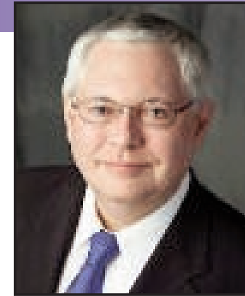
Valuation of Health Care Entity Transactions - Part One



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INTRODUCTION

Forensic analysts (analysts) are often called on to prepare and defend fair market value valuations related to health care provider transactions. Such transactions include both property transfers (such as the acquisition of a professional practice or hospital) and services transfers (such as the entering of an employment contract or management services contract). Virtually all health care entities are subject to government regulations (such as the Medicare fraud and abuse regulations or the Stark laws). This is because these entities receive some form of government reimbursement for the medical services they provide. Among the provisions of the various regulations, health care entities may not pay more than fair market value for certain property and services transfers. These regulations also provide that health care entities cannot make any payments in exchange for patient referrals.

In addition, many health care entities operate as a tax-exempt entity for federal income tax purposes. Such health care entities must comply with additional regulations with regard to the fair market value valuation of their property and services transfers. In particular, such tax-exempt entities cannot enter into property or services transfers that result in private inurement. If tax-exempt health care entities enter into private inurement transactions, the Internal Revenue Service (the Service) may impose so-called intermediate sanctions.

Analysts often prepare fair market value transaction valuations for health care clients. And, such transaction valuations may be challenged by the Department of Health and Human Services (HHS) Office of Inspector General (OIG), the United States Department of Justice (DOJ), the Service, and various state attorneys general. This article summarizes what analysts need to know about the regulatory considerations that affect the valuation of health care entity transfers of property and services. The first section of this discussion summarizes the transfer-related considerations with regard to all health care entities. The second section of this discussion summarizes the additional transfer-related considerations related to tax-exempt health care entities. Analysts who prepare and defend valuations related to health care entity property or services transfers should be familiar with these considerations. The final section of this discussion presents analyst common misconceptions related to health care entity valuations.

SECTION ONE

A description of the generally accepted valuation approaches and methods is beyond the scope of this discussion. Readers are assumed to be familiar with such generally accepted valuation approaches and methods.

GENERAL HEALTH CARE ENTITY VALUATION CONSIDERATIONS

Numerous federal laws govern Medicare fraud and abuse. In this discussion, these laws are referred to collectively as the Medicare fraud and abuse statutes (or, simply, the statutes). The statutes include:

1. The False Claims Act
2. The Anti-Kickback Statute
3. The Physician Self-Referral Law
4. The Social Security Act
5. The United States Criminal Code

The statutes specify the criminal and/or civil remedies that can be imposed on individuals or provider entities that commit fraud and abuse in the Medicare Program, including Medicare Parts C and D, as well as the Medicaid Program. Violations of any of the statutes may result in the nonpayment of claims, civil monetary penalties, exclusion from participation in federal health care programs, and criminal and civil liabilities.

The following discussion summarizes the statutory provisions that analysts should be aware of when they are preparing and defending health care valuations.

The False Claims Act

The False Claims Act protects the government from being overcharged or sold substandard goods or services. The False Claims Act imposes civil liability on any "person" who knowingly submits, or causes the submission of, a

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false or fraudulent claim to the federal government. The "knowing" standard includes acting in deliberate ignorance of—or reckless disregard of—the truth related to the claim.

There is also a criminal False Claims Act statute through which a health care provider (individual or entity) that submits false claims can face criminal penalties.

The Anti-Kickback Statute

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration (directly or indirectly) to induce or reward referrals of items or services reimbursable by a federal health care program. An example of an Anti-Kickback Statute violation is a health care provider who benefits from a below fair market value rent on a hospital-owned medical office building in exchange for patient referrals.

Civil penalties for violating the Anti-Kickback Statute include fines up to three times the amount of kickback. Criminal penalties for violating the Anti-Kickback Statute include fines, imprisonment, or both.

If certain types of health care provider arrangements satisfy a regulatory safe harbor, then the Anti-Kickback Statute will not treat that arrangement as an offense.

Physician Self-Referral Law (the Stark Law)

The Physician Self-Referral Law, often called the Stark law, prohibits a physician from making a referral for certain designated health services (DHS) to a health care provider entity (1) in which the physician (or a member of his or her immediate family) has an ownership/investment interest or (2) with which he or she has a compensation arrangement, unless an exception applies.

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice in connection with the delivery of or payment for health care benefits, items, or services to:

1. Defraud any health care benefit program or
2. Obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Other Medicare Fraud and Abuse Penalties

In addition to the civil and criminal actions brought by law enforcement agencies, the Medicare Program has administrative remedies applicable for certain health care fraud and abuse violations.

Under the Exclusion Statute, the OIG may exclude from participation in all federal health care programs any health care providers and suppliers that are convicted of:

1. Medicare fraud
2. Patient abuse or neglect
3. Felony convictions related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care item or service
4. Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

The Medicare fraud and abuse statutes make it illegal to pay, offer, or induce any remuneration in exchange for patient referrals. For example, a hospital cannot pay a physician in exchange for patient referrals to that hospital. In a physician-practice acquisition, a hospital cannot pay any portion of the purchase price in exchange for the physician's current or expected patient referrals to that hospital. Therefore, health care acquirers should not structure a transaction that appears to involve either (1) a "kickback" payment for physician patient referrals or (2) a "lockup" of physician patient referrals.

The various Stark laws prohibit physicians with a financial relationship with a health care entity from referring patients to the entity for DHS covered by either Medicare or Medicaid programs. The Stark laws are

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named for United States Congressman Peter Stark who sponsored the initial bill.

The Stark laws provide a limitation on certain physician referrals. The laws prohibit physician referrals of DHS for Medicare and Medicaid patients if the physician (or an immediate family member) has a financial relationship with that health care entity. A financial relationship is defined to include ownership, investment interest, and compensation arrangements.

Under the Stark laws, the term "referral" is defined more broadly than merely recommending a vendor of DHS to a patient. The Stark law's definition of the term "referral" means, for Medicare Part B services, "the request by a physician for the item or service" and, for all other services, "the request or establishment of a plan of care by a physician which includes the provision of the designated health service."

The term "DHS" is defined to include clinical laboratory services as well as the following: physical-therapy services; occupation-therapy services; radiology, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services; radiation-therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices; home health services and supplies; outpatient prescription drugs; and inpatient and outpatient hospital services.

The Stark laws contain several exceptions. The statutory exceptions include physician services, in-office ancillary services, ownership in publicly traded securities and mutual funds, rental of office space and equipment, bona fide employment relationships, and the like.

The Stark penalties include:

1. Denial of payments for the DHS provided
2. Refund of any monies received by physicians and facilities for amounts collected
3. Payment of civil penalties of up to $15,000 for each health care service that a person "knows or should know" was provided in violation of the Stark laws, and three times the amount of improper payment the health care entity received from the Medicare program
4. Exclusion from the Medicare program and/or state health care programs, including Medicaid
5. Payment of civil penalties for attempting to circumvent the Stark laws of up to $100,000 for each circumvention scheme.

The Medicare anti-kickback laws prohibit both the giving and the receipt of anything of value to induce the referral of medical business reimbursed under the Medicare or Medicaid programs. Unlike the Stark laws, the Medicare anti-kickback law is an "intent-based" statute. The Medicare anti-kickback law statutes make it clear that the health care entity payments for any property or services should be based on a fair market value price (and should not be priced based on a variable formula, such as a patient volume or patient referrals formula).

To comply with the Stark laws related to the payment for services, the health care entity services transfer should be structured as follows:

1. There should be a written agreement signed by parties that specified the services to be covered under the arrangement.
2. The term of the agreement should be specified.
3. The aggregate services contracted for should not exceed those that are reasonable and necessary for the legitimate business purpose of the subject arrangement.
4. The compensation to be paid by the health care entity over the term of the agreement should be:
   a. defined in advance,
   b. not in excess of fair market value, and
   c. not determined in a manner that takes into account patient volume or the value of any patient referrals or other business generated by the parties.

The Stark III regulations (interpreting the Stark laws) became effective over the period of 2007 to 2010 and provide a fair market value exception to include compensation made from a physician to an entity providing DHS. Under the Stark III regulations, the fair market value exception covers payment made from the entity to a physician, as well as from the physician to a health care provider entity, provided:

1. The arrangement is set out in a writing signed by the parties describing the items or services
2. The writing sets out a time frame for the arrangement
3. The writing specifies the compensation, which 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 the physician's referrals
4. The arrangement is commercially reasonable and furthers the legitimate business purpose of the parties
5. The arrangement does not (a) violate the Anti-Kickback Statute or (b) involve the promotion of any business arrangement that violates state or federal law.

In addition, the Stark III regulations clarify that the fair market value exception does not apply to the leases of office space. However, such arrangements must fit the stricter lease of office-space exception.

TAX-EXEMPT HEALTH CARE ENTITY VALUATION CONSIDERATIONS

Health care entities are exempt from federal income tax as organizations described in Internal Revenue Code Section 501(c)(3) only if they are organized and operated exclusively for charitable purposes within the meaning of the statute. However, such tax-exempt health care entities are subject to cer-

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tain restrictions with regard to acquisition, professional services, employee compensation, and other types of transactions.

The Service and many state attorneys general view tax-exempt entities as charitable trusts for the benefit of the public. Section 501(c)(3) is designed to:

1. Ensure the furtherance of public purposes
2. Prevent the diversion of charitable assets into private hands.

Private Inurement

The first type of restriction relates to private inurement. For Section 501(c)(3) entities, no part of the net earnings may inure to other benefit of any private shareholder or individual. This means that an individual can't receive the tax-exempt entity's funds, except as reasonable payment for property or services. There is no minimum threshold related to the private inurement restriction, and there is no de minimis exception.

The private inurement restriction applies only to "private shareholders or individuals," commonly referred to as "insiders" (i.e., those having a personal and private interest in or opportunity to influence the activities of the entity from the inside). The term "insider" does not appear in either the Internal Revenue Code or the Treasury Regulations. However, this term is widely used in the related legal, accounting, and valuation literature.

The Section 4958 intermediate sanctions provisions were added to the Internal Revenue Code in 1996 and use the terms "excess benefits transaction" and "disqualified person."

Private Benefit

The second type of restriction relates to private benefit. Section 501(c)(3) entities should be organized and operated to serve public rather than private interests. Unlike the private inurement transaction restrictions, the private benefit transaction restrictions are not absolute. To be a permissible transaction, a private benefit transaction should be incidental to (or a necessary concomitant of) accomplishment of the public benefits involved. Private benefit should be balanced against the public benefit. The Service has issued regulations that provide examples of the test for serving a public rather than a private interest.

The private benefit prohibition is not limited to insiders. For example, some incidental private benefit is always present in hospital-physician relationships (e.g., when a private practice physician uses a tax-exempt hospital's facilities to treat his or her paying patients).

Any private inurement or too much (i.e., other than incidental) private benefit could cause a tax-exempt health care entity to lose its tax exemption. Until 1995, the revocation of the organization's tax exemption was the only sanction available to the Service. With regard to both private inurement and excess private benefit, currently the Service relies principally on the imposition of Section 4958 intermediate sanctions excise tax penalties.

Excess Benefit

Enacted as part of the 1996 Taxpayer Bill of Rights, Section 4958 allows the Service to impose penalty excise taxes on certain excess benefits transactions between "disqualified persons" and tax-exempt entities.

Excess benefit transactions include:

1. A transaction priced at other than fair market value in which a disqualified person (a) pays less than fair market value to the tax-exempt entity or (b) charges the tax-exempt entity more than fair market value for a property or service
2. An unreasonable compensation transaction, in which a disqualified person receives greater than a fair market value level of compensation from the tax-exempt entity
3. A prohibited revenue-sharing transaction, in which a disqualified person receives payment based on the revenue of the tax-exempt entity in an arrangement specified in the Section 4958 regulations that violates the inurement prohibition under current law.

DISQUALIFIED PERSONS

Section 4958 defines certain individuals to be "disqualified persons" with respect to a tax-exempt entity, including:

1. Voting members of the entity's governing board
2. Individuals who have or share ultimate responsibility for implementing the decisions of the governing body or for supervising management, administration, or operation of the entity (such as president, chief executive officer, chief operating officer, treasurer, and chief financial officer unless demonstrated otherwise)
3. Individuals with a material financial interest in a provider-sponsored organization.

The Section 4958 regulations clarify that this category of disqualified persons can include entities such as management companies.

The Section 4958 regulations indicate that a "disqualified person" is (1) any individual who was, at any time during the previous five years, in a position to exercise substantial influence over the affairs of the entity, (2) certain family members (lineal descendants, brothers and sisters, whether by whole or half-blood, and spouses of any of them), or (3) an entity 35 percent or more of which is controlled by such individuals.

THE INITIAL CONTRACT RULE

The Section 4958 regulations establish an "initial contract rule" to protect from intermediate sanctions liability certain "fixed" payments for the provision of services or the sale of property made under a binding written contract. The initial contract only applies to persons who were not disqualified persons immediately before entering into the initial contract.

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Fixed payments are defined to include an amount of cash or other property that is either (1) specified in the contract or (2) determined using a fixed formula specified in the initial contract. And payments that include a variable component (such as achieving certain levels of revenue or business activity) may qualify as a fixed payment—as long as the components are calculated pursuant to a pre-established, objective formula.

SECTION 4958 PENALTY EXCISE TAXES

Under Section 4958, a disqualified person is liable for (1) an initial 25 percent penalty excise tax on the amount of the excess benefit and (2) an additional penalty tax of 200 percent on the amount of the excess benefit if the transaction is not timely corrected. A manager who knowingly, willfully, and without reasonable cause participates in an excess benefit transaction is personally liable for a 10 percent penalty tax (up to a maximum of $20,000) on the amount of the excess benefit.

No Section 4958 penalties are assessed on the tax-exempt entity itself. A tax exemption revocation remains an option available to the Service in extreme cases.

INTERMEDIATE SANCTIONS

The purpose of the intermediate sanctions provisions of the tax law is to prevent wrongdoing by persons who have a special relationship with tax-exempt entities, particularly charitable entities. Before the enactment of the intermediate sanctions laws, the Service, when faced with one of these inappropriate transactions, essentially had two choices:

1. Apply the private inurement doctrine or the private benefit doctrine and revoke the tax-exempt status of the subject entity
2. Ignore the matter (and perhaps informally attempt to influence the behavior of the parties involved on a going-forward basis)

The revocation of an entity's tax-exempt status is a harsh consequence. And, the loss of the subject entity's tax-exempt status does not necessarily resolve the underlying problem—the party that obtained the inappropriate benefit still has it. Often, the only individuals truly punished in these situations are the beneficiaries of the tax-exempt entity's programs.

Intermediate sanctions are penalties imposed on the person or persons who engage in the inappropriate transaction with the tax-exempt entity. These sanctions are called "intermediate" because they fall between (1) the revocation of the tax-exempt status and (2) inaction on the part of the Service. The sanctions are not applied to the tax-exempt entity that was abused. The sanctions are imposed on the person or persons who improperly benefited from the property or services transfer.

The intermediate sanctions law does not replace either (1) the private inurement doctrine or (2) the private benefit doctrine. Rather, the Service has a range of taxpayer penalty options. The Service can (1) impose the sanctions alone, (2) impose both the sanctions and the private inurement doctrine, or (3) find the sanctions do not apply and nonetheless invoke the private benefit doctrine.

Intermediate Sanction Taxes

The intermediate sanctions are, in fact, federal excise taxes. These federal excise taxes are applied to the amount involved in the impermissible transaction—i.e., the excess benefit. The person who pays for intermediate sanctions tax (again, not the tax-exempt entity itself) is referred to as a disqualified person.

The first intermediate sanctions tax is an "initial tax." The initial tax is 25 percent of the amount of the excess benefit. Also, the excess benefit property or services transaction must be reversed. This reversal or refund of the excess benefit transaction is intended to put the parties in the same economic position they were in before the excess benefit transaction was entered into. This process is referred to as correction of the transaction.

If (1) the initial tax is not timely paid and (2) the offending transaction is not timely and properly corrected, then an "additional tax" may be imposed. This intermediate sanctions tax is 200 percent of the amount of the excess benefit. In some instances, the trustees, directors, or officers with the tax-exempt entity may also be required to pay a tax of 10 percent of the amount of the excess benefit.

Under certain circumstances, the intermediate sanctions tax may be

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abated. The Section 4958 intermediate sanctions excise taxes are generally referred to as "penalties."

EXCESS BENEFIT TRANSACTION PRESUMPTION OF REASONABLENESS

There is a "presumption of reasonableness" that every tax-exempt health care entity may endeavor to take advantage of. That presumption is in favor of the health care entity that a compensation arrangement or property sale or rental is not an excess benefit. To qualify for this presumption of reasonableness, the entity must meet the following three requirements:

1. The compensation arrangement or property sale or rental must be approved by the entity's governing body or a committee of the governing body composed entirely of individuals who do not have a conflict of interest with respect to the subject transaction.
2. The governing body or its committee must have obtained and relied on "appropriate data" as to comparability prior to making its decision.
3. The governing body or its committee must have "adequately documented" the basis for its decision at the time that it was made.

These three presumptions of reasonableness requirements are further described below.

Conflict of Interest

A member of the entity's governing body or its committee will be treated as not having a conflict of interest if he or she:

1. Is not
   a. the disqualified person benefiting from the subject transaction or
   b. a person related to the disqualified person,
2. Is not an employee subject to the control or direction of the disqualified person,
3. Does not receive compensation or other payments subject to approval of the disqualified person,
4. Has no financial interest affected by the subject transactions, and
5. Will not receive any economic benefit from another transaction in which the disqualified person must grant approval.

Appropriate Data

The category of "appropriate data" includes such information and documents as (1) the compensation levels actually paid by similarly situated entities, both for-profit and tax-exempt, for similar positions; (2) independent compensation surveys compiled by independent consulting firms; (3) actual written offers from similar entities competing for the services of the disqualified person; and (4) independent valuations of the fair market value of the to-be-transferred property.

There is a special "appropriate data" relief provision for a tax-exempt health care entity with annual gross receipts of less than $1 million. Such an entity will be automatically treated as satisfying the appropriate data requirement if it has data on the level of compensation actually paid for similar services by five comparable entities in similar communities.

Adequate Documentation

To meet the "adequate documentation" requirement, the entity's governing body or its committee should have written or electronic records showing (1) the terms of the transaction and the date it was approved, (2) the members of the governing body or committee who were present during debate on the transaction and the names of those who voted on it, (3) the comparability data obtained, and (4) what actions were taken about the members who had a conflict of interest.

For a decision to be documented concurrently, the records must be prepared by the next meeting of the governing body or committee occurring after the final action is taken. The records must be reviewed and approved by the governing body or committee as reasonable, accurate, and complete within a reasonable time period thereafter.

For this presumption of reasonableness exclusion, the entity's governing body is (1) a board of directors, (2) a board of trustees, or (3) an equivalent controlling body of the entity. A committee of the entity governing body (1) may be composed of any individuals permitted under state law to serve on such a committee and (2) may act on behalf of the governing body to the extent permitted by state law.

The health care entity should note that if a committee member is not on the governing board and the presumption of reasonableness is relied on, then the committee member becomes an "organization manager" for purposes of the 10 percent excise tax penalty. In other words, the committee member is treated like a member of the governing body if the presumption of reasonableness relied upon is rebutted by the Service.

Also, a person will not be treated as a member of the entity's governing body or its committee if he or she (1) meets with other members only to answer questions and (2) is not present during debate and voting on the transaction.

This presumption of reasonableness is only a presumption. The Service can rebut the presumption of reasonableness if there is information indicating that (1) the amount of the compensation was not reasonable or (2) the property transfer was not at a fair market value price. However, these three requirements should go a long way toward helping an entity avoid the Section 4958 intermediate sanctions penalties. ☙

Our next issue will feature Part Two of this article, "Analyst Misconceptions Regarding Health Care Entity Valuations."