Chapter D

Straightening Out Your Alignment: An Overview of Hospital/Physician Practice Alignment Transactions

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I. Introduction – Why are Hospitals and Physicians Aligning?

There are a number of factors motivating hospitals and physicians to align with each other. As discussed below, these influences range from simple lifestyle preferences to warding off each other as potential competitors. In June 2008, the Medicare Payment Advisory Commission ("MedPac") issued a report to Congress that addressed "Reforming the [Healthcare] Delivery System."[1] The MedPAC Report recommended fundamental changes in healthcare delivery in the United States and in Medicare. As part of its Report, MedPAC examined hospital/physician collaborative relationships and identified a number of trends that have influenced the resurgence of hospitals employing physicians and the factors contributing to this movement.

The MedPAC Report identified four reasons driving hospitals to align with physicians, including collaboration potentially improves a hospital's ability to compete for admissions; improves quality of care; controls the cost of care; and gains leverage with health plans in rate negotiations. The MedPAC Report identified four reasons driving hospitals to align with physicians. According to the MedPAC report, collaboration potentially improves a hospital's ability to compete for admissions; improves quality of care; controls the cost of care; and gains leverage with health plans in rate negotiations.

MedPAC also identified a number of reasons motivating physicians to collaborate with hospitals. First, the potential to increase physicians' productivity. Second, some physicians are interested in pursuing opportunities for sources of income beyond their professional fees, such as joint ventures on ancillary services, bonus payments for meeting certain quality objectives, hourly payment for attending medical staff meetings, joint ventures pertaining to real estate, and attractive bond offerings. Third, to give physicians better leverage in gaining entry to private insurers' provider networks and negotiating better payment rates. Another reason physicians have turned to partner with hospitals has been in defense of the ever-expanding movement by hospitals to extend their services to outpatient medical care. So, rather than have their turf encroached on by hospitals, many physicians have decided to affiliate with hospitals to provide outpatient services.

A non-financial motivating reason identified by physicians is lifestyle preferences. Many physicians want greater scheduling flexibility and fewer administrative responsibilities. Hospital employment offers a more predictable work schedule and a greater likelihood of part-time work.

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[1]The Medicare Payment Advisory Commission ("MedPAC") is an independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program.

In addition, some physicians are increasingly eager to avoid the responsibilities of managing staff, billing insurers, and covering the costs of professional liability (malpractice) insurance. Reduced work or job sharing is something desired more and more by both male and female physicians.Many physicians are married to other physicians or other professionals; they already have comfortable household incomes and do not need to rely on one primary wage earner or sacrifice their lifestyle for the demands of work.

Since the 2008 MedPAC Report, changes to Medicare reimbursement and the implementation of the Affordable Care Act, among other factors, have only served to increase the motivating factors driving physician/hospital alignment. This article will explore the various physician/hospital relatiopnships that have emerged recently.

II. Significance of Valuations

A. Fair Market Value

While fair market value is a question of fact and not law, it has significant legal consequences when structuring a transaction between healthcare providers and potential referral sources. In particular, the federal Anti-Kickback Statute prohibits any knowing and willful offer, payment, solicitation or receipt of any form of remuneration, either directly or indirectly, in return for, or to induce (i) the referral of an individual for a service for which payment may be made by Medicare, Medicaid or another government-sponsored health care program, or (ii) the purchasing, leasing, ordering or arranging for, or recommending the purchase, lease, order or arrangement of, any service or item for which payment may be made by Medicare, Medicaid or another government-sponsored health care program. In cases where the government can establish that the remuneration paid exceeds fair market value, it may infer that the excess was paid as an illegal kickback to induce referrals. Violations of the Anti-Kickback Statute are punishable by monetary fines, civil and criminal penalties (including imprisonment), and exclusion from participation in the Medicare and Medicaid programs and other government health care programs. Violations of the Anti-Kickback Statute also may be separately actionable under the federal False Claims Act.

Given the breadth of the Anti-Kickback Statute and the potentially draconian consequences for unintended violation, in an attempt to clarify which arrangements are not subject to prosecution under the federal Anti-Kickback Statute, the OIG has adopted certain "safe harbor" regulations that outline activities and business relationships that are deemed protected from prosecution and other liability. Although the Anti-Kickback Statute does not require health care providers or others to meet the requirements of the safe harbor regulations, compliance with all of the conditions set forth in a particular safe harbor regulation assures the parties involved of not being prosecuted or sanctioned for participating in the arrangements qualifying for the safe harbor. Many of the safe harbors contain a requirement that remuneration under the arrangement between the parties must not exceed fair market value and not take into consideration the value or volume of referrals or other business between the parties.

Failure to comply fully with all of the conditions set forth in a particular safe harbor does not, of itself, mean that the arrangement in question is illegal. Rather, arrangements that potentially implicate the Anti-Kickback Statute, but that are not fully within a safe harbor

regulation, must be analyzed on a case-by-case basis under the general proscriptions of the Anti-Kickback Statute.

The Stark Law is violated if a physician makes a referral to an entity that he or she, or any member of his/her immediate family, has a financial interest, directly or indirectly, for certain designated health services, which is reimbursed in whole, or in part, by Medicare. Many of the most applicable exceptions under Stark also require that any remuneration between the parties not exceed fair market value and also be commercially reasonable. Unlike the anti-kickback statute where a particular transaction may fail to satisfy a statutory exception or safe harbor, failure to meet ALL of the required criteria of a particular Stark exception will cause the arrangement to be illegal.

Therefore, the general permissibility of financial arrangements between and among physicians and other referral sources under both the federal Anti-Kickback Statute and the federal Stark Law turns generally on whether the remuneration that is payable between the parties is consistent with fair market value for the items and/or services rendered. There is no one definition of "fair market value" but two sources most often cited by valuation consultants have been articulated by the Internal Revenue Service ("IRS") and Stark. These definitions will be described more in detail below.

Finally, the Bradford case is a good illustration of how traditional fair market value methodologies are somewhat incompatible to healthcare transactions.[2] In Bradford, the court made a Stark analysis regarding a sublease of a nuclear camera and a non-compete covenant between Bradford Regional Medical Center and two physicians practicing internal medicine in private practice. The court paid particular focus on the valuation by an independent consultant who performed a fair market value analysis. The "traditional" analysis of the appraiser of the non-compete agreement took into consideration the expected revenues to Bradford with the lease arrangement in place and those expected without the sublease in place to value the non-compete. The court concluded that the methodology used by the consultant that took into consideration expected revenues was based, in part, on the volume and value of referrals generated by the internal medicine physicians.

B. Commercial Reasonableness

Commercial reasonableness is cited in various Stark Law exceptions and AKS safe harbor regulations.[3] Commercial reasonableness is a separate requirement from "fair market value" under Stark and AKS and requires separate analysis. According to CMS, "commercial reasonableness" generally refers to an arrangement that "appears sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of any potential referrals.[4]" CMS later refined its definition in its Stark Phase II final rule as "an

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[2]U.S. ex rel. Singh, et. Al., v. Bradford Regional Medical Center, et al., F. Supp. 2nd (W.D. Pa., Nov. 10, 2010).

[3]See, e.g., Stark exceptions: Office space rental, fair market value. Employment, group practice exception, equipment rental, indirect compensation, isolated transactions, and personal service arrangements. See, e.g., AKS safe harbors: space rental, personal services and management agreements, equipment rental, discounts, acquisition of medical practice, ambulance replenishing, and divestiture.

[4]63 Fed. Reg. 1700 (Jan. 9, 1998).

arrangement will be considered "commercially reasonable" in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician(or family member or group practice) of similar scope and specialty, even if there were no potential designated health services referrals."[5]

Often the two terms are used interchangeably or synonymously. Indeed, a transaction can satisfy either commercial reasonableness or fair market value, but not satisfy both. In some cases, the compensation arrangement may be neither fair market value or commercially reasonable.[6] Recently in Toumey, the court concluded that the hospital overpaid physicians and held that the compensation was in excess of fair market value and not commercially reasonable.[7] Therefore, appraisers should not be asked to simply opine on the fair market value supporting a financial transaction, but also whether or not the arrangement is "commercially reasonable."

III. Physician-Hospital Collaborative Arrangements

A. Employment Model

From the physician's perspective, employment eliminates the risk of owning a private practice, reduces managerial headaches, and provides malpractice coverage from the hospital. Hospitals are increasingly hiring physicians an employees. According to a 2007 report from a large national physician recruitment firm, 43 percent of their physician search assignments in 2006-2007 were for placements in a hospital setting, compared with only 11 percent in 2003-2004.[8]

There are a range of motivations for employing physicians. For example, physician employment is one of several strategies a hospital will use to recruit physicians to its active medical staff. In some cases, employing physicians can be a defensive strategy; the goal is not integration but simply to prevent competitors from acquiring the admitting physicians' practices.

From the hospital's perspective, employing physicians may assure hospitals of having physicians accept on-call coverage and not split their admissions with a rival hospital. Employing physicians overcomes limitations otherwise inherent when relying on community-based physicians providing adequate on-call coverage. The MedPAC report also pointed out the that employed physicians tend to have slightly more loyalty to their hospital than those with looser forms of affiliation. Hospitals have also experienced that, by employing physicians, they can avoid having to rely on the cooperation of community physicians in recruitment efforts. Employment also prevents hospitals from being at the mercy of referring physicians when negotiating the sharing of payments. Also, hiring physicians as employees can bypass regulatory concerns that complicate financial arrangements between hospitals and community physicians by conforming to the statutory exceptions or safe harbors under applicable fraud and abuse laws.

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[5]69 Fed. Reg. 16093 (Mar. 26, 2004).
[6]See Covenant Medical Center settlement available at: http//www.justice.gov/opa/pr/2009/August/09-civ-849.html.
[7]US. Ex rel. Drakeford v. Tuomey Healtcare System, Inc.,
[8]Merritt, Hawkins & Associates (2007).

From the physician's perspective, being employed by a hospital may provide benefits associated with career stability and lifestyle, such as more regular hours, administrative support systems, and the status of being associated with a well-regarded health system or hospital. Also, the desire for higher private-payor reimbursement rates and the rise of malpractice costs have drawn many physicians away from working in small group practices and to seek employment with hospitals or hospital-affiliated multi-specialty practices.

Hiring may be complicated because community physicians perceive hospital employment as a competitive threat to their livelihoods. Other barriers to hospital employment of community physicians in California, Texas, Ohio, Colorado, Iowa, Illinois, New York, and New Jersey are laws banning the "corporate practice of medicine," which preclude hospitals from employing physicians to provide outpatient services.

Another significant trend is the number of hospitals hiring hospitalists. In 2003, there were 11,000 hospitalists. Current estimates from the Society of Hospital Medicine ("SHM") suggests that there may have been over 24,000 hospitalists practicing in 2008. SHM predicts that there may be as many as 30,000 hospitalists by 2010. In 2004, hospitalists were the attending physicians for 2.4 million Medicare beneficiaries or 20 percent of all Medicare discharges; by 2010, SHM is projecting that hospitalists will be the attending physicians for 5.6 million beneficiaries or 43 percent of all Medicare discharges.

Stark provides an exception if a physician is a bona fide employee. The amount of compensation must be consistent with fair market value, not determined in a manner that takes into account the value of any referrals, and commercially reasonable, even if no referrals were made to the employer.[9] Also similar to Stark, remuneration does not include any amount paid by an employer to an employee,[10] who has a bona fide employment relationship with the employer.[11] The term "employee" has the same meaning for purposes of satisfying the safe harbor as it has for federal employment tax purposes.

B. Physician Lease Arrangements

It is not unusual for private practices to lease physicians to hospitals to provide inpatient services or to serve as a medical director or department head. Generally, so long as the services meet the personal services exception under Stark and the personal services safe harbor under the AKS they are not problematic. Occasionally, however, hospitals lease employed physicians to private practices. Often these private practices have staff privileges at the hospital and are a referrals source to the hospital.

1. Stark Law

Effective for referrals made after December 31, 1994,[12] if (i) a physician (or an immediate family member of such physician) has (ii) a "financial interest" in an (iii) entity, (iv)

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[9] 42 U.S.C. § 1395nn(e)(2).
[10] §3121(d)(2).
[11] 42 CFR §1001.952(i).
[12] P.L. 103-66, 13562(b)(2).

the physician may not make a referral to that entity (v) for the furnishing of "designated health services" (vi) for which payment is sought under Medicare or Medicaid, and the entity may not present a claim or bill to any individual, third party payor, or other entity for designated health services. All six of the elements of Stark must be present to implicate the statute. If all six elements are present, the referral will only be protected if an applicable exception applies. There are no safe harbors excluding a referral from the self-referral ban. If a referral arrangement is not specifically excluded by the statute, it is subject to the ban. Stark is violated when DHS services are billed, not when the referral itself is made; thus, the ban is on billing not the referral.

A "financial interest" is broadly defined and includes either an equity interest, including debt, whether directly or indirectly, or a compensation interest with an entity providing DHS (the "DHS entity"). It may be very likely that participating PCMH physicians will enter into some form of agreement with a DHS entity to provide services. Therefore, the structure of the PCMH will need to fit within an applicable Stark exception if the participating physicians are the PCMH have a financial interest in a DHS entity for any DHS services.

Personal Services – Any leased physician arrangement or agreement for a physician to provide personal services will be protected under Stark if it meets the following qualifications:[13]

- The arrangement is set out in writing, signed by the parties, and specifies the covered services.
- The arrangement covers all services to be provided by the physician.
- The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement.
- The term is for at least one year. Phase II modified the one-year requirement to permit a termination clause (with or without cause); however, if the agreement is terminated within the first year of the original term, the parties are not permitted to enter into another agreement for the same or similar services for the remainder of the first year.
- The compensation is set in advance, does not exceed fair market value,14 and is not determined in a manner that takes into account the volume of referrals or other business generated between the parties.
- The services to be performed do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal laws.

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[13]42 U.S.C. § 1395nn(e)(3).

[14]As to fair market value guidance, the preamble suggests that the analysis should first determine what the service could have been bought for in the absence of an arrangement with a referring physician. However, in the absence of reasonable market comparables, the fair market analysis looks at the supplier's costs plus a reasonable return. Relative to the need to obtain an outside appraisal, the preamble suggests that internal audits are susceptible to manipulation and do not have strong evidentiary value.

- A contract for personal service is permitted a holdover not to exceed 6 months so long as the payment terms remain the same.

Indirect Compensation – The financial relationship may exist either "directly" between the DHS entity and the referring physician or "indirectly," that is, where other individual(s) or entity(ies) are interposed in a chain of financial relationships, through ownership, investment interest, or compensation arrangement, between the DHS entity and the referring physician. If a financial interest constitutes an indirect compensation interest, the arrangement may qualify for the indirect compensation exception that meets all of the following requirements:[15] Effective December 4, 2007, Phase III regulations introduced a broader "stand in the shoes" ("SITS") rule for purposes of determining whether a physician has a direct or indirect financial relationship with a DHS entity.[16] Under the new regulations, a physician is deemed to "stand in the shoes" of his or her "physician organization" if the only entity between the referring physician and the DHS entity is the physician's physician organization. In such cases, the referring physician will be deemed to have a direct financial interest with the DHS entity. If a group practice in which a physician has an ownership contract to provide services to a hospital, the relationship between the group and the hospital is a direct financial relationship. For example, where a DHS entity pays fees under a service agreement to an undifferentiated medical group, the fees will be treated as having been paid to each physician. In such cases, the financial arrangement must satisfy an applicable direct compensation exception (e.g., lease, personal services, fair market value, etc.) and not the indirect compensation exception. Note: If the stand-in-the-shoes rules apply to a particular financial arrangement, the indirect compensation exception is not available to protect the arrangement and must rely on a direct compensation exception.

2. Federal Anti-Kickback Statute

Section 1128B(b) of the Social Security Act, known as the anti-kickback statute ("AKS"), prohibits the offer, solicitation, payment, or receipt of any remuneration, in cash or in kind, in return for, or to induce, the referral of a patient for any service that may be paid by a Federal Healthcare Program (most notably, Medicare and Medicaid).[17] Prohibited conduct also includes remuneration in return for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item reimbursed under Medicare or a state health care program. "Remuneration" has been broadly defined to encompass anything of value. The Medicare and Medicaid Patient and Program Protection Act of 1987 required HHS' to promulgate regulations specifying and protecting payment practices encompassing legitimate business practices (so-called "safe harbors") that will not be subject to criminal prosecution, or exclusion from the Medicare and Medicaid as involving prohibited remuneration. If a payment practice fails to comply with any of the promulgated safe harbors, it is not thereby deemed unlawful. However, the payment practice will be measured against the statute, and unlawful remuneration may be found to exist based on the parties' subjective intentions under the particular facts and circumstances presented.[18]

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[15] 42 C.F.R. § 411.357(p).
[16] See generally, U.S. ex rel. Singh, M.D. v. Bradford Reg'l Med. Ctr., 752 F. Supp.2d 602, 618-19 (M.D. Pa. 2010).
[17] 42 U.S.C. § 1320a-7(b).
[18] *Id.* at 35957.

Personal Services and Management Contracts – The requirements for the AKS safe harbor are very similar to the Stark exception. Payments made by a principal to an agent as compensation for services provided by the agent are covered if the following conditions are satisfied: (1) the agency relationship is set out in writing and signed by the parties; (2) the agreement specifies the services to be provided; (3) the agreement is for a period of not less than one year; (4) the amount of compensation is set in advance and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties that would be subject to reimbursement under the Medicare or Medicaid program; (5) the services do not violate any federal or state law; and (6) the services contracted for do not exceed those that are reasonably necessary to accomplish the commercially reasonable business purpose of the services.[19]

Joint Operating Agreements -- The OIG has had longstanding concerns about certain contractual joint venture arrangements that are between those in a position to refer business and those furnishing items or services for which Medicare or Medicaid pays, especially when all or most of the business is derived from one of the joint ventures,[20] and has taken increasingly aggressive positions in this arena. In April 2003, the OIG issued a Special Advisory Bulletin, entitled "Contractual Joint Ventures" (the "SAB"), regarding such arrangements.[21] The SAB focused primarily on questionable contractual arrangements where a healthcare provider that is in one line of business expands into a related healthcare business where substantially all of the operations of the new line of business are contracted out to a would-be competitor. According to the SAB, suspect arrangements may exhibit the following characteristics:

- New Line of Business (e.g., a hospital expanding into durable medical equipment ("DME") services; DME companies expanding into pharmacy business).

- Captive Referral Base – New line of business primarily serves only the patients of entity seeking to expand.

- Little or No Bona Fide Business Risk – The entity seeking to expand primarily contributes referrals to the venture and makes little or no financial or other investment in the business, delegating the entire operations to the other party of the venture, while retaining profits generated from its captive referral base.

- Would-Be Competitor Status of the Parties – The manager/supplier would otherwise be in a position to compete for the captive referrals with the healthcare provider.

- Extensive Services Provided by the Competitor to the Entity Seeking to Expand – The following key services are usually provided by the manager/supplier:

    - day-to-day management;

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[19] 42 CFR §1001.952(d).
[20] See, e.g., OIG's 1989 Special Fraud Alert on Joint Venture Arrangements, reprinted in 59 Fed. Reg. 65372 (Dec. 19, 1994).
[21] See 68 Fed. Reg. 23148 (April 30, 2003).

- billing services;
- equipment;
- personnel and related services;
- office space;
- training;
- healthcare items, supplies and services.

- Remuneration – The arrangement essentially permits healthcare provider to bill insurers and patients for business provided by the manager/supplier. The remuneration of the venture to the healthcare provider (i.e., the profits of the venture) takes into account the value and volume of business generated by the healthcare provider.

- Exclusivity – Typically, the arrangement has a non-compete clause, barring the provider from providing items and services to any patients other than those coming to the provider and/or barring the manager/supplier from providing services in its own right to the provider's patients.

The OIG also noted that while some suspect arrangements may fit within one or more safe harbors, the safe harbor would only protect remuneration for actual services rendered. The safe harbor would not protect the difference (so-called "deemed remuneration") between the money paid by the service recipient/lessee to the manager/lessor and the reimbursement received from the federal healthcare programs.

In 2004, the OIG issued two unfavorable Advisory Opinions involving contractual joint ventures.[22] In Advisory Opinion 04-17, the OIG reviewed a proposed arrangement between certain physician groups and an entity to manage and operate pathology labs on behalf of the physician groups. The OIG reviewed the arrangement against the guidelines it established in its SAB and concluded that the proposed arrangement could potentially generate prohibited payment for referrals. More specifically, the OIG opined that the pathology lab would otherwise be a competitor with the physician groups, the aggregate payment due the pathology lab would vary with referrals from the physician groups, and both the pathology lab and the physician groups would share in the economic benefit of the joint lab operations.

Finally, in 2008, the OIG issued yet another unfavorable Advisory Opinion (08-10) involving a "turnkey" joint venture whereby a physician practice group proposed to provide space, equipment, and personnel to another physician practice group through block leases.[23] There, the OIG concluded that providing the opportunity to generate a fee is itself remuneration

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[22]Advisory Opinion 04-17, December 10, 2004 (pathology laboratory services)**;** Advisory Opinion 04-08, June 23, 2004 (physical therapy).
[23]Advisory Opinion 08-10, August 26, 2008.

that may implicate the AKS.[24]This was the first OIG guidance that has focused directly on the leasing of physician services.

Under this arrangement, a urology group proposed to lease professional services (radiation oncologist), equipment and facility space from an intensity-modulated radiation treatment ("IMRT") facility. All payments under these agreements were certified to be at fair market value. Additionally, and as with the CT PSA, the leases were structured to require the urology group to pay the amounts owed under the agreements, regardless of the number of patients referred to the facility, and regardless of whether the urology group was able to collect its fees from the various payors. Citing to the SAB, the OIG observed that illegal remuneration could be the difference between the money paid by a referral source to a manager/supplier and the reimbursement received by the referral source and pronounced a high risk that the subject arrangement could be found to violate the AKS. According to the OIG, by agreeing to provide services it could otherwise provide in its own right for less than the available reimbursement, the party may be provided with the opportunity to generate a fee and a profit, and whether the arrangement violated the AKS would have to turn on an examination of intent (i.e., whether there was actual intent to create the opportunity to earn the margin in exchange for referring patients to the facility).

C. Clinical Co-Management Agreements

In some cases, a hospital may identify a certain clinical area that it wishes to improve or to develop but it does not have the necessary resources to go it alone. A clinical co-management agreement creates a mechanism for hospitals to partner with physicians to jointly provide key hospital services and improve patient quality outcomes. Co-management arrangements are by designed intended to recognize and appropriately reward participating medical groups/physicians for their combined efforts in developing and improving quality and efficiency of a particular hospital service line.

The arrangement may cover inpatient, outpatient, ancillary and/or multi-site services. Under a typical arrangement, the hospital and physicians have shared involvement in the daily operations of a particular service line. Co-management agreements are a great resource for hospitals to put in place as a mechanism to align physicians and the hospital to jointly manage quality and operational outcomes by making the participating parties accountable and rewarding each for achieving favorable operational results and quality outcomes.

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[24]The Department of Justice also took the position that the opportunity to earn fees constitutes illegal remuneration in the recently unsealed qui tam action against Christ Hospital, The Health Alliance of Greater Cincinnati, and The Ohio Heart Health Center. According to the 2008 Department of Justice press release, cardiologists, including those employed by Ohio Heart, were rewarded for referring business or generating revenue for Christ Hospital with the opportunity to bill for the patients they treated at the Heart Station and for any follow-up procedures these patients required. The value of the kickbacks, the complaint contends, was not in the payment by the hospital for the physicians' services, but rather, *in the ongoing patient business to the physician* resulting from the provision of services to new cardiac patients obtained through the Hospital's outpatient cardiac center. Thus, "remuneration" allegedly consisted of the "opportunity to earn fees." The government has intervened in the lawsuit and potential liability is reportedly nearly $400 million.

Today, there is emerging a trend of co-management arrangements to include multiple specialties at multiple inpatient and outpatient locations across the country. The intended effect of these multiple party co-management arrangements is to impact outcomes positively across the entire continuum of care. If successful, this partnership between the hospital and physicians will complement the current industry trends of hospital consolidation and accountable care organizations.

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The OIG issued Advisory Opinion 12-22 reviewing a cardiac catheterization co-management agreement between a hospital and cardiology group.[25] Under the arrangement, the cardiology practice provided management and medical direction services for the hospital's cardiac catheterization labs in exchange for a co-management fee comprised of (i) a guaranteed, fixed annual payment (the "Fixed Fee") and (ii) a potential annual performance-based payment capped at a maximum of the amount

The OIG analyzed the arrangement under both the civil monetary penalty law and under the anti-kickback statute. While the OIG noted that properly structured arrangements may increase efficiency and reduce waste, such arrangements can potentially influence physician judgment to the detriment of patient care, and can result in stinting on patient care; "cherry-picking" of healthy patients; and steerage of sicker patients to other hospitals; payment to induce patient referrals; and unfair competition among hospitals to foster physician loyalty and to attract more referrals. The OIG concluded that based on the hospital's certifications, the fixed fee, employee satisfaction, patient satisfaction, and quality components contained in the co-

[25]Advisory Opinion 12-22 (December 31, 2012).

management arrangement did not involve an inducement to reduce or limit services, and therefore, did not implicate the civil monetary penalty law.

The OIG also concluded that the cost savings component of the Performance Fee implicated the civil monetary penalty law because it might induce physicians to alter their current medical practice to reduce or limit services. However, the OIG concluded that the arrangement had several features that, in combination, provided sufficient safeguards so that the OIG would not seek sanctions. These factors included the following:

1. The hospital certified that the arrangement had not adversely affected patient care. In addition, the hospital also certified that it monitored both the performance of the cardiology group under the arrangement and its implementation of the cost savings component to protect against inappropriate reductions or limitations in patient care or services. The hospital's Board of Directors, internal auditing staff, and certain hospital staff committees monitored the group's performance under the arrangement. In addition, the hospital also used an independent, external third-party utilization review firm to annually review data related to the components of the Performance Fee and the clinical appropriateness of the cardiac catheterization procedures performed.

2. The parties structured the benchmarks within the cost savings component to allow the group's physicians the flexibility to use the most cost-effective, clinically appropriate items and services. The hospital certified that unique size stents, or other types of drug eluting stents remained available upon request by an interventional cardiologist, and that no physician was ever prohibited from requesting a particular device or supply required to address a patient's unique health needs. The OIG also found that the arrangement was designed to produce cost savings through inherent clinical and fiscal value and not from restricting the availability of devices or supplies. The OIG also found that the benchmarks were based on aggregated performance by the practice and were not based on meeting a specific standard in the case of a particular patient, if a standard was contra-indicated with regard to that patient.

3. The financial incentive tied to the cost savings component was reasonably limited in duration and amount, since it was subject to a maximum annual cap, and the term of the arrangement was limited to three (3) years.

4. Receipt of any part of the Performance Fee under the arrangement was conditioned upon the cardiologists not taking any of the following actions: (i) stinting on care provided to the hospital's patients; (ii) increasing referrals to the hospital; (iii) cherry-picking healthy patients or those with desirable insurance; or (iv) accelerating patient discharges.

The OIG also reviewed the arrangement under the anti-kickback law. While the OIG indicated that the arrangement could result in prohibited remuneration if the requisite intent to induce referrals was present, the OIG determined that it would not impose sanctions under the particular circumstances presented. The OIG based its determination upon the following factors and qualifications:

1. The hospital certified that the compensation paid to the cardiology group under the management agreement (including the Fixed Fee and the Performance Fee) was fair market

value for the services provided. The fact that the practice provided substantial services under the management agreement reduced the risk that the compensation paid was a payment for referrals, rather than for actual services rendered.

2. The compensation paid to the cardiology practice did not vary with the number of patients treated; thus, an increase in patient referrals to the hospital did not result in an increase in compensation paid to the practice under the arrangement.

3. Because the hospital operated the only cardiac catheterization labs within a fifty (50) mile radius, and because the practice did not provide cardiac catheterization services elsewhere, it was unlikely that the hospital offered compensation to the practice as an incentive for the practice physicians to refer business to the hospital, instead of to a competing lab.

4. The specificity of the measures within the arrangement helped to ensure that its purpose would improve quality, rather than reward referrals. The arrangement specifically defined the quality component and based the included measures on nationally recognized standards. The OIG also noted that the arrangement set out particular actions that generated the quality improvements upon which the payments were based. The measures contained in the quality and cost-savings components represented significant changes in cardiac catheterization lab procedures, which the physicians were responsible for implementing. Additionally, the lowest, baseline achievement level for any measure reflected improvement over the hospital's status quo performance for that measure prior to the effective date of the agreement.

5. The management agreement was a written agreement with a three (3) year term, which was limited in duration. The OIG qualified its opinion by stating that while the agreement contained an automatic renewal provision, the advisory opinion applied to the current three (3) year term. The OIG set forth an expectation that quality improvement and cost savings measures under the arrangement would be subject to adjustment over time, to avoid payment for improvements achieved in prior years, and to provide incentives for additional improvements in the future. The OIG noted that "continuing compensation for conduct that has come to represent the accepted standard of care could, depending on the circumstances, implicate the anti-kickback statute."

The OIG also noted that the cardiology practice distributed dividends pro rata, based on percentage ownership in the practice. The OIG indicated that it had no facts indicating that the practice allocated ownership interest based on individual physician participation or performance under the arrangement. The OIG stated that a different conclusion may have been reached had this been the case.

D. Physician Enterprise/Foundation Models

1. Employment Model – Under the provider-based Physician Enterprise Model ("PEM"), the hospital employs physicians directly or through a separate, but affiliated, entity. This entity is the "new" group practice for the physicians. The hospital bills and collects for the physician services. The employed physicians maintain ownership of their former group practice, which now enters into an administrative services agreement with the hospital to manage

the new group practices operations. Essentially, the hospital contracts with the old group practice for turnkey management services for the new group practice such as:

(i) administrative support;

(ii) non-professional staff;

(iii) office space;

(iv) furniture, fixtures and equipment;

(v) patient records; and

(vi) any other support service necessary to carry on the activities of a medical office.

Benefits – One of the primary benefits under this model is that the hospital does NOT buy the medial practice's assets. If necessary, it is easier to unwind. Unwinding failing physician practices turned out to be a great burden on hospitals that were in the unenviable position in the late 1990's of feeling obligated to do so. And there were many. If the relationship fails, the parties simply return to their pre-affiliation positions, without the need for fair market value appraisals of the returning practices and the potential impact on the hospital's finances and bond rating that any resulting investment loss recognition would create.

The physician maintains autonomy over the business matters of the practice because the physician ownership of the old practice entity has not changed. In fact, from the patients' perspective, very little has changed. That is, when the patient is treated by a group practice, everything about the office is the same. The old practice entity remains a viable profit center. As a result, the physicians are incentivized to manage the practice efficiently so as to maximize the profits from the management fee. In essence, the physician management activities are a second source of revenues for the physicians. Other advantages to the physicians include malpractice insurance coverage by the hospital and access to cutting-edge technology.

Because the physicians are now employees of the hospital (or a hospital-controlled affiliate), the hospital can influence physician activities, gain physician loyalty and assure necessary on-call coverage. Since the physicians are now employees of the hospital (or a hospital-controlled affiliate) they can participate in hospital incentive-based compensation arrangements for which they would not previously have been eligible to do. Also, physicians can be paid additional compensation for administrative tasks that they previously were obligated to provide on a voluntary basis when they were community-based physicians with only staff privileges at the hospital.

With respect to certain synergies, the hospital and physicians can be better connected through shared electronic medical records and other equipment and facilities. The physician services may be afforded greater reimbursement rates based on the hospital's better rates with third-party payors or if the physician services qualify for hospital-based outpatient services.

2. Leasing Model – Under the leasing model, the hospital purchases assets from a group practice. Then the hospital leases physician services from the group practice and provides the purchased space and equipment back to the group practice for use by the physicians. The hospital pays the group practice pursuant to an agreement; thus the group practice has a guaranteed steady flow of revenue. The hospital bills and collects for all professional services provided by the group practice physicians, for which arrangement each physician has executed a Form 855 R to assign their benefits to the hospital. In essence, the group practice stays in tact

In other variations of this model, the hospital purchases assets from the group and employs the physicians directly, or through an affiliated entity. The physician are paid under an incentive-based model to provide professional services and to also manage the group practice.

Benefits – This model shares many of the integration benefits of the employment model except that the hospital is purchasing practice assets, which makes it more difficult to unwind if the arrangement does not work out.

Under this model, the group practice stays intact. This is a favorable outcome to patients because nothing has changed. The physicians are still practicing at the same site after the lease arrangement as before. The physicians receive a guaranteed revenue stream under the physician's services agreement and a one-time payment in exchange for the assets sold to the hospital. Also, the physicians maintain autonomy over the group practice operations, which is important to many physicians who are just not yet ready to relinquish control and be employed by the hospital. Finally, the hospital has guaranteed access to physicians for outpatient services and a commitment for on-call coverage.

3. Laws Applicable to Physician Enterprise Models

a. Federal Anti-Kickback Statute (42 U.S.C. 1320a-7b): The AKS prohibits the offer, solicitation, payment, or receipt of any remuneration, in cash or in kind, in return for, or to induce, the referral of a patient for any service that may be paid by a federal healthcare program (most notably, Medicare and Medicaid).[26] Prohibited conduct also includes remuneration in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item reimbursed under Medicare or a state health care program. The Medicare and Medicaid Patient and Program Protection Act of 1987[27] also added a mandate to HHS to promulgate regulations specifying those payment practices that will not be subject to criminal prosecution or exclusion from the Medicare and Medicaid programs (so-called "safe harbors"). If an arrangement meets all of the requirements of a particular safe harbor, the parties will be completely insulated from prosecution. If an arrangement does not meet a particular safe harbor, it does not mean that the arrangement is *per se* illegal, rather the arrangement will be scrutinized to determine if the requisite intent was present to pay or induce referrals or the purchase of goods or services that are reimbursed under a federal healthcare plan.

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[26] 42 U.S.C.A. Section 1320a-7b(b).
[27] P.L. No. 100-93, 100 Stat. 688 (1987).

Under the Employment PEM, the employment arrangement is protected by both the employee exception and safe harbor, which is satisfied so long as the physicians are treated as bona fide employees under applicable federal income tax rules. If the professional services arrangement fails to meet bona fide employee status, the arrangement will nevertheless be protected if it meets the personal services safe harbor (discussed below).

With respect to the management and administrative services provided by the old practice entity to the new practice, the parties will be protected if the arrangement meets all the requirements of the personal services, office space and equipment lease safe harbors. All three of these safe harbors basically require that the arrangement is in writing, signed by the parties, and for a period of at least one year, and the amount is set in advance, is not based on the value or volume of referrals or other business generated between the parties, and does not exceed fair market value.

Under the Lease PEM, the arrangement should be structured to meet the space and equipment safe harbors described above and should be commercially reasonable with respect to the intended use.

b. Ethics in Patient Referrals Act (the Stark law) (42 U.S.C. 1395nn): Effective for referrals made after December 31, 1994,[28] if (i) a physician (or an immediate family member of such physician) has (ii) a "financial interest" in an (iii) entity, (iv) the physician may not make a referral to that entity (v) for the furnishing of "designated health services" (vi) for which payment is sought under Medicare or Medicaid, and the entity may not present a claim or bill to any individual, third party payor, or other entity for designated health services.

All six of the elements of Stark must be present to implicate the statute. If all six elements are present, the referral will only be protected if an applicable exception applies. There are no safe harbors excluding a referral from the self-referral ban. If a referral arrangement is not specifically excluded by the statute, it is subject to the ban. Stark is violated when DHS services are billed, not when the referral itself is made; thus, the ban is on billing, not the referral.

Many of the exceptions under Stark are similar to the AKS. Thus, under the Employment PEM, the employment arrangement will be protected if it meets the employee exception, which, like the AKS, is satisfied if the physicians are treated as bona fide employees under applicable federal income tax rules. Also, if the professional services arrangement fails to meet bona fide employee status, the arrangement will nevertheless be protected if it meets the personal services exception (discussed below).

With respect to the management and administrative services provided by the old practice entity to the new practice, the parties will be protected if the arrangement meets all the requirements of the personal services, office space and equipment exceptions, which requires the same conditions described above with respect to the AKS.

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[28] P.L. 103-66, 13562(b)(2).

Similarly, under the Lease PEM, the arrangement should be structured to meet the space and equipment safe exceptions described above and should be commercially reasonable with respect to the intended use.

c. Civil Monetary Penalty Statute (Section 1128A of the Social Security Act): Prohibits hospital payments to physicians to reduce or limit services to Medicare inpatients, regardless of the medical necessity of the services. A hospital would be in violation of this statute if, for example, it rewarded physicians for reducing the number of days in the intensive care unit or the drugs their patients use. In most cases for which the OIG may seek Civil Monetary Penalties ("CMP's"), the OIG may also seek exclusion from participation in all Federal health care programs.

d. Corporate Practice of Medicine: There are many states that prohibit hospitals from directly employing physicians with respect to outpatient services. These laws, typically case law, are typically referred to as "corporate practice of medicine" laws. Those states with such prohibitions generally require that any physician organization be organized as a for-profit professional corporation, whose shareholders must all be licensed physicians. The basic rationale behind the prohibition is that individual licensed physicians should practice medicine and that permitting a corporation to practice medicine presents a conflict between the physician's divided loyalty of furthering the interest of a corporation and the medical needs of a patient.[29] States that preclude hospitals from employing physicians to provide outpatient services are: California, Colorado, Illinois, Iowa, New Jersey, New York, Ohio and Texas.

In those states with the corporate practice of medicine laws, the hospital could create a "captive" professional corporation with a physician associated with the hospital as the sole shareholder, who holds the stock for the beneficial interest of the hospital. The captive professional corporation would then employ the physicians under the employee PEM or enter into a professional services agreement under the lease PEM. If the captive professional corporation is organized and operated according to certain federal income tax rules, the professional corporation may qualify for federal income tax-exemption under Section 501(c)(3) of the Code.[30]

IV. Valuation Approaches

A. General Principals

For most healthcare related valuation assignments, the appropriate standard of value is "fair market value." Fair market value is defined under the Internal Revenue Service's revenue rulings and modified by the Anti-Kickback Statute to include the value or volume of referrals. The IRS definition defines fair market value as:

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[29]For a further discussion regarding the Corporate Practice of Medicine see "State Prohibition on Hospitals Employment of Physicians," Department of Health and Human Services, Office of Inspector General, Document No. OEI-01-91-00770 (November, 1991).

[30]See IRS Professional Continuing Education Text Book, 2000.

> "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 arm's-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."

However, the CMS definition of fair market value differs from the IRS definition by adding additional guidance regarding referrals, as follows:

> "…the value in arm's-length transactions, consistent with the general market value. "General market value" means the price that an asset would bring, as the result of *bona fide* bargaining between well-informed buyers and sellers **who are not otherwise in a position to generate business for the other party**, on the date of acquisition of the asset." Usually, the fair market price is the price at which *bona fide*s ales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition."

Once the proposed compensation or management arrangement is understood, the appraiser determines the applicability of the three approaches referenced below. Healthcare-focused valuation consultants may have access to both internal and external data specific to physician compensation relationships that might be otherwise unavailable or too costly for a general valuation firm without a healthcare focus. The appraiser uses multiple valuation approaches and multiple sources of data in connection with assessing the FMV of physician compensation arrangements. The appraiser will consider regional compensation differences, the nature and circumstances of the proposed co-management arrangement, and any other factors that are relevant to the arrangement.

The appropriate valuation approach related to any specific asset depends upon the facts and circumstances applicable to that asset as of a particular point in time. Following is a discussion of the primary valuation approaches, as defined by the International Glossary of Business Valuation Terms (the "International Glossary")[31].

Income Approach. The Income Approach is defined according to the International Glossary as "a general way of determining a value indication of a business, business ownership interest, security, or intangible asset using one or more methods that convert anticipated economic benefits into a present single amount."

Cost Approach. The Cost Approach is defined according to the International Glossary as "a general way of determining a value indication of an individual asset by quantifying the amount of money required to replace the future service capability of that asset." The Cost Approach is based upon the Principle of Substitution; *i.e.,* the premise that a prudent individual will pay no more for a property than he/she would pay to acquire a substitute property with the same utility.

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[31]Developed under joint guidance from American Institute of Certified Public Accountants ("AICPA"), American Society of Appraisers ("ASA"), National Association of Certified Valuation Analysts ("NACVA"), The Institute of Business Appraisers ("IBA").

Guideline (or Market) Approach. This approach is defined according to the International Glossary as "a general way of determining a value indication of a business, business ownership interest, security, or intangible asset by using one or more methods that compare the subject to similar businesses, business ownership interests, securities, or intangible assets that have been sold." Similar to a Cost Approach, a Market Approach is based upon the Principle of Substitution.

B. Call Coverage Valuation

In assessing the FMV of on-call compensation arrangements, comparisons to other on-call compensation arrangements in existence at other hospitals in the marketplace (*i.e.*, a direct Market Approach) do not necessarily provide a primary basis for establishing FMV. Such arrangements may (i) contain an overcompensation bias and may not be reflective of rational and disciplined compensation arrangements; and/or (ii) sufficient details may not be available in order to insure valid comparisons. For example, two hospitals in the same marketplace may have vastly different payor mixes, whereby the FMV of compensation for on-call availability may be significantly higher at the hospital with the less favorable payor mix.

Rather than placing primary reliance upon a Market Approach, HealthCare Appraisers (HAI) has dedicated significant effort to establishing a reliable method for valuing physician on-call compensation arrangements. In order to determine the FMV range of compensation using a "Scoring Algorithm Methodology", HAI considers the following primary factors that are specific to specialty coverage at the target hospital:

1. The general nature of the subject physician specialty (to help assess the expected urgency and the implications of on-call events, *e.g.*, whether a surgical intervention is likely);

2. The number of specialists eligible or available to take call on behalf of the target hospital;

3. The target hospital's annual ED visit volume, and the historical or expected frequency of on-call events that require the subject specialist's response *by telephone*;

4. In light of the annual ED visit volume, the historical or expected frequency of on-call events that require the subject specialist's response *by presenting to the target hospital*;

5. The target hospital's ED or applicable payor mix (specific to the subject specialty's patients if available) to help assess the expected remuneration to be derived in connection with the subject specialist's professional services rendered in connection with an on-call event; and

6. Other unique factors that may be relevant to the arrangement (*e.g.*, abnormally high professional liability exposure, very short required response time, or a shortage of providers).

Using these factors, HAI developed a "scoring algorithm" which allows us to establish support and objectivity for our concluded opinion. We consult market data related to on-call coverage agreements (e.g., Sullivan Cotter and Medical Group Management Association

(MGMA)), but such data does not allow differentiation related to the relative "burden" of any particular on-call arrangement. This methodology is consistent with the statements made by the OIG in Advisory Opinions No. 07-10 and 09-05, and is intended to value the legitimate services provided by Contractors. HAI's Scoring Algorithm is specifically designed to consistently measure the actual burden placed on Contractors, and takes into account each of the above factors noted by the OIG in determining the FMV range applicable to the agreement. The results of the scoring algorithm are then applied to the FMV range of hourly clinical compensation earned by the respective specialists in Hospital's marketplace to determine the daily per-diem FMV range for on-call services at Hospital.

C. Employment/PSA Valuation

Appraisers may approach to the valuation of direct employment arrangements and professional services arrangements ("PSA's," which may be apart of the physician leasing model described above) by focusing on matching the appropriate level of pay for the services provided within the dynamics of the arrangement and the candidate's level of productivity. The framework for this approach considers, as some examples, the following factors:

- Level, scope, and acuity of services provided under the terms of the arrangement;
- Mix of services combined or "stacked" under the arrangement and the potential for overlap in services and compensation;
- A review of historical financials and practice *pro formas*; and
- Credentials of the subject physicians providing services.

Once the proposed compensation arrangement is understood, the appraiser will determine the applicability of the three approaches: Income, Market and Cost approaches. The appraiser may use multiple valuation approaches and multiple sources of data in connection with assessing the FMV of compensation arrangements. Appraisers consider regional compensation differences; the nature and circumstances of the proposed compensation arrangements; the physicians' expected productivity; the profitability of the practice; and any other factors that are relevant to the arrangement. The FMV methodology should also incorporate relevant healthcare regulatory guidance for establishing FMV.

Appraisers consider market data on compensation for physician specialties from the various physician compensation surveys that are available, including MGMA, AMGA, SCA, etc. Such analysis should take into account national data, and potentially where relevant and significant in sample size, regional and state data. If appropriate and available, engagement-specific survey data might be ordered from survey publishers based on selected metrics.

Upon completing its data gathering and analysis, the appraiser will synthesize the various indications of value from the various valuation approaches and techniques are completed. This process involves taking into account the availability and quality of data for the approaches and determining the indications that are most relevant for the determination of FMV in the healthcare regulatory context.

When employment or quasi-employment arrangements involve multiple services (*i.e.*, in addition to clinical services), the appraiser must evaluate each component individually using valuation techniques and data relevant to the scope of services. Upon completion of these additional analyses, the appraiser will analyze the total compensation under the proposed agreement for both commercial reasonableness and consistency with FMV.

D. Co-Management Valuation

The Cost Approach can be used to estimate the "replacement" or "replication" cost of the management/administrative services to be provided by the manager. It is very difficult, if not impossible, to accurately determine the specific costs involved in managing a service line. An analysis by "proxy," or an approach that estimates the number of medical director hours required to manage the service line in the absence of a management arrangement, (which is then multiplied by an FMV hourly rate) yields one indication of value. However, within the framework of a joint venture management company, this approach would not consider the hospital's contribution. Further, a key ideal of most co-management arrangements is to reward ***results*** rather than time-based efforts.

The Market Approach recognizes that that there are certain management / administrative requirements associated with every service line management arrangement. However, it is also understood that each co-management arrangement is unique and may include and prioritize different market and operational factors. Therefore, within the framework of the Market Approach analysis, consideration must be given to the required management tasks.

- Specific tasks and responsibilities of the managers must be identified.
- On an item-by-item basis, the relative worth of each task/responsibility is "scored" relative to other comparable arrangements.
- An indication of value of the management services is then established by comparing the "scoring" of the subject agreement to other service arrangements in the marketplace.

The Cost and Market valuation methodologies should be reconciled to arrive at a final conclusion of value. The Cost Approach may "underestimate" the value of the arrangement because in the case of joint ventures, the Cost Approach only considers physician participation (*i.e.*, medical directors). The Market Approach may "overestimate" the value of the arrangement because market comparables may not be exact.

While it may be appropriate to give equal weighting to the two approaches, the valuator may conclude that one method should be weighted more heavily than the other. Once the FMV of the ***total management fee*** is established, an assessment must be made regarding the split between the ***base fee*** and ***incentive fee*** components. The FMV of the base fee must encompass payment of any medical director fees or administrative services related to managing the service line.

The extent and nature of the services drive their value. Thus, the valuation assessment is the same whether the manager consists of only physicians or physicians and hospital management. Determinants of value include:

- The scope of the hospital service line being managed
- The complexity of the service line? (e.g., a cardiovascular service line is relatively more complex than an endoscopy service line)
- The duties being provided under the co-management arrangement (i.e. more extensive duties yield higher value)
- The number of physical locations being managed
- The size of the service line based on service line revenue:
    - Large programs may be subject to an "economies of scale" discount.
    - Small programs may be subject to a "minimum fee" premium.