CHAPTER ONE

Regulatory Issues and the Valuation Process

When performing a medical practice valuation, you must be aware of federal regulatory issues that might impact the valuation process and the final calculation of practice value. The greatest concern you as the valuator should have is what could happen if there is an overvaluation of the medical practice that you are valuing. Depending on the specific reason you are conducting the valuation, an overvaluation might cause someone to get in trouble with the federal government. With this in mind, this chapter will cover three specific regulatory areas: Medicare fraud and abuse, Internal Revenue Service private inurement, and the Stark law.

MEDICARE FRAUD AND ABUSE

As a valuator, you must be aware of Medicare's antikickback statute. This statute makes illegal the payment, offer, or inducement of any remuneration in exchange for patient referrals. For example, a hospital cannot pay a physician money directly in exchange for his or her patient referrals to the hospital. As such, an overvaluation of a medical practice could raise major concerns if a hospital is buying a physician practice because this looks like the hospital might be paying for the doctor's referral patterns. The same can be said of any third party acquiring a physician practice to which the doctor makes patient referrals.

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A consistent trend in the health care industry is the development of integrated delivery systems by hospitals. To accomplish this task, hospitals have been acquiring physician practices, resulting in the need for valuation of the practices it is acquiring. The government has specific concerns about integrated delivery systems under the antikickback statute.

The main concern relates to the price paid for the physician practice. Often what the hospital is really interested in is "locking up" the referral patterns of its referring practices. Many hospitals have had to acquire medical practices to eliminate a competitor from trying to buy the same practices. The government also is concerned that the price paid for the practice is really a payment for the future flow of patient business to the hospital. It is obviously illegal to pay a doctor now (i.e., when the practice is purchased) for the flow of referrals in the future. This is why you never see the purchase price allocated to any portion of the future referral stream.

However, a portion of the purchase price is allocated to intangibles, such as goodwill. It is an inflated goodwill or other intangible figure that will catch the eye of the government. So in the case of an overvaluation, the government could try to make the case that the excess payment was in fact in exchange for future patient referrals.

PRIVATE BENEFIT/PRIVATE INUREMENT

This regulatory issue usually applies when a tax-exempt entity acquires a physician practice. The typical example is when a tax-exempt hospital acquires a physician practice. Under federal tax law, no part of a Section 501(c)(3) organization's net earnings may inure to the benefit of any private shareholder or individual. The transaction cannot benefit any specific individual. So if a benefit or inurement is found, a tax-exempt entity could lose its tax-exempt status or be fined.

Spiraling increases in health care costs have spawned innovative solutions to reduce the price, increase the quality, enhance the efficiency, and improve the availability of medical services. The integration of hospitals and physicians into single organizations with the common goal of benefiting the community is part of this movement. This marriage is how integrated delivery systems are formed. Health Care Financing Administration (HCFA) estimates that $175

billion a year is spent on physician services. Thus, hospitals have a monetary incentive to participate in this marriage.

A tax-exempt hospital that purchases a physician practice generally does so in order to provide a charitable service to the community, as well as to obtain the direct and indirect revenues from that business. Direct revenues come from providing outpatient services. The economic return to the hospital from direct revenues of an acquired medical practice may be nominal, however, and direct revenues are often not the only source of anticipated economic return.

Indirect revenues flowing from the referrals of the clinic's patients to the hospital for services often provide significant returns on the acquiring hospital's investment. At any given time, 60 percent of hospital beds could be empty. Thus, an important factor in hospital acquisitions of outpatient facilities such as physician practices is the hospitals' desire to position themselves for referrals of inpatients. The importance of this factor is expected to increase as health care services are increasingly shifted from inpatient to outpatient settings, under the influence of managed care payment systems.

As previously mentioned, federal (and state) laws prohibit payments for referral of Medicare (and Medicaid) patients. For this reason, valuation appraisals of medical practices do not reflect the indirect value of referrals to hospitals.

An organization cannot be organized or operated exclusively for charitable purposes unless it serves a public rather than a private interest. Thus, to meet the requirements of IRC 501(c)(3), an organization must establish that it is not organized or operated for the benefit of private interests. This private benefit prohibition applies to physicians who, either individually or in a medical group, sell their assets to an exempt organization and subsequently perform services for it. Benefits to the physicians must be balanced against benefits to the public in deciding if private benefit is present.

Private inurement generally involves persons who, because of their relationship with an organization, can control or influence its activities. Such persons are sometimes referred to as "insiders." In some circumstances, physicians may be insiders with respect to an organization to which they sell their practices. In that case, the inurement applies in addition to the prohibition on private benefit. The payment of amounts *exceeding fair market value* for the medical prac-

tice assets acquired from physicians may thus cause an organization not to qualify for IRC 501(c)(3) status.

In deciding if an organization providing healthcare services qualifies for exemption under IRC 501(c)(3), the Service applies a "facts and circumstances" approach based on Revenue Ruling 69-545, *supra.* An important factor in determining if an organization operates exclusively for the benefit of the community, as opposed to private interests, is whether the organization's acquisition of assets from physicians confers private benefit on, or causes its earnings to inure to, the sellers. If the organization pays more than fair market value, private benefit, and possibly inurement, is present, and as such the organization will most likely not qualify for exemption or be subject to some sort of sanction by the Service.

The Service defines fair market value as the price on which a willing buyer and a willing seller would agree, neither being under any compulsion to buy or sell, and both having reasonable knowledge of the relevant facts (Rev. Rul. 59-60, 1959-1 C.B. 237). Whether the price paid for assets exceeds fair market value may be determined in various ways. It is the exempt organization's burden to establish this fact.

Generally, where the sales transaction involves unrelated parties bargaining at arm's-length, the actual sales price may be assumed to be fair market value. However, when hospitals acquire practices owned by physicians who are on their medical staffs, and who continue to provide services through a new affiliated organization, the existence of arm's-length bargaining may be questionable according to the Internal Revenue Service. In the absence of an arm's-length transaction, the best determinant of fair market value is a ***properly performed, unbiased valuation*** of the medical practice.

As you can readily see, if the valuation of a medical practice being acquired by a tax exempt entity is overstated, the consequences could be severe. This is why you must be extremely careful when valuing a medical practice when the reason for the valuation is due to an anticipated acquisition, especially one by a hospital entity.

THE STARK LAW

Stark II is a federal statute that became effective January 1, 1995. Like Stark I, it is intended to curb the abuses inherent in physician self-

referral arrangements. While the Stark I regulations clarified many issues related to Stark II, Stark II regulations have yet to be issued, so little guidance is available to practicing physicians. Like Stark I, Stark II prohibits physicians who have a financial relationship with an entity from referring their patients to the entity for designated health services.

A financial relationship consists of an ownership or investment interest in the entity or a compensation arrangement with the entity. If the physician does not own any portion of the entity, and does not pay the entity or receive any kind of payment from the entity for the referral or for anything else, there is no financial relationship. A financial relationship can exist between a physician and an entity even if that relationship does not involve designated health services or the Medicare or Medicaid programs. For example, a compensation arrangement is defined in Stark II as, in general, any arrangement involving any remuneration between a physician (or family member) and an entity. This remuneration can involve payments for anything, such as payments for rent, payments for nonmedical types of items or services, or payments for housing or travel expenses. Therefore, the purchase of a practice by an entity and the related payment to the physician or physicians could constitute a financial arrangement.

Section 1877(e)(6) of the Stark II regulations provides that an isolated transaction, such as a onetime sale of property or a practice, is not considered to be a compensation arrangement for purposes of the prohibition on referrals if the following conditions are met:

- The amount of remuneration for the transaction is consistent with fair market value and is not determined, directly or indirectly, in a manner that takes into account the volume or value of referrals by the physician.
- The remuneration is provided under an agreement that would be commercially reasonable even if no referrals were made to the entity.
- The arrangement meets any other requirements the Secretary may impose by regulation as needed to protect against Medicare program or patient abuse.

An "isolated transaction" is defined as one involving a single payment between two or more persons. A transaction that involves

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long-term or installment payments is not considered an isolated transaction.

Therefore, to comply with the Stark law, the valuator's appraised figure must represent fair market value and the payment of the purchase price cannot be made in installments. Like Medicare fraud and abuse and the Internal Revenue Service's private benefit/inurement statutes, an appraisal that overvalues a medical practice could have severe legal consequences.