# The Ongoing Debate in the Valuation Community Heightens Stark Legal Risk

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*The myriad of physician-hospital transactions and relationships established in pursuit of the "triple aim" objectives of health reform continue to be challenged by increasing compliance risk relating to regulatory guidelines, such as the Stark Law. As legal counsel works to provide guidance to clients for the purpose of minimizing compliance risk, considerable uncertainty remains regarding when the "fair market value" hurdle has been cleared. Clarity on this topic can be provided by greater consistency of practice within the valuation profession, published positions by the regulatory authorities, and judicial precedent.*

## Introduction

Among the challenges for legal counsel handling physician-hospital transactions and other physician-hospital relationships is assessment of the risks associated with the determination of "fair market value" (FMV) in any particular relationship. Given the strict liability nature of the Stark law, the very large numbers sometimes involved in Stark and related false claims allegations, and the centrality of FMV to compliance with those laws, health care organizations cannot afford to be cavalier about FMV determinations and documentation.

At the same time, FMV is primarily a "fact" question, not a legal question. In loose terms, FMV can be summarized as the range of values (or outcomes) which independent and reasonably prudent hypothetical parties, negotiating at arm's length, could reach with respect to an exchange between them, when neither party is compelled to enter into the transaction or relationship. When independent valuation analysts are involved in evaluating that range, they apply the valuation profession's standards.

From a layman's perspective, in establishing the relevant range, the standards include the following:

1. Estimation of value based on reasonable investment returns associated with potential cash flows that can be generated in light of "market" expected rates of return, given the risk involved
2. Observations of outcomes from actual buyers and sellers entering into comparable transactions or relationships
3. Analysis of what it may cost to "build" or develop the capability rather than buying the capability from another party

Valuation analysts then apply professional judgment based on professional training and experience as to the weight that should be assigned to any particular value approach and arrive at a point estimate or range, which captures their aggregate professional judgments as to FMV.

Technical expertise is necessary to apply the valuation tools, and professional judgment is necessary to establish a FMV conclusion as a "fact." Therefore, health care organizations often elect to rely on valuation analysts (1) to establish the FMV range in a given transaction context and (2) to opine that the parties' proposed transaction falls within that range.

Sometimes there are contradictory views within the valuation profession regarding what can and cannot be considered in determining FMV in transactions involving health care organizations. Therefore, legal counsel trying to comply with Stark and the other "FMV-dependent" compliance elements can quickly become unnerved, and legal

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risk becomes difficult to assess with any confidence.

In the Stark context, the situation is further aggravated by a statutory narrowing of the FMV definition when a transaction is between parties that (1) refer business to one another or (2) generate business between themselves. The Stark FMV definition provides that, in making judgments about FMV, the volume or value of such intra-party activity may not be considered.

Both (1) recent developments within the valuation profession and (2) positions taken by the government (and courts) in recent litigation have created additional uncertainty and have further reduced confidence in the "safety" of health care organizations' conclusions about FMV in particular transactions. For an industry already fearful due to lopsided or outsized penalties and payments even for technical or small violations, and when the costs of litigating are so substantial and the risks of being wrong so great, the recent developments and litigation create heightened anxiety for legal counsel trying to manage compliance and associated risk.

The focus areas for this discussion are: (1) the debate within the valuation profession about the role of the cost method of estimating value and its application in valuing intangible assets in circumstances when the discounted cash flow method produces a value of zero (i.e., no indicated, measurable value in excess of tangible asset value) or less, and (2) the extent, if any, to which future business that results from referrals may be considered in assuming revenue streams under the discounted cash flow method of determining value when the revenue stream includes revenue from designated health services.

The failure of an organization's FMV conclusion in a substantive transaction or relationship can have serious implications—not just for Stark compliance purposes, but also for false claims exposure, anti-kickback exposure, and tax-exempt status.

## Compliance and the Triple Aim

The current health care environment brings the compliance anxiety into sharp relief. Even the casual observer will have noticed the ongoing consolidation of previously independent physician practices into larger health care systems in recent times and the integration of care delivery through ever tighter connections between independent physician organizations and integrated systems through contractual relationships.

These developments do not surprise anyone following health reform. Virtually everyone in the industry can recite the talking points in support of the "triple aim":

1. Improved health for a population
2. An improved experience for patients dealing with the health care system
3. A reduction in the total cost of care

To move in that direction, most industry observers also readily acknowledge the need to reduce variation in delivery of care, reduce "fragmentation" in delivery of care and the related duplication of costs, and align incentives for all parties involved in care, particularly for chronic conditions, disease prevention, and end-of-life care. Integration and tighter physician-hospital coordination are important factors in creating the necessary systems and alignment.

In this context, health care organizations that work with one another already are considering transactions and contractual relationships that will advance the reform goals. Most of those transactions and relationships also require, at some point, a conclusion about whether the economics involved fall within FMV.

The idea that hypothetical parties are negotiating for an item or service carries with it the implication that the prospective buyer has a want or a need for the item or service. Presumably, a reasonably prudent person would not negotiate to acquire something for which he or she has no want or need.

## Real-World, Market-Based Example

A typical fact pattern follows. A fifteen physician primary care clinic operates in an urban setting in a state with a Stark law equivalent. The clinic has established imaging and lab capabilities within its clinic.

The physicians are better than average producers, and the imaging and lab businesses make up about 10 percent of the clinic's net income. All of the clinic's cash income is distributed to the physicians as compensation.

The clinic has a long-standing public affiliation with a local hospital—the physicians are on the medical staff and one of the shareholders has been a member of the hospital's community board of directors.

The clinic is a participant in a narrow network with the hospital and other providers that have a shared-savings arrangement with one of the major payers in the region.

Another regional integrated health system is trying to expand its base of employed primary care physicians in the city and offers to purchase the

clinic and employ all the physicians. The clinic management approaches the hospital with the news and indicates that the clinic would certainly entertain an offer from hospital as well, given its long-term working relationship together.

The clinic management indicates it has a preference for a transaction with the hospital and would join the hospital if the physicians could get just a modest increase in compensation and a fair price for the imaging and lab businesses.

If the clinic is acquired by the other integrated system, the hospital would have a gap in its local service continuum and presumably, in the future, would lose a number of patients to the integrated system based on the integrated service offerings there.

## Scenario 1

Both the hospital and the clinic retain valuation experts to estimate what price could be supported and what compensation arrangement could be justified. Both valuation analysts conclude that the physicians compensation could be increased slightly based on their productivity and the relevant market survey data, particularly since the clinic has a higher nonphysician staffing ratio than indicated by benchmark data.

Both valuation analysts also conclude, based on the proposed compensation and other factors, that the clinic generates no net income and accordingly that the discounted cash flow approach results in a "zero" value (i.e., no indicated, measurable value in excess of tangible asset value) for the clinic.

The hospital's valuation analyst subscribes to the view that if the discounted cash flow approach produces no positive value, no payment for any intangible assets can be justified and suggests that the hospital is limited to offering a purchase based on the concluded value of the tangible assets and compensation adjustments.

The clinic's valuation analyst takes the position that, notwithstanding the discounted cash flow result, the cost approach independently supports a value for the clinic in excess of tangible asset value. This is because it would cost the hospital a substantial amount to rebuild, recruit, and develop the primary care clinic capabilities represented by this clinic.

The clinic's valuation analyst has estimated the replacement costs and proposed that the hospital pay a substantial amount, but well below its calculation of the estimated replacement cost. The clinic's valuation analyst plans to issue a report stating that the suggested purchase amount (supported by the cost approach) is within FMV.

The hospital asks its legal counsel whether it can rely on the clinic's valuation analyst opinion to establish the "fact" that the purchase of the clinic at the proposed amount would be within FMV.

With disagreement within the valuation profession regarding what may be considered valid support of a valuation conclusion, having a valuation opinion may be of marginal value. Litigators note that most of their work involves battles between valuation "experts" who frequently contradict one another. The situation seems more pernicious in the health care regulatory context, however, where the consequence of reliance on the "wrong" valuation analyst can be so monumental.

Some industry observers argue that merely having a formal opinion from an expert should minimize risk. In many cases, however, the mitigation will evaporate if the government alleges an inappropriate standard of value was applied and the valuation analyst was incorrect.

The *Bradford*[1] and *Tuomey*[2] litigations are recent examples in which the government rejected the valuation opinions of a third party. (See "Valuation of Physician Contracts and Structuring Physician Compensation" in this *Insights* issue.) Moreover, mere allegations (never resulting in actual litigation) are often sufficient to trigger substantial settlement payments even when a party does not admit any wrongdoing.

Debates within the health care profession heighten the likelihood of allegations and litigation. This is because there is such easy access to potential experts to give credence to or support for government allegations, regardless of which position is taken by the government.

The government's leverage and the client's uncertainty, in light of the public debate, inevitably heighten compliance risk.

## Scenario 2

The clinic suggests it may accept current compensation levels for the physicians if the hospital would consider paying separately for the imaging and laboratory businesses. Viewed as a division within the practice, the diagnostic and lab businesses produce

about 10 percent of the net bottom line, and on a discounted cash flow basis produce a substantial value. The clinic proposes that the clinic's other tangible assets be purchased at their concluded value.

In reviewing the clinic's valuation report for the imaging and lab businesses, the hospital's counsel notes the following:

1. The valuation analyst assumed that the physicians would continue to refer to the imaging and lab services, which will be owned by the hospital.
2. Each of the businesses would grow in line with the growth of outpatient services generally.

The hospital's valuation analyst concludes that under the Stark definition of FMV and the State importation of the Stark law for application to commercial revenues as well, she should ignore any referrals to the imaging or lab services in performing a valuation of that business. She concludes, with that volume excluded, that (1) there is no value to the imaging or lab business and (2) the hospital cannot separately pay for it.

The valuation analysts consider alternative approaches to address the problem and arrive at the following possibilities:

1. Perform the valuation excluding Medicare cases in order to be certain referrals for designated health services are not included in the assumptions
2. Perform the valuation without any growth assumptions (i.e. use the prior year's historical actual volumes for purposes of future discounted cash flow), eliminating the implication that the physicians would be incented to refer more cases to the services as a result of the transaction and basing value on past legally permitted referrals, not any future referrals.
3. Consider that the discounted cash flow method should not depend on any actual prohibited referrals, but should only indicate a snapshot of the value of an existing business, one in which no prohibited referrals have been valued and, after the transaction is completed, there will be no prohibition on referrals to these services.

   The discounted cash flow method estimates a value for the historical cash flow from the enterprise. In that light, the application of this valuation method is unrelated to any actual business between the parties for Stark purposes.
4. Use all of the above.
5. Just skip it and figure out what compensation is supportable under FMV principles.

The OIG gives a hint of potential concern in these contexts in Advisory Opinion 09-09, fn. 5

## Summary and Conclusion

The scenarios described demonstrate two important realities in the health care compliance arena.

First, the definition of FMV on which so much of Stark law compliance depends, and related guidance from the regulators, is insufficient to permit organizations to plan for and mitigate their risk in a meaningful and effective way. There is simply too much risk that a regulator or a court could reject the definitional basis on which a professional valuation analyst bases an FMV conclusion and on which an organization relies.

Second, when two highly regarded valuation analysts can conclude, based on consideration of essentially the same data, that FMV can be either "X" or "not X," and only one of these can be correct, and when the answer is essential to compliance with a key regulatory requirement, several undesirable outcomes occur.

The high potential for these undesirable outcomes produces an uneven playing field with significant traps for the unwary (parties making decisions based on an unknowable risk), and the unnecessary uncertainty adds considerable costs to the process of moving forward with the integration required to most effectively pursue the triple aim.

The issues can be addressed in any of several ways. The valuation profession can produce uniformity by developing and defending consensus standards. Regulators can adopt and publish a point of view. Providers could more proactively litigate to create precedent.

In the meantime, there will be uncertainty about the confidence level attaching to valuation expert opinions in these settings.

Notes:

1. U.S. ex rel. Drakeford v. Tuomey, 675 F.3d 394 (4th Cir. 2012).
2. U.S. ex rel. Singh v. Bradford Regional Medical Center, 752 F.Supp.2d 602 (W.D. Pa. 2010).



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