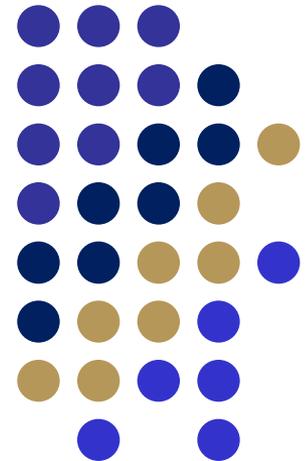


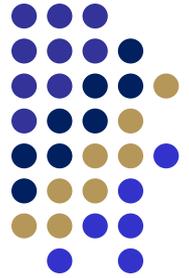
# Fair Market Valuations Exploring the Black Box

*American Bar Association Health Law Section  
Physicians Legal Issues Conference*

Presented by:  
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June 13, 2013



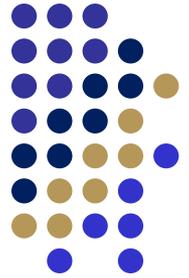
# Outline of Presentation



- Why Valuations are Needed / Why FMV Matters
- Valuation Basics
- Experience from the Physician Practice Side

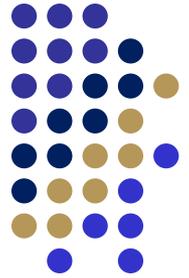
# Why Valuations are Needed

## Answer: Healthcare Laws



- **Intent of Statutes**
  - Desire for medical decisions to be made without influence from financial considerations or incentives
- **Three compelling reasons to comply:**
  - The “Stark” law is Strict Liability
  - Severe Penalties (no “traffic school” for violators – just SRDP)
  - Broader Enforcement efforts are clearly underway
- **Penalties include:**
  - Repayment – of any tainted collections
  - Fines – Substantial size fines for each tainted claim
  - Incarceration; and
  - Exclusion from the Medicare and Medicaid Programs.
- **Enforcement considerations:**
  - Hospitals, hospital executives, and physicians are all targets
  - Even if exonerated or DPA/CIA granted, defending claims is expensive

# Why Valuations are Needed



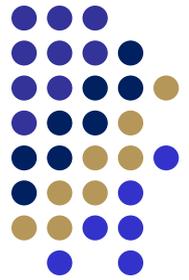
- **Anti-Kickback Statute** (*Criminal Statute – Felony*)
  - Prohibited – Intentional payment for referrals (past, present or future)
  - 22 Safe Harbors offer protection - Key ones require FMV
  - OIG Advisory Opinions – frequently require FMV
- **Stark Statute** (*Civil Law - not criminal*)
  - Prohibited – Financial relationships between physicians and “DHS” entities to which they refer UNLESS the arrangement fits into a Stark exception.
    - Most exceptions require transactions to be: consistent with FMV and “commercially reasonable”
  - Commercial Reasonableness – different from FMV
  - How to determine FMV? Government commentary limited (*more on that shortly*)
- **IRS Private Inurement Guidance** (*for non-profit entities*)
  - Prohibited - Use of public funds to benefit private individuals or for-profit entities.
  - What is legitimate compensation?
    - Payments for items or services needed to ensure the non-profit mission
    - Payments must not exceed FMV for the items or services provided
  - Penalties: Loss of non-profits status (back taxes owed) or “intermediate sanctions”

# Why FMV Matters - Comparison of Key Laws

	<b>Stark</b>	<b>Anti –Kickback</b>	<b>IRS Private Inurement</b>
<b>Parties at Risk</b>	Physicians & DHS Entities only	Everyone	Non-Profit Entities & Individual or For-Profit entity
<b>Types of Referrals</b>	DHS referrals only	Any Federal Program Referrals	Existence of referrals okay; but are they strategic value?
<b>Intent Required</b>	Strict liability, no intent required	Intent required	Depends on situation; Rebuttable presumption key
<b>Criminal vs. Civil</b>	NOT Criminal Civil penalties only	Both Criminal and Civil penalties	Civil; penalties vary, depending on circumstances
<b>Exceptions/ Safe Harbors</b>	Exceptions are <u>mandatory</u> (if no exception met, arrangement is prohibited)	Safe Harbors are <u>voluntary</u> (if not in a safe harbor, may still be okay)	Rebuttable Presumption (in Intermediate Sanctions rules)
<b>FMV</b>	Most exceptions require FMV	Not required, but OIG has said lack of FMV is evidence of a possible kickback	All payments for reasonably necessary items and services must be at FMV (IRS std)
<b>Commercial Reasonableness</b>	Many exceptions require CR	Not required, but OIG strongly prefers it	Goods or services must be necessary to achieve entity's mission or objectives.

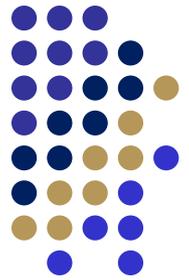
# Why Valuations are Needed

## Stark Definition of FMV



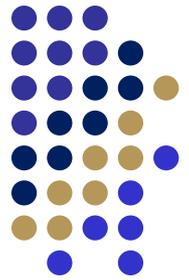
- The value in arm’s-length transactions, consistent with the general market value.
- “General market value” means the compensation that would be included in a service agreement as the result of *bona fide* bargaining between well informed parties to the agreement **who are not otherwise in a position to generate business for the other party.**
- “...the definition of “fair market value” in the statute and regulation is qualified in ways that do not necessarily comport with the usage of the term in standard valuation techniques and methodologies. For example, the methodology ***must exclude valuations where the parties to the transactions are at arm’s length but in a position to refer to one another.***” [emphasis added]

# Why Valuations are Needed Above or Below FMV?



- What payments are consistent with FMV?
  - Less than upper limit of FMV range
  - Greater than lower limit of FMV range
  - Must be between low and high of the FMV range
- Which way is the money flowing?
  - From Hospital to Physicians
  - From Physicians to Hospital
- Which way are the referrals flowing?
  - From Physicians to Hospital
  - From Hospital to Physicians
  - BOTH directions

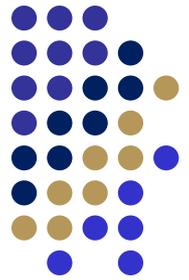
# Why Valuations are Needed Above or Below FMV?



	Hospital Pays Physicians (e.g., Med Director, Call Coverage, etc.)	Physicians Pay Hospital (e.g., Space Lease)
Physicians refer Patients to Hospital <i>(Stark &amp; AKS apply)</i>	BELOW Upper Limit of FMV	ABOVE Lower Limit of FMV
Hospital Refers Patients to Physicians <i>(only AKS applies)</i>	ABOVE Lower Limit of FMV	BELOW Upper Limit of FMV
Both Parties Refer Patients to Each Other <i>(Stark and AKS apply)</i>	WITHIN FMV Range	WITHIN FMV Range

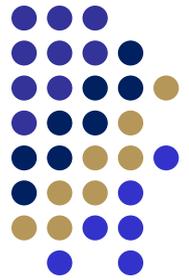
# Why Valuations are Needed

## Recent Cases & Settlements



- **Tuomey Case** – 2013 (retrial), 2012 (appellate opinion)
  - Hospital employs doctors part-time for outpatient surgeries only, doctors remain independent for inpatient work; Purpose and FMV questioned
- **Bradford Case** – 2010
  - Hospital pays doctors for use of camera and broad non-compete
- **Recent OIG Opinions**
  - **12-22** – Favorable opinion on co-management transaction
  - **12-15** – Favorable opinion on call coverage arrangements
  - **12-06** – Negative opinion on two ASC-Anesthesia transactions
- **NFIB v. Sebelius** (ACA Supreme Court case - 2012)
  - FMV impact: Enforcement efforts, Sunshine rules, ACOs, Payor mix
- **Recent Settlements** (in 2012)
  - Parkview – Lease rate – FMV opinion shopping was claimed
  - Renown – FTC challenges acquisition as too anti-competitive

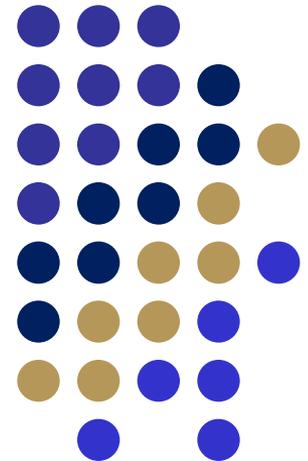
# Why Valuations are Needed - Some Older Cases to also Consider:



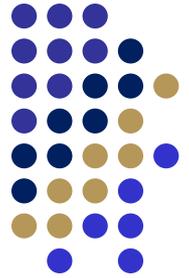
- **United Shockwave Settlement** – July 2010
    - Urologists use referral threats to win lithotripsy contract at hospital
  - **OIG Advisory Opinion 09-09** – July 2009
    - Footnote questions the viability of the income approach
  - **Covenant Settlement** – August 2009
    - Iowa doctors on a PCE deal allegedly overpaid – expenses questioned
  - **Kosenske Case** – Appellate Opinion - January 2009
    - FMV is hypothetical, not what actual parties can negotiate
  - **Villafane Case** – April 2008
    - FMV unsuccessfully challenged in academic medical center case in Kentucky
  - **Derby Case** – IRS case from 2008
    - Intangible Assets case
  - **Tenet - Alvarado/Northridge Cases** – 2006
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## *Valuation Basics*

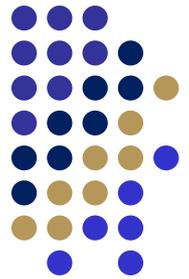


# Valuation Basics



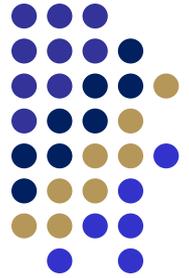
- Three Basic Approaches to Value
  - Cost Approach
  - Income Approach
  - Market Approach
- Source of Basic Valuation Approaches:
  - IRS Revenue Ruling 59-60
  - Finance community – academic and practical
- FMV vs. Investment Value or “Strategic” Value
  - Value unique to the actual parties cannot be considered

# Valuation Basics



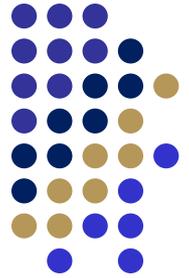
- Problems in Healthcare Valuation
    - Stark regulations suggest that traditional approaches may not always be possible to utilize
    - Data between parties in a position to refer cannot be utilized (does that leave anything?)
    - Valuation of healthcare service arrangements is still a relatively new area within the valuation profession
    - Many arrangements must also be commercially reasonable (different from FMV)
    - Independent appraisals not required, but are preferred
    - Some debate among lawyers and appraisers – e.g., intangible value
  - Practical Problems for Parties
    - Parties' expectations are oftentimes difficult to counter
    - Rigorous, arm's-length negotiation may not result in a FMV outcome
    - Certain market data is simply not reliable
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# Valuation Basics



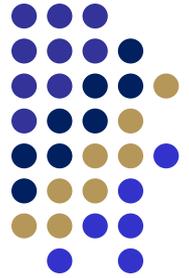
- Problems with Income Approach:
  - Income/Revenue often considers the referrals
- Problems with Market Approach
  - Comparable data limited
  - May included transactions between parties in a position to refer to one another
- Problems with the Cost Approach
  - Substitution of service transactions may not be practical
  - Book Value (or Cost to Replace) may understate value

# Valuation Basics



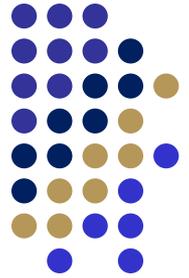
- Problems with Survey Data:
  - Surveys are voluntary – not random samples
  - Respondent pools vary widely (some groups not well represented)
  - Limited regional and local data
  - Cherry-picking from surveys or tables within surveys
  - Survey data can be misleading (e.g., physician productivity data)

# Valuation Basics



- Value often tied to current healthcare payment system:
  - Fee-for-service system
  - Fees divided between professional and “technical” components – splits payment for various aspects of care
  - Burden to care for uninsured falling to hospitals due to EMTALA
- Changes to system are coming – but slowly
  - Increase in insured patients – but are these good payors
  - Shared Savings Program and other value-based initiatives – how will this impact fee-for-service pay structures?

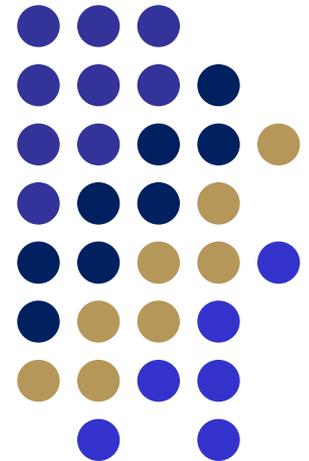
# Valuation Basics



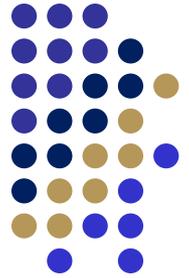
- Commercial Reasonableness
  - Not officially defined in Stark, but commentary defines it
  - Key question : Would the parties do this deal if there were no referrals?
- Examples of commercially unreasonable
  - Too many medical directors
  - No chance to earn a profit – is this okay?
  - Paying for early termination rights
  - Overbroad non-compete

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*Experience from the Physician Practice Side*



# Some Practical Questions



1. How can you get an evaluation of commercial reasonableness?
2. Can a hospital ever pay a doctor more in compensation than the profit the doctor generates in her practice? *E.g.*, What if you are preparing for ACO,s and medical homes that may lose money at first.
3. How long is a valuation good for? What does this mean for doctors entering into a negotiation for a transaction with a hospital?
4. Is it possible to value co-management services in co-management agreements? What is the basis of the valuation? How about Commercial reasonableness?
5. Does Tuomey mean you can never use two valuers, one for one side and one for the other?
6. Do you always have to use a valuator?
7. In valuing compensation can you stack compensation for different tasks performed by the doctor? *E.g.*, clinical services, medical director services, co-management services, quality payments, etc.?
8. Is a doctors practice worth anything beyond the depreciated value of its equipment?
9. How do you prepare a medical group for the realities of valuation in a hospital transaction?

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*Questions?*

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