 patients to their facilities, while simultaneously addressing physicians and other providers experiencing a reduction in patient volume. From the appearance of the first U.S. case of COVID-19 on January 20, 2020<sup>1</sup> to the announcement of a public health emergency and beyond, there have been various government support programs, regulatory waivers, and public health advisories.<sup>2,3</sup> With all these changes, including federal and state waivers, it is important to understand that financial arrangements continue to be under regulatory scrutiny and carry the burden of having to be commercially reasonable.<sup>4,5</sup>

Longstanding practices within healthcare compliance still apply in the face of COVID-19 and the existing waivers. The “new normal” that so many are talking about does not signify a moment to deviate from the analytical process, otherwise such deviation may place the health system at immense compliance risk. Considering COVID-19, there are a number of valuation scenarios that are repeatedly confronting compliance officers, health lawyers, and health systems as they rise to meet the challenges brought on by the pandemic. This article examines several prototypical cases to illustrate how to think through fair market value (FMV) in the context of COVID-19, federal/state waivers, and the changing healthcare delivery landscape. The cases include (1) valuing physician base compensation in the context of reduced production volume, (2) evaluating the compensation structure of hospital-based coverage agreements, (3) providing a potential undue benefit through deploying hospital-employed advanced practice providers (APPs), (4) evaluating the inputs when performing healthcare entity valuations, and (5) ensuring medical timeshare leases are not overpriced.

## Case Analysis 1 – Base Guarantee Compensation: When and How to Support Compensation in the Context of COVID-19

*Dr. Smith is a general surgeon employed by a health system with a base guarantee. His production has been negatively impacted by COVID-19 through the system’s decision to stop elective surgeries to maintain critical supplies and bed capacity for COVID-19 patients. Are there enough productivity and/or services that Dr. Smith is performing to support his base compensation?*

Health systems across the country are confronted with this question and finding that the answer is: It depends. To get closer to an answer, compliance teams need to define the base compensation in terms of the requirements and/or services that are being performed by the physician. What services is Dr. Smith performing? Is he at increased risk of contracting COVID-19? Is he performing additional services within or outside of his primary care specialty?

In this analysis, we will lay out two strategies to address the above questions and remain compliant: (a) address COVID-19 related needs through physician re-deployment, and (b) modify compensation design to align the base guarantee with expected levels of production.

### Address COVID-19 Related Needs Through Physician Re-deployment

Given the emerging needs surrounding the pandemic, some physicians experiencing a reduction in patient volume<sup>6</sup> are being redeployed to provide COVID-19 related services for the health system. Re-deployment can occur in clinical, administrative, or other service areas. Table 1 on page 16 illustrates the typical services provided by a physician for their base guarantee.

**Table 1: Components of value to derive base guarantee**

| Services / Requirements        | Value          |
|--------------------------------|----------------|
| Clinical Services              | A              |
| Administrative Services        | B              |
| Call Coverage Services         | C              |
| Other Services                 | D              |
| <b>Total Base Compensation</b> | <b>A+B+C+D</b> |

Options to support the base compensation include accounting for hours worked toward clinical redeployment; re-aligning the value for services provided; and recruiting physicians for needed administrative services.

#### *Clinical Redeployment*

To provide the necessary coverage, physicians are being redeployed to staff urgent care clinics, telehealth services, and inpatient COVID-19 units. Anesthesiologists, orthopedists, and cardiologists are seeing the greatest demand for their services and as a result, are forming COVID-19 teams to care for the surge of patients.<sup>7</sup> For example, Henry Ford Health System created a database of their 1,500 physicians illustrating each physician's training and skill set in order to determine who meets the guidelines to be able to provide ICU treatment versus general medical care.<sup>8</sup> These hours should be used in support of the clinical services being provided by those physicians.

#### *Re-alignment of value*

Re-aligning value also may provide support through either assigning greater value to each hour worked or by shifting value from production to quality-based metrics. While many health systems have not compensated physicians for hazard pay, the value associated with the increased health risk to physicians exposed to COVID-19 may be considered as support for the base guarantee. This concept is not without precedent considering hazardous duty pay in other areas (environmental differential pay,<sup>9</sup> imminent danger pay in the military,<sup>10</sup> off-shore drilling compensation,<sup>11</sup> etc.). The adjustment to compensation typically ranges between 10% to 30% of base compensation.<sup>12</sup> Further, given the industry shift toward quality-based care, compliance teams may consider adding a greater proportion of value toward quality metrics for the physician. By shifting a portion of compensation to incentives based on clinical quality, patient service, and organizational citizenship, compliance teams can document value attributable to these metrics and thereby further identify support for a physician's compensation.

#### *Administrative Support*

Physicians can also serve vital administrative roles toward combating the pandemic. Health systems are finding an increased need for clinical expertise to be included on administrative teams. To determine administrative compensation, the specialty data used should match the skill set, expertise, and job requirements needed. In terms of comparables, administrative compensation survey data should be prioritized when possible over solely utilizing clinical compensation

surveys.<sup>13</sup> Table 2 below demonstrates the importance of choosing the correct compensation level for the service given the difference between salaries reported from clinical compensation surveys versus medical directorship surveys.

**Table 2: Clinical Compensation Surveys vs Medical Directorship Surveys**

| Survey Percentiles                                         | 25 <sup>th</sup> Percentile | 50 <sup>th</sup> Percentile | 75 <sup>th</sup> Percentile | 90 <sup>th</sup> Percentile |
|------------------------------------------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| Family Medicine Clinical Compensation <sup>1</sup>         | \$108                       | \$127                       | \$153                       | \$188                       |
| Family Medicine Medical Director Compensation <sup>2</sup> | \$125                       | \$127                       | \$150                       | \$150                       |
| <b>Hourly Rate Discrepancy</b>                             | <b>\$17</b>                 | <b>(\$0)</b>                | <b>(\$3)</b>                | <b>(\$38)</b>               |
| Neurosurgery Clinical Compensation <sup>1</sup>            | \$354                       | \$438                       | \$558                       | \$693                       |
| Neurosurgery Medical Director Compensation <sup>2</sup>    | \$265                       | \$300                       | \$300                       | \$359                       |
| <b>Hourly Rate Discrepancy</b>                             | <b>(\$89)</b>               | <b>(\$138)</b>              | <b>(\$258)</b>              | <b>(\$334)</b>              |

<sup>1</sup> 2020 MGMA DataDive Provider Compensation and Production 2020 Survey. MGMA

<sup>2</sup> 2020 MGMA DataDive Medical Directorship Compensation Survey. MGMA

As seen in Table 2 above, the administrative hourly rates are lower across the majority of the percentiles when compared to the clinical survey data. The discrepancy widens proportionally as the clinical compensation increases with higher paid sub-specialists.

In summary, compliance teams should employ the following best practices when deriving the values to support the base guarantee:

- » Document all hours worked and identify value in any increased risk physicians are bearing under the pandemic.
- » Convert a portion of the base compensation to include quality metrics.
- » Review multiple surveys to ensure validity while minimizing the use of statistically insignificant data from small sample sizes.
- » Utilize the correct level of compensation from the surveys. Reported compensation in the surveys represents total compensation, including other earning streams (i.e. medical directorship, on-call coverage, graduate medical education (GME), sign-on bonuses, quality incentives, etc.). Therefore, when deriving a clinical only value, potential adjustments to the survey data need to be considered.
- » Evaluate total administrative hours for reasonability and determine the administrative hourly rate as a function of the total number of administrative hours worked.

#### **Modify Compensation Design to Re-align the Base Guarantee to Expected Production Levels**

For some physicians experiencing significantly less volume, redeployment may not be enough to support their base guarantee. As a result, health systems will need to adjust their compensation terms. The health system's compliance risk increases if the physician also receives various earning streams in addition to their base guarantee. Table 3 on page 17 illustrates this risk by comparing the compen-



sation metrics for a general surgeon at 8,000 wRVUs versus 5,000 wRVUs with a base guarantee of \$400,000 per year.

| Table 3: Impact of production on base compensation |                                                      |                                                            |                |
|----------------------------------------------------|------------------------------------------------------|------------------------------------------------------------|----------------|
| Compensation Category                              | High Production Volume at 8,000 wRVUs                | Low Production Volume at 5,000 wRVUs                       | Value          |
| Base Guarantee                                     | \$400,000 per year                                   | \$400,000 per year                                         | A              |
| Call Coverage                                      | \$ 90,000 per year                                   | \$ 90,000 per year                                         | B              |
| Medical Direction / Administrative                 | \$ 35,000 per year                                   | \$ 35,000 per year                                         | C              |
| GME Didactic / Other Services                      | \$ 10,000 per year                                   | \$ 10,000 per year                                         | D              |
| <b>Total Physician Compensation</b>                | <b>\$535,000 per year</b>                            | <b>\$535,000 per year</b>                                  | <b>A+B+C+D</b> |
| <b>MGMA Benchmarking &amp; Ratio Analysis</b>      |                                                      |                                                            |                |
| <b>Total Compensation per wRVU</b>                 | <b>\$66.88 per Wrvu (50<sup>th</sup> Percentile)</b> | <b>\$107.00 per wRVU (&gt; 90<sup>th</sup> Percentile)</b> |                |

As can be seen through this analysis, the total compensation can vary significantly in terms of the effective compensation to wRVU ratio. Under the reduced volume and the unadjusted base guarantee, the effective compensation to wRVU ratio is \$107 which benchmarks at 102% of the 90th percentile. Given production at the 25th percentile, maintaining the physician's base compensation at this level would increase the system's compliance risk. Some of the steps that can be taken to mitigate the risk are as follows:

- » Reduce the base to a level consistent with clinical production.
- » Require some or all of the earning streams (on-call, administrative, and APP supervision services) to be compensated under the base guarantee.
- » Continue with current base under the assumption that production volume is expected to return to prior levels and any deficit would be reconciled at year end or upon early termination.
- » Calculate the effective wRVU conversion rate and/or compensation to professional collection ratio to ensure that the base guarantee is not out of balance with the work requirements.

Physician compensation needs to be specific to each physician and his/her set of circumstances. As a result, compensation plans need to be responsive while proceeding through the pandemic.

## Case Analysis 2 – When Hospital Inpatient Demand Goes Down: Structuring a Compliant Hospital-based Coverage Agreement

*Anesthesiology Services, Inc. has an agreement with the health system for anesthesia coverage for six sites of service under a collections guarantee. Given reduction in elective procedures and non-COVID-19 services, the volume of professional services provided by the anesthesia group dropped by 50%. The health system is concerned about maintaining an agreement that is compliant.*

Hospitals are currently reviewing professional services agreements (PSAs), like the one described above with Anesthesiology Services, Inc., to ensure that the health system remains compliant and financially viable given the impact on inpatient services from the pandemic. What is the compensation structure for the PSA? How does the structure translate into the health system's payment obligation? How do we account for relief fund packages, such as the Paycheck Protection Program (PPP), received by contractors and physician groups?

In this case analysis, we will discuss the analytical framework by which compliance teams can review their hospital-based PSAs and account for: (1) receipt of COVID-19 relief funding by contractors and (2) declines in patient volume.

### Account for PPP and Other COVID-19 Relief Funds

Relief funds received by contractors and physician groups are meant to help cover the cost associated with their practice in light of the reduction in patient volumes due to the pandemic. While these funds are not professional collections, they do need to be accounted for, especially under a collections guarantee compensation structure. In this case, Anesthesiology Services, Inc. has received PPP funding to help cover payroll costs. The health system is reconciling the group's collections against the monthly collections guarantee. In doing so, it is critical for systems to include all PPP and other COVID-19 relief funds received in their reconciliation process. Otherwise, the health system may be paying more than appropriate to the contractor. Table 4 below illustrates the impact from excluding such funds from the reconciliation calculation.

| Table 4: PPP and other COVID-19 relief funds under a collections guarantee |                          |                       |                                               |                  |
|----------------------------------------------------------------------------|--------------------------|-----------------------|-----------------------------------------------|------------------|
| Reconciliation                                                             |                          | Collections Guarantee | Collections Guarantee with PPP / relief funds | Variance         |
| <b>Collections Guarantee</b>                                               | A                        | \$3,900,000           | \$3,900,000                                   |                  |
| <b>Less: Professional Collections</b>                                      | B                        | (\$2,500,000)         | (\$2,500,000)                                 |                  |
| <b>Less: PPP / Relief Funds</b>                                            | C                        | \$0                   | (\$500,000)                                   |                  |
| <b>Health System Payment to Contractor</b>                                 | <b>A minus B minus C</b> | <b>\$1,400,000</b>    | <b>\$900,000</b>                              | <b>\$500,000</b> |

Given the sample reconciliation statement above, the health system would save \$500,000 per year by correctly incorporating the relief funds into the collections guarantee reconciliation. If excluded, the health system's potential overpayment may result in a compliance and/or financial risk. As such, all collections received and used by the contractor toward the services provided under the PSA need to be included in the reconciliation process.

### Establish a Maximum Stipend in the Context of a Collections Guarantee Structure

The benefit of the collections guarantee structure is that both parties share in the financial risk. However, the primary risk to the health system under this structure is when production volume declines. In this case, Anesthesiology Services, Inc. has experienced a 50% drop

in patient volume. Given this drop in volume and associated professional collections, the health system is potentially exposed to paying higher than expected compensation to the contractor. Table 5 below provides an illustration of this exposure by comparing the impact on the health system's contractual payment under current patient volumes with the payment at pre-pandemic levels.

| Table 5: Potential financial risk under a collections guarantee     |               |                       |                 |               |
|---------------------------------------------------------------------|---------------|-----------------------|-----------------|---------------|
| Service-Line Income Statement                                       |               | Pre-pandemic analysis | Pandemic Impact | Variance      |
| Professional collections                                            | A             | \$2,500,000           | \$1,500,000     | (\$1,000,000) |
| Physician / APP compensation                                        | B             | (\$3,500,000)         | (\$3,500,000)   | \$0           |
| Physician malpractice                                               | C             | (\$100,000)           | (\$100,000)     | \$0           |
| Operating expenses                                                  | D             | (\$300,000)           | (\$300,000)     | \$0           |
| Net income/loss                                                     | G             | (\$1,400,000)         | (\$2,400,000)   | (\$1,000,000) |
| Implied annual collections guarantee                                | Sum B+C+D+E+F | \$3,900,000           | \$3,900,000     | \$0           |
| Implied annual stipend paid by health system                        | A minus G     | \$1,400,000           | \$2,400,000     | \$1,000,000   |
| Adjustment to Compensation Terms (Setting a Maximum Annual Stipend) |               |                       |                 |               |
| Service-Line Income Statement                                       |               | Pre-pandemic analysis | Pandemic Impact | Variance      |
| Maximum Annual Stipend under PSA                                    |               | \$1,700,000           | \$1,700,000     |               |
| Implied annual stipend paid by health system                        |               | \$1,400,000           | \$1,700,000     |               |
| Financial risk shifted to contractor                                |               | \$0                   | \$700,000       | \$700,000     |

As can be seen, the annual collections guarantee remains \$3,900,000; however, the drop in patient volume has resulted in the anesthesia group collecting \$1,000,000 less as a result of the pandemic. Holding constant expenses, the health system will absorb this collections loss through their annual required payment. Under a collections guarantee compensation structure, the health system bears most of the risk associated with patient volume fluctuations. This risk can be mitigated by contractually setting a maximum stipend to be paid under the subject agreement. This adjustment to the compensation terms is shown in Table 5 above. For instance, if the maximum was set at \$1,700,000, then the health system would have saved \$700,000, instead of being obligated to pay the additional \$1,000,000.

### Case Analysis 3 – Proceed With Caution When Deploying Hospital Employed APPs to Assist Contractors and Community Physicians

*Hospitalist Services, Inc. has an agreement with the health system to cover the inpatient units under a stipend arrangement. Given the surge of COVID-19 patients, the volume of professional services provided by the hospitalist group has increased*

*by 75%. The group is concerned about caring for the increase in patient volume and believes it needs to add more staffing and compensation. Amid this surge in COVID-19 patients, the hospital decides to hire 3 APPs for the service to use while holding constant the current stipend.*

APPs are increasing in number across the U.S. healthcare system and are commonly used within hospital-based specialties.<sup>14</sup> The pandemic has resulted in increased regulatory flexibility surrounding the use of APPs in terms of supervision, reimbursement, and scope of practice.<sup>15,16</sup> This flexibility has continued to fuel a not-so-uncommon practice for health systems to employ hospital-based APPs and place them within a hospital-based service line as members of the patient care team. This occurs in a wide range of specialties, including but not limited to hospitalist medicine, intensive care medicine, emergency medicine, obstetrics and gynecology, general/trauma surgery, radiology, and neonatology services.

In this case, APPs employed by the health system are material as it relates to the value of the subject agreement with Hospitalist Services, Inc.—this is a salient point that is often overlooked. If APPs are being used but are not employed by the contractor, the costs associated with them should not be a factor in either deriving the stipend or the collections guarantee. As Table 6 below illustrates, there is a significant difference (\$240,000 per year) to the subject agreement compensation depending on the APP costs factored into the model. This carries a potential compliance risk for providing an undue benefit to the hospitalist group.<sup>17</sup>

| Table 6: APPs Employed by Health System: Calculating the Undue Benefit |                                                  |                                                |           |
|------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------|-----------|
| Income Statement                                                       | Hospitalist Service – APP Employed by Contractor | Hospitalist Service – APP Employed by Hospital | APP Value |
| Total Revenues                                                         | \$1,000,000                                      | \$1,000,000                                    |           |
| Expenses:                                                              |                                                  |                                                |           |
| Physician Costs                                                        | \$1,200,000                                      | \$1,200,000                                    |           |
| APP Costs                                                              | \$240,000                                        | -                                              |           |
| Professional Liability                                                 | \$60,000                                         | \$60,000                                       |           |
| Operating Expenses                                                     | \$126,000                                        | \$126,000                                      |           |
| Total Expenses                                                         | \$1,626,000                                      | \$1,386,000                                    |           |
| Implied Subsidy                                                        | \$626,000                                        | \$386,000                                      | \$240,000 |

From a billing perspective, the health system and the hospitalist group may be out of compliance if the group is receiving reimbursement for services provided by the APP under incident-to or shared/split visits rules. Regardless if all medical documentation requirements are met by the physician group, the fact that the APP is not employed or leased by the same entity as the hospitalist, may violate the billing guidance specific to Medicare payers.<sup>18</sup> In addition, only the APP's employer may be reimbursed for their services. As a result, a case could potentially be made for falsely submitting claims for services partly performed by the hospital-employed APPs.

In order for hospital-employed APPs to help shoulder the burden of increased patient volumes associated with COVID-19, there are a few strategies and contractual arrangements that can be used:



- » Have the contractor, such as Hospitalist Services, Inc., employ the APPs directly and adjust their PSA compensation structure accordingly.
- » Hospital may lease APPs to the contractor at FMV rates for the services provided.
- » Split/Shared billing only done when APPs are within the same group as the physician.

## Case Analysis 4 – Healthcare Transactions: Determining the Value of an Entity in an Altered Healthcare Landscape

*A large primary care practice, ABC Family Care, is navigating the pandemic. However, they are experiencing a significant decline in volume and profitability. Given the current environment, they turn to the local health system to purchase their practice. The challenge for the compliance team is determining a value that appropriately factors in the impact from COVID-19, recognizes future stability in cash flows as the practice moves through the pandemic, and ensures that the transaction passes compliance scrutiny.*

COVID-19 is fueling a change to the healthcare landscape that will result in increased acquisition activity with physician groups, home health agencies, and ambulatory surgery centers, to name a few.<sup>19</sup> In this case, the physician owners of ABC Family Care are looking for a strategic alignment in order to increase stability and create opportunity for greater profitability. Given the consolidation in the healthcare space, business development teams at health systems across the nation will be under pressure to put forth competitive offers while maintaining compliance. As health systems look to acquire these entities for the purposes of growth, mission alignment, or vertical/horizontal integration, there will be increased scrutiny of these transactions in addition to the existing regulatory constraints. This is especially so given the large sums of healthcare relief funding provided by the government, coupled with the significant number of distressed healthcare entities. In a recent Federal Trade Commission (FTC) blog, Ian Conner with the Bureau of Competition alluded to preventing anti-competitive behavior by closely observing transactions in the context of the pandemic.<sup>20</sup> California has recently put forth Senate Bill 977 where parties would need to obtain regulatory approval prior to consummating the transaction.<sup>21</sup> More states may follow the lead of the FTC and California. Given the potential for increased regulation, it is all the more important to ensure that established appraisal standards, outlined by industry associations like the American Society of Appraisers (ASA), National Association of Certified Valuation Analysts (NACVA), and American Institute of Certified Public Accountants (AICPA), dictate the approach to valuing the entity in light of COVID-19.

In this case analysis, we will review some of the critical elements that drive healthcare entity valuations as well as discuss appropriate methods and standards to be used in factoring in the effects of the pandemic on each. Decisions made regarding each of these elements have a material impact on the ultimate value derived from the analysis. To illustrate this point, we will focus on a few key areas:

(a) factoring in risk, (b) projecting reliable cash flows, (c) addressing the marketability of the entity, and (d) identifying comparable transactions.

### Discount Rate: Factoring in the Risk

The components of the discount rate generally include (1) a risk-free rate, (2) an equity risk premium, (3) small company size premium, and (4) company-specific risk. On one hand, current interest rates on treasury bills are at historic lows, suggesting that the current risk-free rate of return in the market is significantly lower today than it was a few months ago. On the other hand, few would argue that there is less risk in the market today, so discount rates would tend to be higher. In order to fully account for current market conditions, it may be necessary to normalize both the risk-free rate and the equity risk premium as well as adjust the company-specific risk to capture the immediate and long-term effects of the pandemic in relation to the specific investment being valued. However, the valuation should take care not to undervalue the entity, such as ABC Family Care, by overstating the discount rate and understating the projected cash flows. This could potentially double count the risk.

### Reliability of Cash Flows: A Call for Scenario Analyses

How reliable are ABC Primary Care cash flows? This is a critical question to answer when determining the value, not only for regulatory and FMV purposes, but also from a strategic and financial viability perspective. Given unemployment rates increasing and individuals losing their employer-based health insurance, will patients limit their visits to the doctor? How will providers continue to increase volumes while also taking steps to maximize the safety of their patients and staff? What impact will advances in telemedicine and their adoption have on the practice? Will these changes be for the short-term, medium-term, or long-term? Cash flows are one of the key drivers in the valuation under the income and market approaches. Performing various scenario analyses by varying recovery periods, and documenting the assumptions under each, will help provide the necessary support to ensure a value that is appropriate and applicable to the entity.

### The Value of Liquidity: Discounts for Lack of Marketability

Applying pertinent premiums and/or discounts to the value remains a necessary adjustment to arrive at an accurate opinion. In the context of the pandemic, special attention should be made toward determining the potential discount for lack of marketability. Given the volatility in the markets along with the uncertainty in the course of the pandemic, the ability to liquidate the value of the business entity could potentially be impacted. If the pandemic causes an increase in mergers & acquisitions activity in the healthcare sector as some suggest, then a smaller discount may be warranted. On the other hand, if the pandemic causes delays in consummating those deals and it takes longer for the transaction to occur, then a larger discount may be appropriate. As a result, the application of a potential discount due to lack of marketability must be considered in the context of current market conditions.<sup>22</sup>

### Market Approach: Comparability is Critical

Valuators will need to nuance the market approach in the coming year as the multiples relied upon in the past may bear little resem-

blance under COVID-19 economic conditions. Comparability to the subject entity is critical to the validity of the market approach. This method looks at multiples derived from a measure of value (i.e. market value of invested capital (MVIC), earnings before interest, taxes, depreciation, and amortization (EBITDA), Price/Earnings). Comparing pre-COVID transaction data to post-COVID measures of value for the subject entity creates an inherent flaw in the resultant value. Despite this flaw, there may be some adjustments that can be made to this method to normalize for the economic impact from COVID-19. Perhaps looking at the relative change in market capitalization within the space may give insight into the adjustment that should be made to the multiple.

Business valuations going forward will vary depending upon the type of entities involved in the transaction. Hospitals that are financially viable will continue their acquisition activity only if it is critical to their strategic plan, while other less fortunate hospitals may be forced to merge or be acquired. Physician groups will be looking to merge and/or partner with private equity firms or health systems. The level of transaction activity as well as the impact from COVID-19 will be specific to the sector within the healthcare industry.

## Case Analysis 5 – What Stark Waivers Don't Waive: Overpayment for Medical Office Timeshares Is Still Not Permissible

*Dr. Jones' partner has just retired, leaving some additional space in his practice underutilized. To expand their service area in obstetrics/gynecology (OB/GYN), a health system enters into a medical office timeshare with Dr. Jones to place one of their employed OB/GYN physicians in Dr. Jones' office two (2) half days per week. Under the Stark waivers, timeshare arrangements are mentioned.*

While medical office timeshares are mentioned, all timeshare arrangements are not equally covered by the blanket Stark waivers. Only those timeshare arrangements that fall below FMV for the lease of office space, equipment, and services apply under the blanket waiver.<sup>23</sup> As a result, while there is coverage on the lower end of FMV range, the health system still needs to concern itself with potentially paying Dr. Jones above FMV for the timeshare lease.

Given the current environment and the pressures to increase volumes for physicians and hospitals, the health system may be willing to pay higher rates than normal for the timeshare lease. Higher than normal does not necessarily mean above FMV; however, it is critical that the system understand the value drivers that determine the rate. To determine the reasonability of a rate, the compliance team will first need to identify the components and services within the lease arrangement.

### Space

The space should be calculated from an architectural drawing defining the square footage utilized in the subject agreement. Common areas along with dedicated exclusive use areas need to be clearly demarcated in the analysis to ensure that the space utilization is calculated accurately. After the total square footage applicable to

the tenant is identified (exclusive use square feet plus allocated shared common area square feet), it is multiplied by the FMV full-service rental rate of the space. It is recommended that this rate be determined by a real estate appraiser and account for building operating expenses.

### Furniture and Equipment

Similar to the space analysis, the furniture and equipment utilized within the common and dedicated exclusive use areas need to be included. This may constitute waiting room chairs, desks, tables, computer/office equipment, etc. Obtaining market comparables versus utilizing depreciation schedules will yield a more accurate assessment of value. In addition, the Stark Law has a provision that dictates the ability to include medical equipment under these arrangements depending on whether the equipment is shared or used exclusively.<sup>24</sup> Equipment cost paid for by the tenant can be excluded.

### Services

There is variability in the specific services offered under these arrangements. These services may include telecommunication services, front desk receptionist duties, nursing staff assistance, medical and office supplies, cable television, magazines, water and coffee supplies, among others. The provision of a receptionist and nursing staff of the leasing practice is often overlooked. A physician tenant may not be able to provide their own front desk receptionist, relying on the medical office's receptionist to greet a patient, provide paperwork to the patient, and notify the nurse the patient has arrived. Excluding this cost has a material impact on the FMV timeshare rate and needs to be included to ensure compliance.

### Short-term Use Premium

A major component often missing from the medical office timeshare value is a short-term use premium. In other industries, a premium is paid for the part-time use of space or services (i.e. conference room, executive office suite, rental car, hotel, equipment, etc.). Medical office timeshares are no exception; in fact, it is essential to ensuring compliance. This premium can be impacted by the number of tenant time slots leased, the landlord utilization risk, and current market comparable transactions.

Each component of a timeshare transaction should be evaluated and added together to guide health systems in determining the upper end of value. Should the lease rate exceed such an analysis, the arrangement will need to be adjusted accordingly.

## Summary

While the cases discussed do not cover all of the newly emerging challenges, the cases do illuminate the analytical framework and valuation principles needed to assess financial arrangements and provide a defensible value. Understanding and employing time-tested valuation principles within the context of the COVID-19 pandemic will help ensure safe navigation through the financial and regulatory risk in the current environment. Although the environment may be changing, the approach toward determining value should not.



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