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HOSPITAL ACQUISITIONS OF PHYSICIAN PRACTICES: A LEGAL AND FAIR MARKET VALUE ANALYSIS

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Introduction and Overview

- Current Trends in Physician Practice Acquisitions
- Fair Market Value Definitions
- Physician Practice Valuation Methods
- Comparison of Valuation Methods
- Legal Restrictions Impacting the Value of Physician Practices
- Health Care Reform's Impact on Physician Practice Acquisitions and Physician-Hospital Integration
- Questions and Answers

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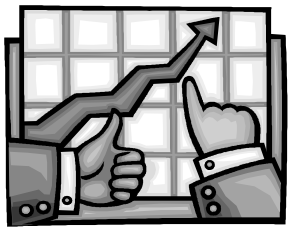
Current Trends in Physician Practice Acquisitions

- Market Share/Competition/Strategy
- Medicare Reimbursement
- Burdens of Private Practice
- Capital Requirements/EMR
- Health Delivery System Changes
- Healthcare Reform Impact



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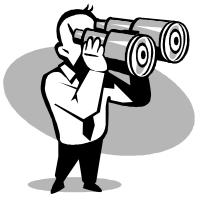
Fair Market Valuation Definitions

- As Viewed by the Hospitals and Physicians
- As Viewed by the Federal Government
- As Viewed by the Valuation Experts



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Physician Practice Valuations

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Standards of Value

Typical Standards of Value are:	Most Likely Used For/By:
Fair Market Value "the price at which property would change hands between a willing buyer and a willing seller, neither party being under any compulsion to buy or sell, and both having reasonable knowledge of all relevant facts, and with equity to both." • *As defined by IRS Revenue Ruling 59-60*	· **Tax Purposes** · **Seller Advisory** · **Management Decision - Making**
Fair Market Value ""…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 a bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party…." • *As defined by federal Stark regulations at 42 C.F.R. §351*	· **Regulatory – Stark and Anti-kickback Statute Requirements**
Investment Value "the specific value of an investment to a particular investor or class of investors based on individual investment requirements…" • *As defined by The Dictionary of Real Estate Appraisal*	· **Strategic and Financial Investors**

Valuation Methods and Key Considerations

Income Approach

- Based on discounted cash flows, or capitalized cash flows; *Key Concept: Understanding Provider Compensation vs. Practice Value.*

- Reliability of Management Projections
- Historical Trends
- Industry Trends
- Future Outlook
- Regulatory Outlook
- Discount Rate

Asset Approach

- Based on the underlying identified assets

Key Tangible Assets:
- Working Capital
- Plant, property & equipment
- Investments

Potential Key Intangible Assets:
- Trade Name
- Covenant not to Compete
- Trained & Assembled Workforce
- Patient Charts

Liabilities:
- Interest bearing debt
- Capital leases

Valuation Methods and Key Considerations, cont'd

Market Approach: Based on sales of other similar practices

Comparable Transaction Method
- Transaction Database
- Sources of Information
- Relevancy of Approach
- Single Location Engagements

Physician Practice Valuations

- **Understanding Key Value Drivers:**
  - Patient Volumes
  - Physician and Mid-level Production
  - Reimbursement Rates
  - Service/Procedure Mix
  - Payor Mix: Where Do the Dollars Come From?
  - Physical Facility, Equipment, and Staffing
  - Operating Expenses
  - Management
  - Local Demographics
  - Competitor Environment
  - Capital Structure: Debt Concerns
  - Compensation vs. Practice Value

Case Study

Physician Compensation Analysis

Physicians	Provider Performance 12/31/2008	12/31/2009	Annualized 3/31/2010	Average
Physician 1				
Gross Charges	$ 700,000	$ 725,000	$ 750,000	$ 725,000
Collections	420,000	435,000	450,000	435,000
Work RVUs	5,500	5,600	5,700	5,600
Physician 2				
Gross Charges	710,000	735,000	760,000	735,000
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	MGMA Survey Data per Physician 25th%	Median	75th%	90th%
Gross Charges Per Physician	$ 433,280	$ 571,110	$ 749,408	$ 982,326
Collections Per Physician	277,786	356,452	447,812	557,409
Compensation Per Physician	158,697	196,934	247,635	317,830
Work RVUs	3,657	4,691	5,739	7,126

Income Approach Example

Forecast Period	Normalized Base Year	Years 1	2	3	4	5	Terminal
Revenues	$ 1,427,295	$ 1,540,308	$ 1,640,241	$ 1,714,246	$ 1,774,493	$ 1,827,813	$ 1,882,648
Operating Expenses	727,484	768,640	806,494	837,518	865,073	891,049	917,780
EBITDAC	699,811	771,668	833,747	876,728	909,420	936,764	964,868
EBITDAC Margin	*49.0%*	*50.1%*	*50.8%*	*51.1%*	*51.2%*	*51.3%*	*51.3%*
Physician Compensation	495,269	535,683	571,463	597,928	619,445	638,410	657,563
Physician Benefits	108,959	117,850	125,722	131,544	136,278	140,450	144,664
Total Physician Compensation	604,228	653,533	697,185	729,472	755,723	778,860	802,227
EBITDA	95,583	118,135	136,562	147,256	153,697	157,904	162,641
EBITDA Margin	*6.7%*	*7.7%*	*8.3%*	*8.6%*	*8.7%*	*8.6%*	*8.6%*
Tax Depreciation		23,081	45,838	45,505	45,650	46,092	49,822
EBIT		95,054	90,724	101,751	108,047	111,812	112,819
Income Taxes		36,406	34,747	38,971	41,382	42,824	43,210
Net Operating Profit After Tax		58,648	55,977	62,780	66,665	68,988	69,609
Plus: Tax Depreciation		23,081	45,838	45,505	45,650	46,092	49,822
Less: Capital Expenditures		30,806	32,805	34,285	35,490	36,556	49,822
Less: Incremental Debt-Free Cash-Free Working Capital		2,118	9,993	7,401	6,025	5,332	5,484
Net Available Cash Flow		48,805	59,016	66,600	70,800	73,192	64,126
Present Value Factor		0.938	0.826	0.727	0.640	0.563	
Present Value of Cash Flow		$ 45,792	$ 48,745	$ 48,425	$ 45,319	$ 41,242	

Present Value of Discrete Cash Flows	229,524
Present Value of Terminal Year Value	341,044
Present Value of Cash Flows	570,568
Indicated Business Enterprise Value	**$ 571,000**

Terminal Multiple	9.44
Terminal Value	605,242
Present Value Factor	0.563

Cost Approach Example

	Book Value March 31, 2010 (1)	Market Value March 31, 2010	Contemplated Transaction
ASSETS			
Cash & Equivalents	$ 133,234	$ -	$ -
Accounts Receivable	-	102,000	-
Practice Supplies	-	1,000	1,000
Total Current Assets	133,234	103,000	1,000
Lab Equipment	-	1,500	1,500
Medical Equipment	-	4,040	4,040
Office Furniture & Fixtures	-	33,690	33,690
Medical Furniture & Fixtures	-	8,600	8,600
Telecommunication Equipment	-	7,750	7,750
Office Equipment	-	6,200	6,200
Computer Hardware	-	6,590	6,590
Off-the-Shelf Software	-	27,000	27,000
Total Property Plant & Equipment	91,736	95,370	95,370
Workforce	-	11,000	-
Patient Files	-	24,000	-
Trademark / Trade Name	-	42,000	-
Total Intangible Assets	-	77,000	-
TOTAL ASSETS	**224,970**	**275,370**	**96,370**
Other Current Liabilities	10,127	10,127	-

Scenario Analysis: Sensitivity Analysis

Hypothetical value of the Practice based on various physician compensation scenarios.

	Compensation Level MGMA Benchmark 25th%	Median	75th %	90th %	Asset Purchase (all tangible assets only)	Asset Purchase (all tangible and intangible assets)	Contemplated Purchase Compensation (selected tangible assets only)
Avg Comp per Physician	$ 158,697	$ 196,934	$ 247,635	$ 317,830	$ 276,680	$ 271,580	$ 282,820
Avg Benefits per Physician	38,087	45,295	54,480	63,566	55,336	54,316	56,564
	196,785	242,229	302,114	381,396	332,016	325,896	339,384
Total Comp Pool (2 doctors)	393,569	484,457	604,229	762,792	664,032	651,792	678,768
Indicated FMV - Income Approach	**$ 1,882,000**	**$ 1,313,000**	**$ 563,000**	**$ (719,000)**	**$ 188,243**	**$ 265,243**	**96,370**
Total FV of Identifiable Assets	265,243	265,243	265,243	265,243	188,243	265,243	96,370
Residual Value	**$ 1,616,757**	**$ 1,047,757**	**$ 297,757**	**$ (984,243)**	**$ -**	**$ -**	**$ -**

- **Compensation v. Practice Value**
- **Should you buy intangibles and goodwill?**

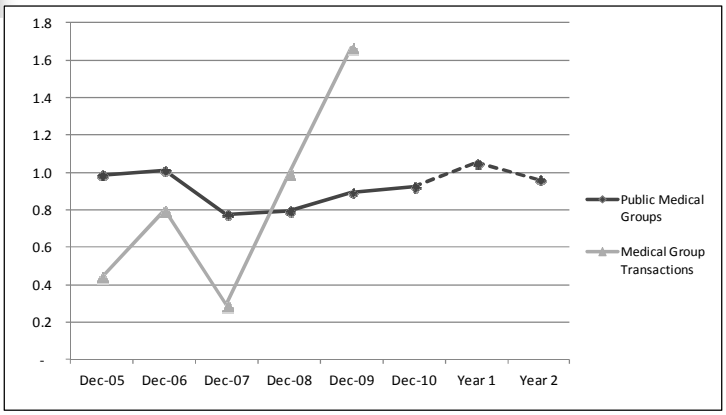
Market Approach Example

Date	Acquirer	Practice	State	Price
06/02/09	Mednax, Inc.	Associates in Neonatology, PA	TX	10,000,000
10/20/08	Emergency Medical Services Corp.	Templeton Readings, LLC	MD	27,500,000
07/22/08	Cross Country Healthcare, Inc.	Medical Doctor Associates	GA	115,900,000
06/11/08				14,615,385
04/24/08	Tri-Isthmus Group, Inc.	Southern Plains Medical Group	OK	1,350,000
03/20/08	HealthTronics, Inc.	Advanced Medical Partners, inc.	TX	13,100,000
02/25/08	Vital Health Technologies, Inc.	Momentum Medical Group, Inc.	CA	8,000,000
11/15/07	ProHealth Care	Medical Associates Health Center	WI	40,000,000
08/08/07	IntegraMed America, Inc.	Vein Clinics of America, Inc.	IL	28,000,000
04/01/07			MI	146,000
03/05/07	Pacer Health Corp.	Family Medical Associates	GA	1,176,300
10/13/05	The Blackstone Group	Team Health Inc.	TN	1,000,623,000
10/05/05	PainCare Holdings, Inc.	Floyd O. Ring, Jr. MD, PC	CO	5,000,000
04/19/05	Omni Medical Holdings, Inc.	Plum Creek Out Patient, Inc.	IL	800,000

Selected LTM Financial Information:	
LTM Net Revenues	1,427,104
LTM Operating Income	NMF
Indicated Fair Market Values:	
Price / LTM Net Revenues	885,050
Price / LTM Operating Income	NMF
Indicated Fair Market Value (Rounded)	**$890,000**

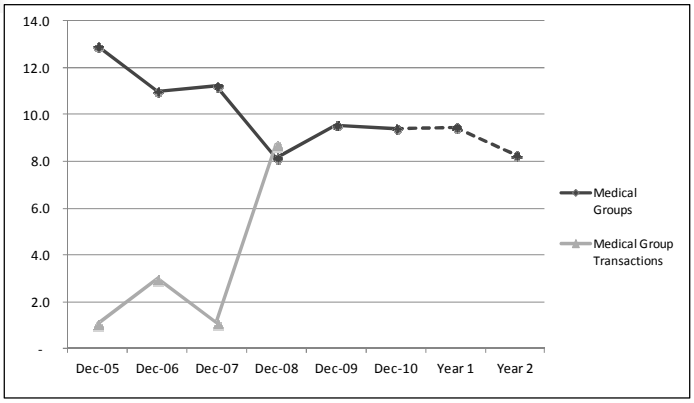
Market Pricing and Volume Trends

Total Enterprise Value / Revenue Multiples



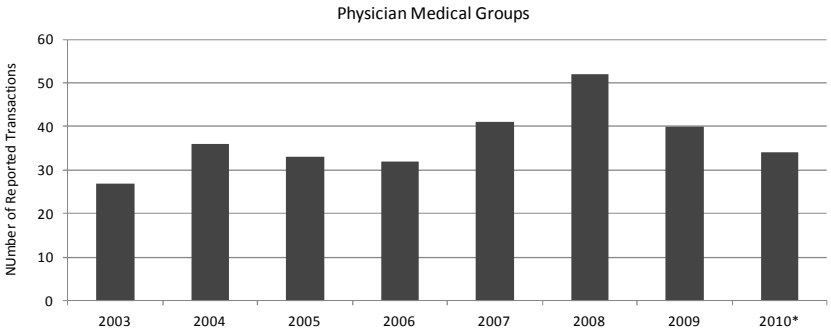
- Medical group transactions lagged behind publicly-traded company multiples until 2008.
- Publicly traded companies have been trading between 0.8x - 1.0x revenue since 2005 and are forecasted to remain relatively flat over the next two years.

Total Enterprise Value / EBITDA Multiples



- EBITDA = Revenues – Cost of Revenues – Other Expenses + D&A
- Forecast for EBITDA is relatively flat with a small decline
- Financial metrics for medical group transactions have been limited in 2009 and 2010

Reported Sales of Medical Practices

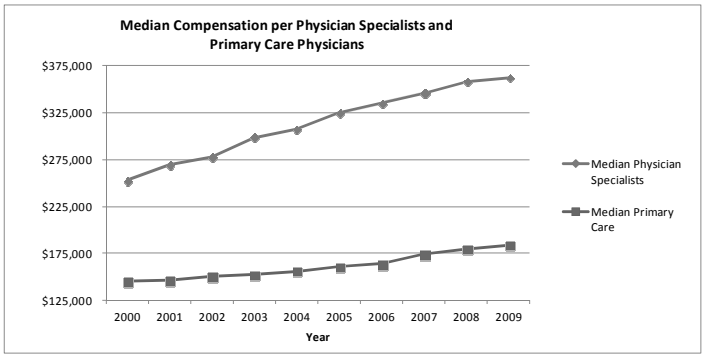


Year	2003	2004	2005	2006	2007	2008	2009	2010*
Total	27	36	33	32	41	52	40	34
Percent Change	N/A	33.3%	-8.3%	-3.0%	28.1%	26.8%	-23.1%	-15.0%

*Data through September 30, 2010

Additional Considerations

- **Provider Compensation**
  - Must be at *Fair Market Value* for regulatory purposes
  - Specialist compensation increasing



Source: MGMA Physician Compensation and Production Surveys, 2010 Report Based on 2009 Data

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Legal Restrictions Impacting the Value of Physician Practices

- Anti-Kickback Statute
- Stark Law
- State Laws
  - Licensure Laws
  - Fee-Splitting Statutes
  - Corporate Practice of Medicine Restrictions

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Anti-Kickback Statute

(42 U.S.C. §1320a-7b(b) and implementing regulations at 42 C.F.R. §1001.952)

- Makes it illegal for any person to knowingly and willfully pay or receive any compensation in return for:
  - a referral for any item or service paid for by a federal health care program; or
  - purchasing, leasing or ordering any good, facility, service or item paid for by a federal health care program.

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Safe Harbors

- Rental of space or equipment
- Personal services and management contracts
- Sale of practice
- **Amounts paid by employers to employees with bona fide employment relationships**
- Practitioner recruitment

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The Stark Law

Stark Law prohibits a physician from making referrals for "designated health services" to entities with which the physician or immediate family member has a direct or indirect financial relationship.

- Only applies to Medicare Designated Health Services (or DHS).
- **Intent is not a factor—strict liability.**

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Stark Law Exceptions

- Rental of office space or equipment
- ***Bona fide* employment relationships**
- Personal service arrangements
- Physician recruitment
- Isolated transactions
- Group practice and in-office ancillary services
- Fair market value compensation

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Bona Fide Employment Relationships

Bona fide employment relationships:

(1) The employment is for identifiable services.

(2) The amount of the remuneration under the employment is:

(i) Consistent with **fair market value**; and

(ii) not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician.

(3) The remuneration is provided under an agreement that would be **commercially reasonable** even if no referrals were made to the employer.

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Compensation Stacking Issues

Multiple Compensation Arrangements:

- Salaried Physician
- Independent Contractor and Medical Director Agreements
- Service Line Co-Management Arrangements
- On-Call Services

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Bradford Regional Medical Center

- Hospital subleased a nuclear camera from a practice.
- Compensation was not fair market value.
- Violated the Stark Law because the arrangement took into account anticipated referrals.
- Court found Bradford and the physicians were aware the arrangement implicated the Stark Law and Anti-Kickback Statute, but there was a genuine issue of material fact to preclude finding that they acted "knowingly" for purposes of the False Claims Act.

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Tuomey Medical Center

- Violated Stark Law for part-time employment agreements
- Had third-party determination of fair market value
- Ordered to repay $45 million in medical reimbursement

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North Ridge Medical Center

- Employed 12 physicians with compensation in excess of FMV
- Compensation nearly doubled physicians' previous income
- Post-hire referrals increased
- Stark Law violations
- Exception for employment arrangements requires compensation be FMV, commercially reasonable, and not take into account the volume or value of referrals

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Covenant Medical Center

- Covenant paid five employed physicians amounts that the government alleged were above fair market value and were not commercially reasonable.
- Defendants claimed the compensation formulas were based on personally performed services and consistent with FMV.
- DOJ claimed the physicians salaries were among the highest in the country.
- In 2009, Covenant settled for $4.5 million the False Claims Act allegations, based on the underlying Stark Law violations.

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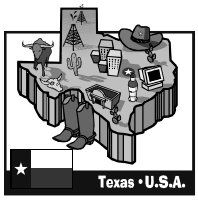
State Laws

- Requirements Vary by State
- State Licensure Law
- Fee-Splitting Statutes
- Corporate Practice of Medicine



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Tax Exempt Hospital Restrictions

- IRC 501(c)(3) Exemption Standards
  - No private inurement
  - Only incidental private benefit
- Intermediate Sanctions
  - Excess benefit for disqualified person
  - Presumption of reasonableness

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IRS Guidance for Practice Acquisitions

- Timely valuation of assets
- FMV price/Retained goodwill
- Retained rights
- Reasonable compensation/incentives
- Charitable purposes

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Health Care Reform's Impact on Physician Practice Acquisitions

Increased interest in aligning the interests of physicians and hospitals:

- Physicians may no longer invest in hospitals
- Hospitals continue to employ physicians
- Hospitals continue to purchase ancillary services owned by physicians
- Incentives for hospitals to coordinate care and payment with physicians (*i.e.*, bundled payments and accountable care organizations)

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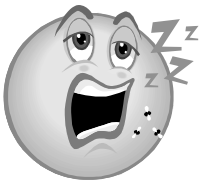

Questions and Answers

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Current Trends in Physician Practice Acquisitions
The Relationship of Physician Compensation to the Practice's Fair Market Valuation

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Introduction

How does the prospective physician compensation model affect the value of a physician's practice? As hospital acquisitions of physician practices are increasing, this is a frequently asked question and an important factor in the fair market valuation of medical practices. Since physician compensation is a key factor in motivating physician performance, the model should reward performance. Likewise, since physician compensation is typically the largest expense of a practice, it has a significant impact on profits to a buyer, which ultimately, drives the value of the practice. Therefore, it stands to reason that the value of a medical practice is significantly influenced by the future physician compensation model and its impact on anticipated profits.

Current Trends in Medical Practice Transaction

Health reform's emphasis on increasing the number of insured patients, improving quality, and constraining reimbursement, is once again driving an increase in hospital acquisitions of medical practices. Medical practice acquisitions can enable a hospital system to transition into a comprehensive healthcare system by becoming the "medical home" to a patient population and facilitate the creation of accountable care

organizations. For many physicians, health reform and reimbursement pressures are creating an uncertain outlook for future compensation, at a time when the aging baby boomer population and the expansion of insureds are expected to increase the demands placed on physicians. As a result, physicians are increasingly interested in being employed by hospitals, instead of owning their practices, in an effort to safeguard their compensation and provide a better quality of work life. This is particularly evident in cardiology and primary care practices.

A New Day

Many hospital leaders will recall a similar increase in medical practice acquisitions in the mid-to late 1990's. That acquisitive period was followed by a large number of divestitures once the physicians' employment contracts expired and as hospitals and physician practice management companies struggled to efficiently operate the practices and keep their physicians incentivized to improve their productivity levels and quality outcomes.

However, this appears to be a new day, where hospitals, facing financial challenges caused by a weak economy, reimbursement pressures, and tough capital markets, are endeavoring to make careful decisions regarding medical practice acquisitions, including the amount they are willing to pay, the types of assets they are willing to purchase, and the post-transaction physician compensation models. Likewise, physicians, facing an ever increasing uncertain future under health reform and the uncertainty that

persistently follows Medicare's Sustainable Growth Rate reimbursement model, may feel the valuations of their practices will suffer in the foreseeable future and therefore they may have less negotiating flexibility. Instead of simply remaining as an independent practice, which is always an option, physicians may feel compelled to make a deal even if it is for a transaction price below their expectations.

Medical Practice Valuations

A valuation of the medical practice should equip the buyer and seller with relevant information to enable the parties to negotiate the sales transaction, including the fair market valuation of the assets and the future compensation model. Inconsistencies between the contemplated transaction structure and the assumptions used in the practice valuation analysis can result in misleading and flawed valuation results. Some of the key transactions terms that should be considered and understood in performing the valuation analysis include:

- Future physician employment terms and compensation model
- Non-compete terms that the physicians will be subject to
- Future status of the practice's ancillary services (i.e. will they stay in the practice or will they move to the hospital setting?)
- The legally permissible sources of future physician compensation (i.e. ancillary services)

- The services and assets of the practice that will be purchased and what will remain with the practice, if any
- Does the practice own or lease its facility and will the buyer either assume the lease or purchase the facility?
- What is the future status of the key physicians? Are any of them retiring and/or planning on leaving the practice?
- Will the practice be converted to a hospital department or will it continue to be operated and billed as a non-facility entity?

Understanding these key features of the transaction will facilitate the valuation of the identifiable assets and the valuation of future compensation in the context of the contemplated transaction.

Compensation Models and the Impact on Practice Valuations

Under the income approach, the valuation of a medical practice is based on the present value of the future net free cash flow of the practice. The higher the net free cash flow of the practice (net of physician compensation) the higher the practice value. Since physician compensation is an expense of the practice, the *higher* the future compensation paid to physicians, the *lower* the practice valuation outcome.

The valuation of the practice can be performed under various compensation models. Some of the physician compensation models observed in the marketplace include:

- Profit-based models (i.e. “take what you make”/”eat what you treat”)
- Production-based models, such units of production such as wRVU or CPT units
- Revenue-based models, using a defined percentage of net revenues
- Base compensation plus production and quality incentive models

The valuation analysis of the practice should utilize the compensation model (or models) under consideration by the hospital and physicians. This allows for the projected net free cash flows of the practice to reflect the planned compensation arrangement. Various sensitivity analyses can be performed to allow the parties to see how one compensation model may impact the practice value versus the other compensation models being considered. A similar analysis can be performed in order to determine the compensation arrangement that will result in a discounted cash flow value that supports a particular mix of practice assets being acquired and that falls within a fair market value range.

Sensitivity Analysis: Compensation vs. Practice Value

The purpose of the sensitivity analysis is to observe the impact that various physician compensation levels have on the practice’s value as estimated using a discounted cash flow (DCF) analysis. The first step in performing this analysis is to perform a benchmarking exercise to assess how the practice is performing against relevant industry benchmarks. In the example below, a hypothetical two physician, primary care

practice is benchmarked against industry peers using the Medical Group Management Association (MGMA) physician production and compensation survey data.

	Provider Performance			
Physicians	12/31/2008	12/31/2009	Annualized 3/31/2010	Average
Physician 1				
Gross Charges	$ 700,000	$ 725,000	$ 750,000	$ 725,000
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The physicians' productivity measures for the most recent period place the physicians within the 75th percentile.

Once this is determined, a DCF analysis can be performed using the corresponding 75th percentile compensation level, as well as the other compensation levels. By holding all variables other than physician compensation constant, these analyses demonstrate the sensitivity of practice value to various levels of physician compensation.

The table below summarizes the results of the practice valuation at various levels of future physician compensation, as well as sensitivity to the structure of the transaction.

	Compensation Level MGMA Benchmark				
	25th%	Median	75th %	90th %	**Asset Purchase (all tangible assets only)**
Avg Comp per Physician	$ 158,697	$ 196,934	$ 247,635	$ 317,830	$ 276,680
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Total FV of Identifiable Assets	265,243	265,243	265,243	265,243	188,243
Residual Value	**$ 1,616,757**	**$ 1,047,757**	**$ 297,757**	**$ (984,243)**	**$ -**

The first four columns summarize the value indications for the practice based on a DCF analysis at four different physician compensation levels, from a low of 25th percentile to the high of 90th percentile physician compensation. As expected, the practice value *decreases* as the compensation *increases* and, in this example, even becomes a negative at the 90th percentile compensation level.

Using physician compensation at the 75th percentile level, a DCF analysis results in a practice value indication of $563,000. This $563,000 practice value exceeds the estimated value of the practice's identifiable assets of $265,243 (as estimated under an asset approach), with the difference generally attributable to goodwill.

The last column in the table provides the level of compensation at which the value indication resulting from a DCF analysis is approximately equivalent to the estimated value of a particular mix of assets being purchased. For example, assume the hospital was only buying the practice's tangible assets (valued at $188,243 using an asset approach). A DCF analysis can be performed to solve for the compensation level that will result in an $188,243 value indication. In the example, using a compensation rate of $276,680 plus benefits of $55,336 results in a discounted cash flow value of $188,243. This $276,680 compensation rate falls between the 75th and the 90th percentile survey ranges. A compensation study can then be performed to help the hospital in its assessment of whether this level of compensation falls within a reasonable fair market valuation range. Such study may consider other factors such as employment terms, required services to be performed, and physician eminence.

Conclusion

As hospitals and physicians negotiate medical practice transactions, they should consider involvement of the valuation professional to provide various analyses to assist in their assessment of the nature and structure of the transaction and prospective compensation models. By involving the valuation analyst, the parties can benefit by understanding the potential impact of these factors on purchase consideration and future compensation. For example, a sensitivity analysis to analyze the potential impact that various compensation models may have on a practice valuation can provide useful

information for the parties to consider in negotiating the sale of a practice and a future compensation arrangement that aligns their interests and fits within the fair market value ranges.

Hospital and Physician Alignment: A Legal and Fair Market Value Analysis

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Introduction:

The organizational, operational, reimbursement and legal structures of our health care system has changed over time. One thing that remains the same is the proverbial ping-pong game of buying and selling medical practices. Throughout the 1980s and 1990s physicians groups were acquired or sold to hospitals and physician practice management companies. Mainly due to the advent of managed care arrangements, which utilized gatekeeper physicians that hospitals wanted to employ.[1]

Current Trends in Physician Practice Acquisition:

This inclination toward physician integration has returned in the 2000s with the hospital employment of physicians now the trend once again.[2] The reasoning behind this hospital-physician integration includes:

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[1] Peter Pavarini, *Why Hospitals are Employing Physicians (Again)*, www.srr.com, p. 1.

[2] Depending upon various state law requirements, and in particular the enforcement of the corporate practice of medicine doctrine in various states, hospitals may not be able to directly employ physicians. In these situations, there are often hospital affiliated non-profit entities that may be organized to employ the physicians.

- Continuous rising health care costs.
- Increased competition for physician services.
- Hospitals desire to increase their market share.
- Health care reform has raised demand for primary care physicians.
- Medicare reimbursement changes may be harmful and uncertain.
- Physicians seeking security with their compensation and workloads.
- Physicians finding that private practices are difficult to manage.
- New medical technology and electronic medical records are expensive.
- Physicians may no longer invest in hospitals due to health care reform.
- Hospitals want to purchase ancillary services owned by physicians.
- New incentives for hospitals to coordinate care and payment with physicians (*i.e.*, bundled payments and accountable care organizations).

Physician Practice Valuations:

When a hospital acquires a physician practice or employs a physician, in order to comply with our health care regulatory environment, such as meeting a Stark Law exception, the compensation to the physicians must be fair market value. So how should these practices be valued? The different parties have varied perspectives on how physician practices should be value and what's considered "fair market value."

From the hospital's perspective, the estimates of what's considered fair market value should be conservative. The hospital prefers to pay less and lessens its risk of a government investigation resulting from overpaying physicians to induce referrals. The

hospitals rely heavily on their valuation experts to provide them with a fair market value analysis of physician compensation.

From the physician's perspective, the higher the income the better. Let's face it, who doesn't want more money? However, the physicians also prefer to stay within reasonable norms of fair market value to avoid scrutiny from the government. Physicians may counter the hospital's fair market value analysis with their fair market value opinion provided by their valuation expert. A valuation may be conducted in a number of ways and take into account variable facts.

Often, creative and alternative ways to structure compensation and employment terms are developed to result in reasonable compensation that appeases all interests. In addition, along with the salary, payment for medical directorships, service line co-management arrangements, and on-call services need to be factored into the fair market value analysis.

Legal Restrictions Impacting the Value of Physician Practices:

I. Federal Law:

a. Anti-Kickback Statute:

The Anti-Kickback Statute makes it illegal for any person to knowingly and willfully pay or receive any compensation for a referral for any item or services paid for by a federal health care program; or the purchasing, leasing or ordering of any good,

facility, services or item paid for by a federal health care program.[3] It is an extremely broad criminal statute, violations of which may result in fines, imprisonment and exclusions from federal government health care programs such Medicare or Medicaid. The compensation for a referral applies to almost anything of value.

In addition to the criminal penalties, violators may be subject to civil monetary penalties and/or False Claims Act liability. Safe harbors have been established for common business arrangements, and eliminate the risk of an Anti-Kickback violation. Safe harbor compliance is voluntary and failure to comply with a safe harbor does not mean there is a violation of Anti-Kickback. Arrangements that do not fit in a safe harbor must be evaluated on a case-by-case basis.

The new health care reform law changed the "intent" requirement of proof by the government attempting to impose Anti-Kickback liability. Previously, the Anti-Kickback Statute had an elevated standard of proof with respect to intent to violate the statute. The courts had established a "good faith" defense, if the provider believed he was not paid to refer patients. The courts had ruled that a provider know that the Anti-Kickback law prohibits offering or paying remuneration to induce referrals, and that the provider engage in the prohibited conduct with the specific intent to violate the law for there to be an Anti-Kickback violation. One court ruled payments for referrals were not an Anti-

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[3] *See* 42 U.S.C. §1320a-7b(b) and implementing regulations at 42 C.F.R. §1001.952.

Kickback violation, when the defendant did not believe non-physicians could give referrals and receive kickbacks under the statute.

The health care reform law lowers the standard of proof for the Anti-Kickback Statute by providing that a person need not have actual knowledge of the Anti-Kickback Statute or specific intent to commit an Anti-Kickback violation for a violation to exist. This change effectively eliminates the "good faith" defense and the protective rulings of previous court decisions.

Some of the Anti-Kickback safe harbors that are most applicable to physician practice acquisitions are summarized below:

- **Employees** – ‘‘Remuneration’’ does not include any amount paid by an employer to an employee, who has a bona fide employment relationship with the employer, for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare, Medicaid or other federal health care programs. There is no fair market value requirement for this safe harbor.
- **Personal Services and Management Contracts** - The aggregate compensation paid should be set in advance, consistent with *fair market value* in arms-length transactions and not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or other federal health care programs.

- **Practitioner Recruitment** – The amount or value of the benefits provided by the entity may not vary (or be adjusted or renegotiated) in any manner based on the volume or value of any expected referrals to or business otherwise generated for the entity by the practitioner for which payment may be made in whole or in part under Medicare, Medicaid or any other federal health care programs. There is no fair market value requirement for this safe harbor.
- **Rental of Space or Equipment** - The aggregate rental charge should be set in advance, consistent with *fair market value* in arms-length transactions and not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or other federal health care programs.
- **Sale of Practice** – ‘‘Remuneration’’ does not include any payment made to a practitioner by a hospital or other entity where the practitioner is selling his or her practice to the hospital or other entity, so long as the practitioner who is selling his or her practice will not be in a professional position after completion of the sale to make or influence referrals to, or otherwise generate business for, the purchasing hospital or entity for which payment may be made under Medicare, Medicaid or other federal

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As you can see, some of these safe harbors have a requirement that the compensation paid is fair market value, and some of them do not. So a valuation of the payment is not necessary in all cases. However, the Stark Law has more stringent requirements for its exceptions compared to the Anti-Kickback safe harbors.

b. Stark Law:

The Physician Self-Referral Statute, commonly known as the "Stark Law", prohibits referrals by physicians who have a direct or indirect financial relationship with an entity for the furnishing of designated health services ("DHS") for which payment otherwise may be made under Medicare, unless an exception applies. Financial relationships include direct or indirect ownership and compensation arrangements. DHS include inpatient and outpatient hospital services.[5] A physician's professional services are not DHS. An entity, such as a hospital, that furnishes services pursuant to a prohibited referral of a Medicare beneficiary may not bill Medicare, or any individual,

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[4] *See* 42 C.F.R. §1001.952.

[5] Other DHS categories include clinical laboratory services, radiology services, home health services, durable medical equipment and supplies, outpatient prescription drugs, prosthetics and orthotics, physical and occupational therapy services, radiation therapy, and parenteral and entreal nutrients.

third party payor or other entity for the DHS performed pursuant to the prohibited referral and must refund any Medicare payments received pursuant to a prohibited referral.

Stark is a strict liability law. Compliance with an applicable exception for the business arrangement is mandatory. Hospitals and physicians that knowingly violate Stark may be subject to civil monetary penalties liability under the False Claims Act and/or exclusion from federal health care programs. Because all inpatient and outpatient hospital services furnished to Medicare beneficiaries are DHS, hospitals and referring physicians must diligently review all financial relationships for compliance with Stark. Any financial relationship between a hospital and a physician, whether or not the financial relationship relates to the provision of DHS, must fit within a Stark exception if the physician refers to the hospital.

Some of the Stark Law exceptions that are most applicable to physician practice acquisitions are summarized below:

- **Bona Fide Employment Relationships** – The amount of the remuneration under the employment arrangement is consistent with the *fair market value* of the services; and is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician.
- **Personal Service Arrangements** - The compensation to be paid over the term of each arrangement is set in advance, does not exceed *fair market value*, and, is not determined in a manner that takes into account the

- **Physician Recruitment –** The hospital does not determine (directly or indirectly) the amount of the remuneration to the physician based on the volume or value of any actual or anticipated referrals by the physician or other business generated between the parties. There is no fair market value requirement for this exception.
- **Rental of Office Space or Equipment** – The rental charges over the term of the agreement are set in advance and are consistent with *fair market value*, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties. In order to be *fair market value*, compensation for the rental of equipment may not be determined using a formula based on (i) a percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services performed or business generated through the use of the equipment; or (ii) per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred between the parties.
- **Isolated Transactions** - The amount of remuneration under the isolated transaction is consistent with the *fair market value* of the transaction; and not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician or other

- **Indirect Compensation Arrangements** – The compensation received by the referring physician (or immediate family member) in an indirect compensation arrangement is *fair market value* for services and items actually provided and not determined in any manner that takes into account the volume or value of referrals or other business generated by the referring physician for the entity furnishing DHS.
- **Fair Market Value Compensation** – Compensation resulting from an arrangement between an entity and a physician is in writing and specifies the compensation that will be provided under the arrangement. The compensation must be set in advance, consistent with *fair market value*, and not determined in a manner that takes into account the volume or value of referrals or other business generated by the referring physician. The arrangement is commercially reasonable (taking into account the nature and scope of the transaction) and furthers the legitimate business purposes of the parties.[6]

As noted above, most of these exceptions to Stark require fair market value compensation for items or services actually needed and furnished, and commercial

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[6] 42 C.F.R. §411.357.

reasonableness of the financial arrangement. “Fair market value” means 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.

Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.[7] Hospitals and physicians should have appropriate processes for making and documenting reasonable, consistent and objective determinations of fair market value compensation and commercial reasonableness, such as seeking an opinion from a valuation expert.

c. Tax Exempt Requirements

A hospital, clinic, or other similar health care provider may qualify for tax-exempt status under Internal Revenue Code (“IRC”) 501(c)(3) provided it is organized and operated exclusively for charitable purposes. To qualify as a health care provider that promotes health as its charitable purpose, the organization must meet the community

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[7] 42 C.F.R. §411.351.

benefit standard described in Revenue Ruling 69-545, 1969-2 C.B. 117, as well as the other requirements of the IRC 501(c)(3) and its regulations.[8]

According to "Valuation of Medical Practices" guidance published on the Internal Revenue Services ("IRS") website, an integrated hospital and physician organization providing health care services qualifies for exemption under IRC 501(c)(3), depending upon a "facts and circumstances" approach (based on Rev. Rul. 69-545, supra). In order to determine if an organization operates exclusively for the benefit of the community, as opposed to private interests, it is important to resolve whether the organization's acquisition of assets from physicians confers private benefit on the sellers. If the organization pays more than fair market value, private benefit, and possibly inurement, is present, and the organization does not qualify for exemption.[9]

According to the IRS, fair market value is 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.[10] There are various ways to determine

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[8] Janet E. Gitterman and Marvin Friedlander, *Health Care Provider Reference Guide*, 2004 EO CPE Text, at http://www.irs.gov/pub/irs-tege/ eotopicc04.pdf (last visited Jan. 22, 2011).

[9] Charles F. Kaiser and Amy Henchey, *Valuation of Medical Practices*, 1996 EO CPE Text, at http://www.irs.gov/pub/irs-tege/eotopicq96.pdf (last visited Jan. 22, 2011).

[10] See IRS Revenue Ruling 59-60, 1959-1 C.B. 237.

whether the price paid for assets exceeds fair market value, and it is the exempt organization's burden to prove this fact.[11]

In general, where the sales transaction involves unrelated parties bargaining at arm's-length, the actual sales price may be assumed to be fair market value.[12] However, when hospitals acquire physician practices with physicians on the hospitals' medical staffs, and these physicians continue to provide services through a new affiliated organization, the existence of arm's-length bargaining may be questionable. "In the absence of an arm's-length transaction, the best determinant of fair market value is a properly performed, unbiased valuation appraisal of the medical practice."[13]

II. State Law

The various states have variable health laws impacting hospital and physician transactions. What may be a compliant transaction in Texas, may not work in California. In particular, the various state medical practice acts, administered by their state medical boards, define what constitutes the practice of medicine and who may practice medicine in that state.

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[11] Charles F. Kaiser and Amy Henchey, *Valuation of Medical Practices*, 1996 EO CPE Text, at http://www.irs.gov/pub/irs-tege/eotopicq96.pdf (last visited Jan. 22, 2011).

[12] *Id.*

[13] *Id.*

Along those lines, some states have strong corporate practice of medicine doctrines, such as Texas and California, that find corporations to be unfit vehicles for the practice of medicine since (i) corporations are incapable of licensure; and (ii) laypersons, and general profit motives of corporations, should not interfere with the physicians' professional and ethical obligations to patients. Under the corporate practice of medicine doctrine, corporations are prohibited from operating medical practices, employing physicians, or sharing professional fees.

A solution to the corporate practice of medicine restrictions is, in some states, to form specific entities that are authorized to provide medical services. Such entities include professional associations, certified non-profit health corporations, or federally qualified health centers. These organizations can lawfully employ physicians without running afoul of the corporate practice of medicine. As described above, the federal and state health care regulatory environment not only place restrictions on the ability of physicians and hospitals to align, but also create complications on how to structure hospital and physician transactions.

Health Care Reform's Impact on Physician Practice Acquisitions:

The Patient Protection and Affordable Care Act ("PPACA") passed on March 23, 2010. On March 30, 2010, the health care reform effort culminated with the passage of H.R. 4872, the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, which modifies and adds to PPACA.

In general, PPACA calls for pilot programs and demonstration projects to test accountable care organizations ("ACOs"). What are ACOs? They are organizations

designed to connect groups of providers, such as physicians and hospitals, which are willing and able to take responsibility for improving health status, quality, efficiency and experience of care for a defined patient population. An ACO is a provider-led organization, whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population.

There are different ways to structure an ACO, but the goal is to align the interests of hospital and physicians, whether through employment, joint venture, or other affiliation arrangement. In the ACO structure, the hospitals and physicians will share in their reimbursement and savings. For example, as participants in an ACO, the hospitals and physicians may receive a single payment, referred to as a "bundled payment," for a specific treatment. These providers would assume the financial risk for the cost of services for a particular treatment and for preventable complications.[14]

How will these alternative payment structures for physicians and hospitals fit within the federal and state legal confines? Will a physician's portion of a bundled payment meet the definition of fair market value for purposes of meeting an Anti-Kickback safe harbor, Stark Law exception or the IRS tax exemption requirements? Will the transactions within an ACO be considered "arms length transactions"? There are still many unknowns. However, the future publishing of health care regulatory guidance along

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[14] The Rand Corporation, *Analysis of Bundled Payment*, at http://www.randcompare.org/analysis-of-options/analysis-of-bundled-payment (last visited Jan. 22, 2011).

with trial and error of hospital and physician alignment strategies will ideally result in harmonious relationships among our providers, so they will work for the common goal of improving health outcomes and providing quality services for patients.

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