



**hfma**<sup>™</sup> southwestern ohio chapter  
healthcare financial management association

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# **A Practical Examination of Fair Market Value in Healthcare**

**Chip Hutzler, JD, MBA, AVA**

# Outline of Today's Discussion

- Why Does “Fair Market Value” Matter? (7 slides)
- Comparison of FMV to non-healthcare settings (4 slides)
- FMV: Common Pitfalls in Transactions (5 slides)
- FMV: Specific Examples – Spotting Problems and Avoiding Them (27 slides)

# Why Does Fair Market Value Matter?

What is driving the need for FMV opinions?

*Laws!*

# Healthcare Laws & Regulations that impact FMV

## Key Federal Laws:

- **Anti-kickback Statute**
- **“Stark” (Federal Self-Referral Statute)**
- **IRS Non-Profit Entity Rules**

## Other Federal Laws:

- **Criminal False Claims Act**
- **Civil False Claims Act**
- **Intermediate Sanctions (aka Taxpayer Bill of Rights)**
- **EMTALA Statute**
- **HIPAA Statute**
- **Federal Sentencing Guidelines**
- **Anti Trust laws (laws governing anti-competitive conduct)**
- **Health Care Fraud**

- **Criminal Forfeiture for Health Care Offenses**
- **False Statements Related to Health Care**
- **Obstruction of Criminal Investigations of HealthCare Offenses**
- **Money Laundering**
- **Mail Fraud**
- **False Statements**
- **Wire Fraud**

## State Laws:

- **Baby Kickback/Baby Stark statutes**
- **State requirements on indigent care**
- **State laws governing anti-competitive conduct**

# Purpose of FMV 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)**
  - **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**

# Anti-Kickback Statute

- Criminal Statute - Felony
- Prohibited – Intentional payment for referrals
  - Includes any past, present, or future referrals
- 22 Safe Harbors offer protection
  - Key ones require FMV
- OIG Advisory Opinions – frequently require FMV
- Not well-enforced initially – why?

# “Stark” Law

- 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”
- How to determine FMV?
  - Use “any reasonable method” - [What does that mean?](#)
  - Cannot use market data between parties in a position to refer to one another
  - Stark FMV “Safe Harbors” - eliminated in 2007
  - FMV hourly rate for “clinical services” may be different from the FMV hourly rate for “administrative services”

# IRS - Private Inurement Guidance

- Applies to all non-profit entities (501(c)(3) entities)
- Prohibited: Use of public funds to benefit private individuals or for-profit entities.
- What is legitimate compensation?
  - Payments must be for only those items or services needed to ensure the non-profit mission of the entity (needs assessment)
  - Payments **must not exceed FMV** for the items or services provided by private individuals or entities
- Penalties:
  - Loss of non-profit status – owe back taxes (yikes!)
  - Intermediate Sanctions:
    - Tax applied to excess paid to private party
    - Tax applied to board members who approved deal
    - Additional taxes applied depending on timing

# Review - Basic Healthcare Law

- Anti-Kickback Statute
- Stark Statute
- IRS Regulations – Private Inurement

Common thread – each law requires:

Most compliant transactions to be

[consistent with FMV](#)

# Exciting Developments in 2008-09

## ■ Stark modifications

- “Stand in the shoes”
- Period of disallowance
- Anti-markup rules
- Gainsharing/P4P rules
- Per Click arrangements
- Block Leases
- Percentage of Revenue Lease Arrangements
- Under Arrangements

## ■ EMTALA

- Proposed guidance on community call coverage plans

## ■ No changes to FMV in 2008-09, but CMS did reiterate and clarify that:

- FMV must not be based on comparable transactions between parties in a position to refer to one another.

## ■ Kosenske v. Carlisle HMA case – Court weighs in

# Comparative look at FMV

# Genesis - In the Beginning...

- IRS Revenue Ruling 59-60
  
- International Glossary of Business Valuation Terms – definition of FMV:
  - 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 arms 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.

# Compare IRS Definition with 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.

# Compare Both Stark and IRS Definitions with Investment Value

## ■ Investment Value (or Strategic Value):

- The value to a particular investor based on individual investment requirements and expectations.

# Compare Basic Valuation Approaches for calculating FMV

- The three major approaches to value:
  - Income Approach (DCF)
  - Cost Approach (or Asset Approach)
  - Market Approach

# FMV: Common Pitfalls

# 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

# The “No Risk” Risk Premium

- FMV should not be influenced by the inclusion of gratuitous contract provisions that add “false” risk.
- Examples –
  - Early termination provisions that are not likely to be exercised
  - The perpetual renewal of a one-year lease
  - Leaseback arrangements for space or personnel

# Commercial Unreasonableness

- While most conceivable compensation arrangements can be valued, when does an arrangement lack commercial reasonableness?
  - Advertising on physician practice websites by recipients of referrals (e.g., pathology labs)
  - Payment to physicians to coordinate their own on-call schedules
  - Lease arrangements for equipment that should be purchased
  - Hospital transaction costs that exceed the value of the underlying transaction

# Preconceived Expectations of Value and Sidewalk Valuators

- The definition of *fair market value* (i.e., the concept of a hypothetical willing buyer and willing seller) is counter-intuitive to the lay person.
- Regulatory guidance regarding use of non-arms length market data causes further confusion
- *Strategic value* (i.e., *investment value*) is often confused with FMV.
- Physicians' expectations are oftentimes difficult to counter.

# Misapplication of an FMV Opinion

## ■ Examples –

- Opinion was valid only over a range of outcomes
- Misapplied “units” (e.g., surgical cases vs. procedures; unrestricted vs. restricted call; 24-hour on-call rate applied to a 14-hour call period)
- FMV opinion is ambiguous or conditional
- FMV opinion included critical governing assumptions that were not considered in its application

# FMV: Specific Examples Spotting Problems and Avoiding Them

# Types of Examples

- Employment Arrangement
- Medical Directorship
- On-Call Arrangement
- Recruitment Arrangement
- Collections Guarantees/Subsidies
- Per Click Lease
- Under Arrangement Transaction
- Gainsharing Arrangement
- Management Services Arrangement
- Professional Services Arrangements

# Employment Example

## ■ Facts:

- Backwater hospital wants to employ Dr. Dolittle to provide a combination of clinical, administrative and call coverage duties
- Dr. Dolittle's position will be 30% clinical and 70% administrative
- Proposed compensation consists of base salary, incentive bonus, sign-on bonus, quality bonus and a bonus from an ancillary services pool

# Employment Example

## Issues to Consider

- Establishing base compensation for a physician of the physician's specialty, who performs clinical and administrative duties in a 30/70 ratio
- Criteria for quality bonus?
- Structure of ancillary services bonus pool?
- FMV range for "total" compensation?
- Data used - wRVUs?
- Compensation stacking
  - Physician duties require services of greater than 1.0 FTE
  - Unlikely to be performable due to quality or time constraints

# Employment - National Benchmark Data Mistakes

- Poor alignment of compensation v. productivity
- Use of worked RVUs v. total RVUs
- Compensation per Work RVU (misleading statistic)
- Employment v. shareholder data – most benchmarks combine, but some benchmark sources separate the data. This is most notable in specialties that generate substantial income from ancillary services. For the specialty of oncology, as reported in the 2008 MGMA Report, the 90<sup>th</sup> percentile for shareholders is \$966,135 and for employees is \$515,705.

# Employment - Misuse of RVUs

- Overview of relative value units (or RVUs)
- Key difference between *total* RVUs and *work* RVUs
  - *Total* RVUs include *work*, *practice expense* and *malpractice*.
- Possible over-counting due to:
  - Assistant at surgery
  - Multiple procedures
  - Midlevel providers
  - Site of service differences
- Recent Changes in RVUs are misapplied to benchmark data

# Employment - Ancillary Revenue

Compensation in an ***employment arrangement*** is based, in part, on ancillary revenue generated by the employed physician's referrals to employer/hospital.

Example: The specialty of oncology generates substantial revenue from ancillary services.

# Medical Director/Admin Example

## ■ Facts:

- Dr. Bigbucks is board certified in general surgery, neurosurgery and pain medicine
- Hospital plans to engage Dr. Bigbucks to provide medical director services for its pain clinic
- Hospital proposes to pay Dr. Bigbucks \$250 per hour for up to 20 hours per week,
- Dr. Bigbucks is party to two other administrative Agreements with Hospital; each provides for up to 20 hours of services per month at \$150 per hour.
- Dr. Bigbucks' spouse is a cardiologist who admits many patients to hospital and has single-handedly built Hospital's cardiology service

# Medical Director/Admin Example

## Issues to Consider

- Duties of the director of the pain clinic
  - Is role or number of hours reasonably needed or required (*i.e.*, not developing arrangement only to “retain” physician in service area).
  - Hours worked not documented.
  
- Any Overlap?
  - Dr. Bigbuck’s duties under his existing administrative agreements with the hospital (is there any overlap with the planned agreement? Is the nature of the duties similar under the three agreements, even if they do not overlap?)

# Medical Director/Admin Example

## Issues to Consider

- What other program directors are paid by Hospital (Is \$250 per hour “typical”?)
- Use of clinical v. administrative benchmarks.
- Expense reimbursement:
  - If a hospital has an administrative compensation arrangement with a physician (i.e., medical directorship), hospital should only reimburse expenses that are directly related to the administrative role.
  - Bad Examples: Clinically-oriented CME, compensation for administrative role when billing for clinical services.

# On-Call Arrangements

## ■ Facts

- Dr. Lester Burnham provides orthopedic call coverage at Extra Smiley Sauce Hospital
- Jan 1, 2007 – Jan 1, 2009 Lester was paid \$1,500 per day
- Jan 1, 2009 - present, Lester was paid \$2,000 per day
- Starting July 1, 2009, Lester wants to get paid \$2,500 per day

# On-Call Arrangements

## Issues to Consider

- Questions surrounding changes in level of burden
- Is this a retrospective analysis (Period of Disallowance concerns?)
- Are there other Drs. on the panel and are they paid the same as Lester?
- What other arrangements are there with Lester? (Stacking, concurrent coverage, trauma, etc.)
- Concurrent coverage at competing hospitals – backup?
- Is coverage unrestricted or restricted?
- Can the *per diem* be raised on July 1?
- Set in advance?

# On-Call - Use of Tainted Market Data

- On-Call compensation - Sullivan Cotter indicates that only 9% of hospitals establish on-call payment rates through FMV analysis.
  - 57% use a consensus process involving management and physician leadership
  - 41% negotiate individually with each physician/practice
- Virtually all compensated on-call arrangements exist between physicians and hospitals to which they refer

*Source: 2008 Physician On-Call Pay Survey Report, Sullivan Cotter and Associates, Inc.*

# Recruitment Example

## ■ Facts

- Hospital in Ohio has shortage of orthopedic surgeons in the community
- Hospital identifies an experienced orthopedic surgeon who lives in Florida, and is interested in moving to Ohio.
- Hospital identifies a local group practice that is interested in hiring the new physician
- Hospital wants to provide an income guarantee

# Recruitment Example

## ■ Issues to consider

- **Lots of non-FMV issues (relocation, agreement with Group, restrictions, community service period, etc.)**

- **FMV issues:**

- Cash compensation for a private-practice physician of the recruited physician's specialty and qualifications.

- PLUS Allocable operating costs for a physician of the recruited physician's specialty in private practice

- **Special allocation rules for Group practice scenario:**

- **Requirement 1:** except for "*actual costs incurred in recruitment,*" all remuneration from the hospital *is passed through to and remains with the recruited physician*

- **Requirement 2:** "In the case of an income guarantee... the costs allocated by the physician or physician practice do not exceed the actual additional incremental costs attributable to the recruited physician"

# Collections Guarantees/Subsidies

## ■ Facts:

- Neonatologists are in a multi-specialty group practice with OB/GYNs and maternal fetal medicine specialists
- All members of the multispecialty group are members of the staff of Hospital
- Hospital wishes to enter a collections guarantee agreement for the group to provide neonatology services;
- Hospital does not have a NICU, but does have a growing birthing center such that management wants a neonatologist present “full time” (40 hours/week) for high risk deliveries and emergent situations

# Collections Guarantees/Subsidies

## ■ Issues to Consider

- Number of FTE neonatologists that are required to perform the services under the Agreement (1.0, or more?)
- Group's historical collections *for neonatology services*
- What is known about the need for the neonatology services (Regulations that require the availability of such services, etc.)
- Anti-Kickback concerns?
- Reverse Kickback concerns?
- Exclusivity concerns – under Kosenske case

# Per Click Example

- Fact pattern - description
  - Equipment lease
  - OB/GYN Practice A leases LEEP equipment from OB/GYN Practice B on a per click basis.
  - No referrals from Practice B to Practice A for LEEP services.

# Per Click Example

## ■ Issues to Consider

- Not all Per Click deals are prohibited
- Lithotripsy not DHS, but other referrals for DHS may impact Lithotripsy arrangements
- Block Leases for blocks less than 4 hours in duration are “suspect”

# Real Estate: High Risk

- Gross v. triple net lease documentation to support lease amount.
- Incorrect square footage for leased space.
- Hospital/lessor losing money on real estate holdings when most real estate leasing companies in market are generating profit/margin.
- Not charging for increases in maintenance or annual increases when lease contemplated such increases.
- Enhanced tenant improvements not factored into lease rate.
- Time share arrangements
  - Not accounting for “vacancy” in time share arrangements.
  - Time share “creep” (i.e., using staff, supplies, or specialized equipment not factored into time share compensation arrangement).

# Under Arrangement example

## ■ Fact Pattern:

- ASC performs ambulatory surgery services “under arrangements” with hospital
- ASC performs the services, hospital bills for them
- The services performed by the ASC for hospital’s patients include lithotripsy
- ASC provides the lithotripsy services under a lease arrangement with urologists

# Under Arrangement Deal

## ■ Issues to Consider:

- After 10/1/09, both the ASC and the hospital may be considered entities that furnish DHS
  - New definition of “entity” includes both the entity that bills Medicare and receives reimbursement for the DHS service, and the entity that *performs* the service; referrals are to both entities
- ASC services are *not* DHS, but hospital ambulatory surgery services *are* DHS
- Outpatient hospital ambulatory surgery services are generally reimbursed at a higher rate than ASC services
- Courts have established that lithotripsy is not DHS, but other urology referrals for DHS could impact lithotripsy deals.
- Thus, there is new pressure to assure that relationships with the urologists are Stark-compliant and FMV.

# Under Arrangement Use of Tainted Market Data

- The all time favorite...lithotripsy.
  - Virtually no “untainted” market values exist.
  - Even formerly “independent” litho providers found they needed to JV with physicians to survive.
  - A Cost Approach can demonstrate that lithotripsy margins are inordinately high.
  - Consequences to a hospital include loss of lithotripsy procedures...and loss of all other procedures performed by urologists.

# Gainsharing Example

## ■ Facts

- Hospital enters into arrangement with group of physicians
- To assist with cost efficiency of particular procedures, without affecting quality of care
- Physicians share in cost savings, based on a percentage.

# Gainsharing Example

## ■ Issues to Consider

- How is this different from P4P or Co-management
- Is FMV required?
- How long can this arrangement continue (5 year? 10 years?)
- Stark unfinished gainsharing exception?
- Why is a separate gainsharing exception needed?

# The “Behind the Scenes” Management Company

- A physician practice (the “Manager”) that engages a third party management company to fulfill the Manager’s obligations to a hospital may undermine the arrangement.
  - Both the Manager and the third party management company may seek a “full profit” for their efforts.
  - The Manager may appear to be profiting from arbitrage, or the overall arrangement may appear to be a sham.

# Professional Services

## ■ Facts

- Pathologists have exclusivity with Hospital
- For certain patients Hospital bills globally and pays pathologists a case rate based on procedures performed.

# Professional Services

- Issues to Consider

- Can payment to pathologist be too high? too low?
- Reverse Kickback?



# HealthCare Appraisers

INCORPORATED

**Corporate Office/Delray Beach**  
75 NW 1<sup>st</sup> Avenue, Suite 201  
Delray Beach, FL 33484  
561-330-3488

**Dallas Office**  
1333 W. McDermott Dr., Suite 200  
Allen, TX 75013  
469-519-1201

**Denver Office**  
858 Happy Canyon Road, Suite 240  
Castle Rock, CA 80108  
303-688-0700

**Chicago Office**  
421 N. Northwest Hwy., Suite 201  
Barrington, IL 60010  
847-756-6150

