Fundamentals of Healthcare Valuation for Health Lawyers and Compliance Officers

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Agenda:

- Why “Fair Market Value” matters
- Definition of Fair Market Value
- Basic Valuation Practice and Principles
- Common Recurring Issues, Problems and Pitfalls
- Documenting Compliance
- “Hot Button” Valuation Questions
- Hypothetical Example
- Questions

Why FMV Matters
Answer: Healthcare Laws

- **Intent of Statutes**
  - Physician decision-making can be influenced by improper financial incentives.
  - Can affect utilization, patient choice and competition
- **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 FMV Matters – Healthcare Laws:

- **Anti-Kickback Statute** *(Criminal Statute – Felony)*
  - Prohibited – Intentional payment for referrals (past, present or future)
  - 25 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

	Stark	Anti–Kickback	IRS Private Inurement
Parties at Risk	Physicians & DHS Entities only	Everyone	Non-Profit Entities & Individual or For-Profit entity
Types of Referrals	DHS referrals only	Any Federal Program Referrals	Existence of referrals okay; but are they strategic value?
Intent Required	Strict liability, no intent required	Intent required	Depends on situation; Rebuttable presumption key
Criminal vs. Civil	NOT Criminal Civil penalties only	Both Criminal and Civil penalties	Civil; penalties vary, depending on circumstances
Exceptions/ Safe Harbors	Exceptions are mandatory (if no exception met, arrangement is prohibited)	Safe Harbors are voluntary (if not in a safe harbor, may still be okay)	Rebuttable Presumption (in Intermediate Sanctions rules)
FMV	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)
Commercial Reasonableness	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 FMV Matters
Recent Cases & Settlements

- **Memorial Health** – 2014
  - Physician compensation paid to employed primary care doctors
- **Bradford Case** – 2014 (physician part continues)
  - Hospital pays independent physicians for use of camera and non-compete
- **Tuomey Case** – 2014 (appeal); 2013 ($237.5 million verdict)
  - Hospital employs doctors part-time for outpatient surgeries only, doctors remain independent for inpatient work; purpose and FMV questioned
- **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
- **Recent Settlements** (in 2014)
  - **Halifax Hospital –** ($85 million settlement) Multiple compensation arrangements with employed physicians challenged based under technical and FMV arguments
  - **All Children's Health System –** ($7 million settlement) FMV of compensation and the Hospital's implementation of its compensation plan challenged; clarified Stark's relationship to Medicaid
  - **Infirmary Health System –** ($24.5 million settlement) Technical issues with compensation and compliance with in-office ancillary services definition challenged

Why FMV Matters
Some Older Cases to also Consider:

- **United Shockwave Settlement** – July 2010
  - Urologists use referral threats to win lithotripsy contract at hospital
- **OIG Advisory Opinion 10-16** – September 2010
  - OIG questions requestor's survey method for determining FMV
- **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

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]

Anti-Kickback Statute Definition of FMV

- No statutory definition.
- Safe harbor regulations require FMV but do not define it.
- OIG Guidance
  - Special Fraud Alert – Arrangements for the Provision of Clinical Laboratory Services (October 1994):
    - Presumption that compensation outside of FMV is in exchange for referrals.
    - "By 'fair market value' we mean value for general commercial purposes. However, 'fair market value' must reflect an arms-length transaction which has not been adjusted to include the additional value which one or both of the parties has attributed to the referral of business between them."
  - OIG Compliance Guidance for Individual and Small Group Practices (October 2000):
    - "The OIG's definition of 'fair market value' excludes any value attributable to referrals of Federal program business or the ability to influence the flow of business. Adhering to the rule of keeping business arrangements at fair market value is not a guarantee of legality, but is a highly useful general rule."
  - OIG Supplemental Guidance for Hospitals (January 2005):
    - Hospitals should have appropriate processes for making and documenting reasonable, consistent, and objective determinations of FMV.
    - Is the determination of FMV based upon a reasonable methodology that is uniformly applies and documented?
    - If FMV is based in comparables, the hospital should ensure the market rate for the comparable services is not distorted.

Basics of Valuation

- 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

Basics of Valuation
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

Basics of Valuation
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 ***(Stark & AKS apply)***	BELOW Upper Limit of FMV	ABOVE Lower Limit of FMV
Hospital Refers Patients to Physicians ***(only AKS applies)***	ABOVE Lower Limit of FMV	BELOW Upper Limit of FMV
Both Parties Refer Patients to Each Other ***(Stark and AKS apply)***	WITHIN FMV Range	WITHIN FMV Range

Common Valuation Issues & Pitfalls

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

Common Valuation Issues & Pitfalls

- 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)
  - As one example (from 2013 MGMA data), for orthopedic surgery:
  - 90th percentile cash compensation = $976,000
  - 90th percentile wRVUs = 13,795
  - 90th percentile compensation per wRVU = $113.16
  - Therefore, 13,795 x $113.16 = $1,561,000!! (*i.e.,* 160% of the 90th percentile)

Common Valuation Issues & Pitfalls

- 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?

Common Valuation Issues & Pitfalls

- 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

Common Valuation Issues & Pitfalls

- Commercial Reasonableness
  - Not officially defined in Stark, but commentary defines it
    - Subjective Concept: Sensible, prudent business agreement from the perspective of the parties
    - Objective Concept: Would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician of similar scope and specialty, even if there were no potential for DHS referrals
  - Key questions: Would the parties do this deal if there were no referrals? Does the deal stand on its own?
- Examples of commercially unreasonable
  - Too many medical directors
  - Purchase of an EMR system, with no intention to ever use it
  - Complex arrangements with illogical components
  - No chance to earn a profit – is this okay?
  - Paying for early termination rights
  - Overbroad non-compete

Documenting Compliance - Roles

- Role of the Client
  - The burden of establishing FMV and CR ultimately rests with the client
  - Internal governance and documentation processes
- Role of the Valuator
  - Recommend compensation parameters and provide expertise
  - Issue an objective third-party opinion on FMV and CR
- Role of Legal Counsel
  - Manage the valuation process consistent with the a/c privilege
  - Work with the client to develop compensation terms that meet the valuator's FMV/CR parameters
  - Careful examination of the valuation opinion to enhance defensibility
  - Not to opine on FMV and CR

Documenting Compliance – Opinions

- Purpose of a Valuation Opinion
  - Documentation should support compliance in case of a challenge
  - Focus should be on defensibility
- Valuation Opinion Pitfalls
  - Valuator lacks health care knowledge and experience
  - Does not apply applicable health care regulatory standards/ valuation principles
  - Assumptions and qualifications undermine the conclusion
  - Has a short “shelf life” and/or burdensome ongoing maintenance
  - Is not conclusive, persuasive or accurate

Documenting Compliance - Strategies

- Government focus on compensation that “looks bad”
  - Cases have “bad facts”
  - Assume every communication with the client will become public
- Compensation-focused compliance
  - Process is critical and should document “good purposes”
  - Adoption of compensation plan, parameters, committee, etc.
  - External third-party valuations of FMV and CR
  - Work with an experienced health law attorney
- OIG Supplemental Guidance (2005)
  - Hospitals should have appropriate processes for making and documenting reasonable, consistent and objective determinations of FMV
  - Is the determination of FMV based upon a reasonable methodology that is uniformly applied and documented?

“Hot Button” Valuation Questions

1. How do you value and pay for quality, and who is entitled to the payment?
2. When would a valuator’s opinion “take into account” referrals?
3. What factors should (and should not) be looked at when determining commercial reasonableness?
4. Can a hospital ever pay a doctor more in compensation than the profit the doctor generates from professional fees?
5. How long is the “shelf-life” of a valuation? What are the implications of relying on an expired opinion?
6. How do you value services in co-management agreement? What is the rationale?
7. In valuing compensation can you stack compensation for different tasks performed by the doctor?
8. Is a doctor's 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?
10. Does compensation in a physician group practice even need to be FMV?
11. Can you value mid-level supervision?

Hypothetical Example

- Valuation of Medical Director: General Surgery
- Step One: Determine salary range for clinical services of General Surgeons

	n=	Mean	25th Percentile	Median	75th Percentile	90th Percentile
AMGA	1,259	$400,000	$304,000	$370,000	$461,000	$571,000
HCS	587	$314,000	$245,000	$277,000	$335,000	$474,000
MGMA	1,130	$402,000	$304,000	$368,000	$480,000	$607,000
SCA	959	$0	$277,000	$333,000	$417,000	$527,000
TW	216	$345,000	$297,000	$350,000	$401,000	$455,000
Lowest Value		$0	$245,000	$277,000	$335,000	$455,000
Median Value		$345,000	$297,000	$350,000	$417,000	$527,000
Highest Value	4,151	$402,000	$304,000	$370,000	$480,000	$607,000

(Data above is total cash compensation for all respondents reported by surveys from 2012, except MGMA which is 2013.)

Hypothetical Example

- Step Two: “Gross up” salary range for benefits and taxes:
  - Low: $350,000 + $58,000 = **$408,000**
  - High: $480,000 + $60,000 = **$540,000**
- Then, convert to an hourly rate:
  - Low: $408,000/2,080 hrs = **$196/hour**
  - High: $540,000/2,080 hrs = **$260/hour**

Hypothetical Example

- Step Three: Consider Market Data for Administrative Services
  - CMS has expressed that the FMV rate for administrative services may be different from the FMV rate for clinical services (Stark Phase III) -
  - Also consider
    - Arrangements in our client database
    - Other arrangements not in our client database
    - Client/physician provided data for nearby hospitals
    - Nature of similar services in other industries
- Administrative Survey Data for General Surgery:
  - IHS 2012 Medical Director Survey – 90th Percentile: $225/hour *(n= 56)*
  - MGMA 2013 Medical Director Survey – 90th Percentile: $207/hour *(n= 20)*

Hypothetical Example

- Step Four: Consider other Factors:
  - Program Background – Size, Location, etc.
  - Nature of Duties and Responsibilities of Position
  - Any Other Similar Positions? – Co-directors, etc.
  - Required Hours
  - Qualifications, Experience, Training of Physician

- Step Five: Synthesize information to arrive at appropriate FMV range for general surgery medical directorship.
  - Important to avoid opportunity cost calculation
  - *E.g.,* FMV ranges from **$196 to $220 per hour**

(Note concluded values are not intended to be an actual FMV opinion)

Questions?

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