Valuation of Health Care Entity Property or Services Transfers

Robert F. Reilly, CPA

Health care providers comply with a myriad of professional regulations. Health care providers also comply with a myriad of administrative regulations. This is because most health care providers are regulated by—and receive reimbursements for their professional services from—numerous government organizations. Such health care provider entities are subject to the regulatory regime of the various Medicare fraud and abuse statutes and the various Stark statutes. In addition, tax-exempt health care entities are subject to regulation by the Internal Revenue Service and by state attorneys general. Valuation analysts ("analysts") consider this regulatory environment when health care entities enter into transactions related to the transfer of property (e.g., the purchase of a professional practice or hospital) or the payment for services (e.g., an employment agreement or professional services agreement). This is because analysts are called on by the parties to such a health care property or services transfers. The analysts are asked to perform fair market value valuations related to the proposed health care transaction. This discussion summarizes what analysts (and transaction participants) need to know about the fair market value valuation of health care entity transfers of property or services.

Introduction

This discussion describes many of the regulatory reasons why a health care entity may retain a valuation analyst ("analyst") to perform:

1. a property transfer (e.g., purchase of a clinic or professional practice) transaction valuation,
2. a services transfer (e.g., reasonableness of compensation) transaction valuation, or
3. some other type of fair market value valuation analysis.

The first section of this discussion considers tax regulations regarding the valuation of tax-exempt health care property or services transfers.

The second section of this discussion considers nontax regulatory issues regarding the valuation of health care property or services transfers.

The last section of this discussion describes several analyst misconceptions regarding the valuation of health care property or services transfers.

Tax-Exempt Entity Valuation Issues

The private inurement and excess benefit issues regarding tax-exempt health care entities cover two types of transfers: (1) property and (2) services. Both transaction types should be analyzed to conclude a fair market value opinion related to the transfer.

The term "fair market value" is defined the same way for both property and services transfers in Treasury Regulation 53.4958-(b)(1)(i):

> Fair market value is defined as the price at which property or the right to use property would change hands between a willing

> buyer and a willing seller, neither being under any compulsion to buy, sell, or transfer property or the right to use property and both having reasonable knowledge of relevant facts.

Most analysts are familiar with property transfer valuations. This transaction type occurs when the tax-exempt entity buys or sells a business entity, a business ownership interest, or business operating assets.

Common examples of such property transfers include the tax-exempt health care entity buying (or selling) the equity—or the assets—of a hospital, clinic, physician practice, outpatient surgical center, dialysis center, MRI center, urgent care center, HMO, home health care agency, medical equipment provider, or any other health care/provider delivery organization. These property transfer transactions may include the purchase or sale of either the assets or the equity of the health care provider entity.

Such property transfers may include the tax-exempt entity either buying or selling a medical office building, specialty medical equipment, or other type of real estate or tangible personal property.

As part of the tax-exempt entity transaction, the analyst may be asked to opine on the fair market value of the property transfer.

Some analysts are less familiar with services transfer valuations. This transaction type occurs when the tax-exempt entity hires employees or contracts for professional services.

Common examples of such services transfers occur when the tax-exempt health care entity compensates a chief executive officer (CEO) or other executives, pays a medical director (or other physician professionals), hires a physician group to manage emergency room or operating room operations, rents office or professional space to (or from) physicians, leases equipment to (or from) physicians, provides billing or other administrative services to physicians (or from other for-profit service providers), or generally enters into any joint venture or related contractual agreement with physicians or other health care providers.

As part of the tax-exempt entity transaction, the analyst may be asked to opine on the fair market value of the services transfer.

The private inurement prohibition requires that a public charity that has tax-exempt status under Internal Revenue Code Section 501(c)(3) operate so that none of its income or assets unreasonably benefits any of its board members, trustees, officers, or key employees. These individuals are commonly referred to as "insiders."

The private inurement prohibition precludes any tax-exempt entity income or assets from unfairly or unreasonably benefiting (either directly or indirectly) individuals who have:

1. close relationships with the entity and
2. the ability to exercise control over the entity.

A common type of private inurement is excessive compensation paid to insiders. Private inurement can result in:

1. the revocation of the health care entity's tax-exempt status or
2. the imposition of significant "intermediate sanctions" (discussed below).

Private inurement can result from transactions related to:

- the sale of the tax-exempt entity's asset to an insider;
- the entity's purchase of an asset from an insider;
- the entity's rental of real estate or tangible personal property from, or to, an insider;
- the entity's lending of money to an insider; and
- the use of the tax-exempt entity facilities and/or any other assets by an insider.

The principal factor in assessing whether a tax-exempt entity transaction with an insider violates the private inurement prohibition is whether the transaction is fair and reasonable under the circumstances. For example, it is not inappropriate for a tax-exempt hospital to buy a medical office building from a physician group at, or below, its fair market value. However, it is inappropriate for the tax-exempt hospital to lease the medical office building to a physician group for less than its fair market value rent.

Individuals working for a tax-exempt health care entity expect to be reasonably compensated. Such individuals are not expected to accept reduced compensation simply because they provide services to a tax-exempt entity rather than to a taxable entity. The private inurement regulations simply require that the total compensation paid by a tax-exempt entity to an insider be fair and reasonable.

Whether compensation is fair and reasonable is determined on a case-by-case basis. A fair market

value compensation analysis involves procedures similar to those used to value any other services transfer. This compensation valuation requires the analyst to gather comparable data regarding what similarly situated individuals employed by similar organizations are paid.

The analyst typically considers the following factors in the compensation valuation:

- The compensation paid by similar entities, both tax-exempt and taxable, for equivalent positions in the same geographic area
- The tax-exempt entity's need for the particular services of the individual
- The uniqueness of the individual's background, education, training, experience, and responsibilities
- Whether the compensation was approved by an independent board of directors
- The size and complexity of the entity's income and assets and the number of employees that the entity employs
- The individual's prior compensation arrangements, the individual's job performance, and the relationship of the individual's compensation to the compensation paid to the entity's other employees
- The number of hours that the individual spends performing his or her job

Total compensation paid by a tax-exempt health care entity to an insider includes more than just salary or wages. It also includes all forms of compensation, such as bonuses, commissions, royalties, fringe benefits, deferred compensation, severance payments, retirement and pension benefits, expense allowance, and insurance benefits.

An unreasonably large or excessive salary paid by a tax-exempt entity to an insider can be considered private inurement. Private inurement can occur when the insider also receives other forms of compensation from the tax-exempt entity.

The tax-exempt health care entity can avoid private inurement issues regarding the compensation it pays to an insider as long as the entity is able to do the following:

- Describe fully and accurately all aspects of the insider's total compensation package
- Explain exactly how the entity determined the insider's total compensation package
- Describe adequately and accurately the insider's duties and responsibilities
- Provide adequate documentation, such as comparable salaries paid by similar entities, that demonstrate the reasonableness of the insider's compensation
- Demonstrate through appropriate documentation that the entity's governing body approved the amount of the insider's compensation and that the insider (or someone related to the insider) did not participate in the approval process
- Demonstrate that the amount of the insider's total reportable compensation agrees with the amount reported on the insider's Form W-2 or Form 1099—in order to avoid an automatic excess benefit transaction
- Demonstrate through appropriate documentation that the insider's use of any of the entity assets (such as cars, real estate, credit cards, laptops, or cell phones) for any reason other than fulfilling the entity's tax-exempt purpose, were properly included in his or her compensation and properly included in the insider's Form W-2 or Form 1099—in order to avoid penalties for automatic excess benefit transactions

In an excess compensation case, the "excess benefit" is the amount by which (1) the total compensation paid by the tax-exempt entity to the insider exceeds (2) the reasonable value of the services provided by the insider.

If a comparison of comparable executive salaries indicates that the tax-exempt hospital CEO is being paid $100,000 more than comparable individuals performing similar functions at similar hospitals (and that there is no legitimate reason for such excess compensation), then the amount of the "excess benefit" received by the insider would be $100,000.

Section 4958(a)(1) imposes an initial tax equal to 25 percent of the excess benefit. In this example, the CEO insider (i.e., not the tax-exempt hospital itself) would have to pay a $25,000 penalty to the Service. In addition, the CEO insider would have to make the hospital whole by repaying the $100,000 excess benefit, plus interest.

If the CEO insider does not make the tax-exempt hospital whole within the time frame set by the Service, Section 4958(b) imposes an additional tax equal to 200 percent of the excess benefit of the CEO insider—that is, an additional $200,000 tax penalty in this example.

Section 4958(a)(2) also imposes a tax equal to 10 percent of the excess benefit on any tax-exempt entity executive, typically a board member who knowingly approved the excess benefit transaction, unless his or her participation was not willful. In

the above example, the tax on any hospital board member who knowingly approved the unreasonable or excessive CEO salary would be $10,000.

It is important to note that the term "participation" includes a board member's silence or inaction where he or she is under a duty to speak or act—as well as any affirmative action by the board member. The board member is not considered to participate in an excess benefit transaction, however, if he or she opposed the transaction. For example, the board member could have his or her objection to the compensation transaction noted in the board meeting minutes.

The board member's participation will not normally be considered to be "knowing" within the meaning of Section 4958(a)(2) if there was full disclosure of all relevant facts to an appropriately qualified analyst and the board member relied on a reasoned written opinion by that analyst that the subject payment was reasonable.

To help tax-exempt entities comply with these regulations, the Service established a "rebuttable presumption" that payments to insiders are presumed to be reasonable and not excessive if the following procedures are performed:

- The tax-exempt entity's board obtains and relies on appropriate comparability data prior to making its determination.
- The total compensation package is approved in advance by the tax-exempt entity's board, and no individuals who have an actual or potential conflict of interest with respect to the compensation arrangement participates in the deliberations.
- The tax-exempt entity's board adequately and contemporaneously documents the basis for its determination.

If the above procedures are performed, the Service may only rebut the presumption of reasonableness if it can demonstrate that the comparability data relied on by the board was inappropriate. For a tax-exempt entity with annual gross receipts of less than $1 million, a board is considered to have appropriate comparability data if it has data on compensation paid for similar services by three comparable organizations in the same or similar communities.

All Health Care Entity Valuation Considerations

All health care entities (tax-exempt or otherwise) comply with numerous other federal and state regulations regarding property or services transfers. This section summarizes the regulatory considerations regarding the valuation of such transfers.

There are numerous federal laws that govern Medicare fraud and abuse. Most of the statutory provisions do not encompass property or services transfers. The analyst does not have to be familiar with most of these laws. Health care providers should be familiar with—and comply with—all of these laws. In this discussion, these laws are referred to collectively as the Medicare fraud and abuse statutes (or, simply, the statutes).

These statutes include the following:

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

These 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 these statutes may result in the nonpayment of claims, civil monetary penalties, exclusion from participation in federal health care programs, and criminal and civil liabilities. A health care provider can be liable without any actual knowledge or a specific intent to violate the law.

These statutes are introduced below.

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 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.

In addition, there is a criminal False Claims Act statute through which an individual or entity health care provider 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 would be 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 can include fines up to three times the amount of kickback. Criminal penalties for violating the Anti-Kickback Statute can 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 such an arrangement as an offense.

Physician Self-Referral Law (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 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.

The Stark Law is discussed below.

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 Department of Health and Human Services (HHS) Office of Inspector General (OIG) will 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; or
4. felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

The OIG has discretion to impose exclusions on a number of other grounds. Excluded providers cannot participate in federal health care programs for a designated period. An excluded health care provider may not bill federal health care programs (including, but not limited to, Medicare, Medicaid, and State Children's Health Insurance Program) for services he or she orders or performs. At the end of an exclusion period, an excluded health care provider must affirmatively seek reinstatement. Reinstatement is not automatic.

Under the Civil Monetary Penalties Law, civil monetary penalties apply for a variety of misconduct. The Civil Monetary Penalties Law authorizes penalties of up to $50,000 per violation, and assessments of up to three times the amount claimed for each item or service, or up to three times the amount of remuneration offered, paid, solicited, or received.

Health care provider violations that may result in a civil monetary penalty include:

1. presenting a claim that the health care provider knows or should know is for an item or service not provided as claimed or that is false and fraudulent,
2. presenting a claim that the health care provider knows or should know is for an item or service for which Medicare will not pay, and
3. violating the Anti-Kickback Statute.

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, neither tax-exempt nor taxable health care acquirers should structure transactions that appear 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 named for United States Congressman Peter Stark who sponsored the initial bill.

The Stark laws provide a limitation on certain physician referrals. The law prohibits 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. Instead, the Stark laws 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 the following:

1. Denial of payments for the DHS provided
2. Refund of any monies received by physicians and facilities for amounts collected, 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
3. Exclusion from the Medicare program and/or state health care programs including Medicaid

4. 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 not on a variable formula, such as a patient volume or patient referrals formula).

The Stark II statute became effective on January 1, 1995. Like the Stark I statute (which became effective on January 1, 1992), Stark II was intended to curb abuses inherent in physician self-referral arrangements. Like Stark I, Stark II prohibits physicians who have a financial relationship with a health care entity (whether tax-exempt or taxable) from referring patients to the entity for DHS covered by either Medicare or Medicaid programs.

A financial relationship consists of (1) an ownership or investment interest in the health care entity or (2) a compensation arrangement with the health care entity. There is no financial relationship if the physician does not:

1. own any portion of the health care entity and
2. pay the health care entity or receive any kind of payment from the entity for the referral or for anything else.

Under the various Stark laws, a financial relationship can exist between a physician and a health care entity even if that relationship does not involve DHS or the Medicare or Medicaid programs.

A compensation arrangement is defined in the Stark II statute as any arrangement involving any remuneration between (1) a physician (or family member) and (2) a health care entity. This remuneration can involve payments for anything, such as payments for rent, payments for nonmedical services, or payments for housing or travel expenses.

The Stark statutes would interpret the purchase of a physician's practice by a hospital (and the related payment to the selling physicians) as a financial arrangement.

Section 18779(e)(6) of the Stark II regulations provides that an isolated transaction, such as a one-time sale of property (such as a professional practice), is not considered a compensation arrangement for purposes of the prohibition on patient referrals.

This prohibition does not apply if the following conditions are met:

- The amount of remuneration for the one-time transaction sale is consistent with fair market value and is not determined, directly or indirectly, in a manner that takes into account the volume or the value of physician patient referrals.
- The remuneration is provided under an agreement that would be commercially reasonable even if no patient referrals are made to the acquirer health care entity.
- The arrangements meet any other requirements the Secretary (of Health and Human Services) may impose by regulation as needed to protect against Medicare program or patient abuse.

The term "isolated transaction" is defined as a transaction involving a single payment between two or more persons. A transaction that involves long-term or installment payments Is not considered to be an isolated transaction.

To comply with the various Stark laws, any health care entity property or practice purchase should be:

1. priced at fair market value and
2. structured with a purchase price that is not paid in patient referral-related installments.

To comply with the various Stark laws related to the payment for services, any 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 Phase III final rule of Stark II became effective on December 4, 2007 (except for certain "stand in the shoes" provisions described below—which became effective on December 4, 2008). And, the Center for Medicare and Medicaid Services (CMS) self-referral disclosure protocol rules (described below) were published on September 23, 2010.

The Phase III final rules are sometimes referred to as the Stark III regulations. These Stark III regulations (and particularly the transaction and valuation provisions) are summarized below:

1. The "stand in the shoes" provision. A physician's relationship with an entity providing designated health services (such as a hospital) through a direct single intervening physician organization (such as a group practice) may no longer take advantage of the favorable provisions of the Stark laws indirect compensation exception.

    Under Stark III, a physician is considered to "stand in the shoes" of his or her physician organization. Therefore, the relationship between the physician organization itself and the entity providing DHS must meet a Stark law exception.

    In making this rule change, the Stark III regulations tighten the indirect compensation exception. The indirect compensation exception is still available for compensation relationships where there is more than one entity between (a) the provider of DHS and (b) the physician.

    But this is only the case as long as the physician is paid in a manner that does not reflect the volume or value of patient referrals to the health care entity providing the DHS.
2. Shared space. To the extent that a physician or practice relies on the Stark law "in office" ancillary services exception to provide DHS

to patients (such as imaging or clinical lab services), such services must be (a) provided in office or (b) leased on a block-time basis, rather than a per-click basis.

3. Independent contractors. A group practice that obtains the services of an independent contractor physician (such as a pathologist or radiologist) in connection with the provision of designated health services must contract with that physician directly.

   Contracting with the physician's practice or with a staffing service will not allow the group practice to bill for the independent contractor's services as a "physician in the group practice."

4. Recruited physicians. A group practice that accepts economic assistance for the recruitment of a physician must abide by (a) certain new accounting rules that are tightened and (b) certain restrictions which have been loosened as to noncompetition items.

5. Academic medical centers. The Stark III regulations make some clarifications to the academic medical center exception. The academic medical center exception as a whole provides greater latitude as to specific compensation payments as long as the aggregate compensation paid is at fair market value.

   Some of the Stark III clarifications include (a) the requirement to aggregate physician faculty member compensation relationships in order to determine fair market value and (b) the method for counting faculty member physicians.

6. Productivity bonuses. The Stark III regulations permit payment of a productivity bonus to a physician for income directly derived from DHS referrals that are "incident to" the physician's performance of services.

   This expansion is of limited practical effect because (a) this benefit is limited to productivity bonuses but not profit sharing and (b) referrals truly "incident to" the physician's referrals are generally few.

7. Fair market value. The fair market value exception is expanded to include arrangements whereby a physician makes payments to an entity providing DHS (such as a payment for health services), and not just to situations where an entity makes payments to a physician (such as a medical director agreement).

8. Amendments. The Stark III regulations clarify that amendments to agreements implicated by the Stark laws are acceptable so long as the economic elements of the agreement (such as the rate of physician compensation or the square footage of a lease) remain materially unchanged by the amendment.

9. Holdovers. The Stark III regulations specifically allow for month-to-month holdover payments after the expiration of a rental agreement or a personal services arrangement (such as an agreement with a pathologist or radiologist) (a) for up to six months and (b) as long as the terms and conditions of the expired agreement do not change during the holdover period.

10. Other issues. The Stark III regulations provide additional clarifications and minor revisions that provide some practical guidance regarding nonmonetary compensation, compliance training, and professional courtesy.

The Phase II Stark laws created a "safe harbor" in the definition of fair market value for hourly payments to physicians for their personal services. Although acknowledging that several methods of estimating fair market value exist, the CMS would automatically consider the following compensation valuation methods to result in fair market value:

1. An hourly payment less than or equal to the average hourly rate for emergency room physician services in the relevant physician market
2. The 50th percentile national compensation level based on one of several specified compensation data surveys

In response to health care industry comments, CMS announced two statements regarding the fair market value hourly rate compensation.

First, while a fair market value rate may be used to compensate a physician for both clinical and administrative work, CMS stated that there may be a distinction between the rate paid to a physician for administrative work as opposed to the rate paid to a physician for clinical work.

Second, CMS announced that a fair market value hourly rate could be used to determine an annual salary, provided that the hourly multiplier used to calculate such salary accurately reflected the number of hours a physician actually worked.

Prior to the issuance of the Stark III regulations, the fair market value exception protected arrangements whereby an entity providing DHS paid

compensation to a physician, family member of a physician, or group of physicians for the provisions of items or services if the arrangement met five specific requirements.

The Stark III regulations expand the fair market value exception to also include compensation made from a physician to an entity providing designated health services. 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 that the following conditions are met:

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.

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

On August 19, 2008, CMS finalized the Stark IV regulations. The Stark IV regulations became effective on two different dates: some provisions became effective on October 1, 2008, and other provisions became effective on October 1, 2009.

Prior to the Stark IV regulations, CMS proposed to revise the Stark space and equipment lease exceptions to prohibit per use of per click charges under a lease with (1) the health care provider entity as the lessee and (2) the physician as the lessor.

In the Stark IV regulations, the space, equipment, fair market value, and indirect compensation exceptions prohibit rental charges that use a formula based on:

1. a percentage of the revenue attributable to the services performed or generated in the office space or with the equipment or
2. per-unit of service, to the extent the charges reflect services provided to a patient referred between the parties.

These Stark IV regulations revisions became effective on October 1, 2009.

In the Stark IV regulations, the "stand in the shoes" provisions were revised to clarify when a physician must, and when a physician may, "stand in the shoes" of his or her physician organization. Physicians who have an ownership or investment interest in a physician organization must be treated as standing in the shoes of that physician organization.

In contrast, a physician with a titular ownership interest is not required to stand in the shoes of his or her physician organization, although such a physician is permitted to do so.

The CMS defined a "titular" ownership or investment interest as an interest that does not include the ability or right to receive financial benefits or ownership or investment, including distribution or profits, dividends, proceeds of sale or similar returns on investment. The Stark IV regulations stand in the shoes revisions were effective on October 1, 2008.

Tax-Exempt Health Care Entity Transactions

Tax-exempt entities are exempt from federal income tax as organizations described in 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 entities are subject to certain 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. The regulatory scheme of Section 501(c)(3) is designed to:

1. ensure the furtherance of public purposes and
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) tax-exempt 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 goods 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). It is noteworthy that the term "insider" does not appear in either the Internal Revenue Code or the Treasury Regulations. However, the term "insider" is widely used in the related legal, accounting, and valuation literature.

Private Benefit

The second type of restriction relates to private benefit. Section 501(c)(3) tax-exempt 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. And, 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 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 hospital to lose its tax exemption. Until 1995, the revocation of the organization's tax exemption was the only sanction available to the Service.

However, with regard to both private inurement and excess private benefit, the Service currently relies principally on the imposition of Section 4958 intermediate sanctions excise tax penalties.

Excess Benefit

Section 4958 allows the Service to impose penalty excise taxes on certain (excess benefits transactions between "disqualified persons" and Sections 501(c)(3) or 501(c)(4) tax-exempt entities.

Excess benefit transactions include the following:

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
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," 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); and
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.

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.

Also, 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 tax-exempt entity 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.

Intermediate Sanctions

The purpose of intermediate sanctions is to prevent wrongdoing by persons who have a special relationship with tax-exempt entities, particularly charitable entities.

Before the intermediate sanctions laws, when faced with one of these inappropriate transactions, the Service 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)

Revocation of an entity's tax-exempt status is a harsh consequence. 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. 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. Rather, 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—that is, 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 the 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 abated. The intermediate sanctions excise taxes are generally referred to as "penalties."

Excess Benefit Transaction Presumption of Reasonableness

There is an important "presumption of reasonableness" that every tax-exempt health care entity may endeavor to take advantage of. That presumption is

in favor of the tax-exempt 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 a tax-exempt health care entity 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 a tax-exempt 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 tax-exempt health care entity governing body or its committee must 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. Also, 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, a tax-exempt entity 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 tax-exempt 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.

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.

A health care entity subject to the intermediate sanctions law should note that 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.

These three requirements often help a tax-exempt health care entity avoid the Section 4958 intermediate sanctions penalties.

Analyst Considerations Regarding Private Inurement

This section presents a list of analyst considerations with regard to valuations performed for tax-exempt health care entities. These valuations include fair market value valuations of:

1. property and
2. services.

These considerations may not affect the specific valuation approaches, methods, and procedures that the analyst selects and performs. And, these considerations may not affect the analyst's conclusions regarding the fair market value of the property or services transfers.

However, these considerations relate to the intermediate sanctions law and regulations that the analyst should be aware of during the performance of the health care entity valuation.

Tax-Exempt Health Care Entities

The Internal Revenue Code grants a tax exemption for not-for-profit hospitals and other health care entities provided that their net earnings do not inure to:

1. the benefit of private shareholders or
2. individuals with a "personal and private" interest in the health care entity's activities.

Criteria to Be Recognized as a Tax-Exempt Entity

To be recognized as a tax-exempt entity, the health care entity must comply with the following rules:

- Physicians cannot be "in a position to exercise substantial influence over the affairs of (the hospital).
- The total compensation must be "reasonable" and the incentive arrangement may not be a disguised distribution of profits.
- The compensation arrangements must be negotiated or established in the context of an arm's-length relationship.
- There is a ceiling or reasonable maximum compensation level.

No Inurement

No portion of the entity's income or assets may inure to the benefit of "insiders." The term "insiders" may be defined as someone with decision power (e.g., board members, officers, founders, selected physicians, and so on).

Examples of such private inurement may include:

- excessive employee or subcontractor compensation,
- compensation based on the "net earnings" of the tax-exemption entity, and
- any transfer of property or services at less than a fair market value price.

Penalty for Private Inurement

There are penalties for any violation of this no-inurement rule. The Service may apply a broad spectrum of remedies, including:

- revocation of the health care entity's tax-exempt status,
- settlement of the amount of the inurement, and
- the Section 4958 intermediate sanctions excise taxes.

Purpose of Intermediate Sanctions

The purpose of the Section 4958 is to curb potential abuses by penalizing participating parties (both those that benefit from the abuse and those that knowingly authorize it). The intermediate sanctions law applies if there is an "excess benefit" transaction with a "disqualified person."

An excess benefit transaction occurs when the economic benefit given in a transaction is greater than the consideration received by the health care

tax-exempt entity. A disqualified person is any person having the ability to exercise influence over the tax-exempt entity affairs.

Imposition of Penalty Excise Taxes

Section 4958 imposes excise tax penalties on:

1. the disqualified person who has to correct the excess amount (i.e., pay it back to the tax-exempt health care entity) plus pay a penalty tax of 25 percent and
2. the entity manager who has to pay a tax equal to 10 percent of the excess benefit amount (not to exceed $20,000 per transaction).

Rebuttal Presumption of Reasonableness

There is a rebuttable presumption of a reasonableness with regard to the health care entity entering into a property or services transfer when:

1. the transfer is approved in advance by an independent, authorized body of the tax-exempt entity,
2. the decision was based on the appropriate comparability data, and
3. the decision is adequately and timely documented (i.e., written down by the later of the next meeting or 60 days).

Excess Benefit Transaction

An excess benefit transaction is any transaction in which an economic benefit is provided by the tax-exempt health care entity directly or indirectly to or for the use of any "disqualified person" if the fair market value of the benefit exceeds the fair market value of the consideration.

Disqualified Persons

For purposes of Section 4958, a "disqualified person" includes:

1. a voting member of a board of the tax-exempt health care entity;
2. the chief executive officer, chief operating officer, treasurer, or chief financial officer;
3. any person, at any time during the previous five years, in a position to exercise substantial influence over the affairs of the health care entity;
4. identified family members of the above; and
5. a 35 percent controlled entity.

Not a Disqualified Person

For purposes of Section 4958, the following "persons" are not disqualified persons:

1. Entities described in Section 591(c)(3); this exception was created by the Pension Protection Act of 2006
2. Other Section 501(c)(4) entities (applicable for Section 501(c)(4) entities only)
3. Employees receiving less than $100,000 a year in compensation

"To alleviate concerns regarding intermediate sanctions, the entity should establish that its executive and physician employees are not paid more than a fair market value level of compensation."

Reasonableness of Tax-Exempt Entity Compensation

One controversy related to intermediate sanctions requirements relates to the reasonableness of employee or contractor compensation. This compensation issue appears to be the current focus of Service scrutiny with regard to tax-exempt entities.

To alleviate concerns regarding intermediate sanctions, the entity should establish that its executive and physician employees are not paid more than a fair market value level of compensation.

Related to reasonableness of compensation, many health care entities benefit from reliance on a dedicated compensation committee. Such a board-level compensation committee would:

1. adopt a written charter,
2. be comprised of independent directors, and
3. be authorized to approve the health care entity's executive compensation.

Such a board-level compensation committee would also likely adopt a written compensation policy.

When considering the reasonableness of tax-exempt health care entity compensation, the Service looks at how the entity determined and documented the comparability of its executive compensation to other similarly situation entities.

The analyst can assist the tax-exempt health care entity with the following:

1. Compensation levels paid by similarly situated health care entities, both taxable and tax-exempt
2. Independent compensation surveys compiled by independent consulting firms
3. Actual written offers from similar health care entities
4. Independent valuations of the fair market value of the subject executive compensation

The analyst can assemble compensation data and prepare a fair market value compensation valuation that considers the following:

1. Make sure that any analyst relied on is independent and has no incentive to support higher pay and benefits.
2. Use data for the same or the closest functional position, and support these data in the board minutes.
3. Use data for entities with a similar level of annual revenue, or demonstrate that the compensation data was "normalized" to fit entities of a similar size.

In the preparation of a compensation valuation, the analyst may consider the following caveats:

1. The use of for-profit entity compensation data are permitted, but the analyst should avoid relying exclusively on for-profit entity compensation data
2. Include compensation data related to the value of any significant or unusual employee benefits
3. Make sure that every element is considered and the total compensation is assessed for reasonableness (and approved by an authorized body of the tax-exempt health care entity)

The approving body of the entity is protected in its reliance on the analyst's written reasoned analysis, if the analyst certified that he or she:

1. holds himself or herself out to the public as a compensation consultant,
2. performs this type of compensation valuation regularly, and
3. is qualified to perform such a compensation valuation.

Such a written certification should be included in every compensation valuation.

Revocation of the Tax-Exempt Status

The Service may still revoke the entity's tax-exempt status. With regard to health care and other tax-exempt entities, the analyst should be aware that the Service may seek revocation—in addition to the provision of the intermediate sanctions excise taxes.

The Service has announced that it will consider a list of facts and circumstances in determining when the level of excess benefit transactions will jeopardize a health care entity's tax exemption.

These factors include the following:

1. The size and scope of the health care entity's regular and ongoing activities that further exempt purposes before and after the excess benefit transaction or transactions occurred
2. The size and scope of the excess benefit transaction or transactions (collectively, if there are more than one) in relation to the size and scope of the health care entity's regular and ongoing activities that further exempt purposes
3. Whether the health care entity has been involved in repeated excess benefit transactions
4. Whether the health care entity has implemented safeguards that are reasonably calculated to prevent future violations
5. Whether the excess benefit transaction has been corrected or the health care entity has made good-faith efforts to seek correction from the disqualified persons who benefited from it

Analyst Misconceptions Regarding Health Care Property and Services Valuations

This section describes and responds to 10 analyst common misconceptions with regard to valuations of health care entity property and/or services transfers. These analyst misconceptions are considered in this discussion because they are generally due to a misunderstanding of one or more of the relevant regulatory provisions.

That is, these analyst misconceptions typically relate to an erroneous understanding that "the Service only accepts this" or "the OIG doesn't accept that." Therefore, these analyst common misconceptions are addressed from the perspective of the regulatory compliance of the valuation analysis.

There Is a Preferred Valuation Approach or Method

Some analysts believe that certain health care transaction audit or regulatory authorities have a preferred valuation approach or method. None of the health care transfer statutes or regulations mandate a property or services valuation preferred approach.

Any of the generally accepted property or services valuation approaches and methods may be used in a health care entity transfer analysis—as long as the analysis conclusion is fair market value.

There Is a Prohibited Valuation Approach or Method

Some analysts erroneously believe that there is a prohibition against using certain valuation approaches and methods. For example, some analysts believe that the income approach, and particularly the discounted cash flow method, is inappropriate to health care property or services valuations. The basis for this erroneous belief is that such a methodology has to include the income from prohibited patient referrals.

No health care entity can pay a transaction price that includes patient referrals. However, that statement does not invalidate the use of the income approach. The analyst simply has to be careful to exclude any income from post-transaction prohibited patient referrals in the income approach analysis.

Some analysts believe that an adjusted net asset value method is inappropriate if it incorporates some type of a capitalized excess earnings procedure. The basis for this erroneous belief is that no health care entity is allowed to earn excess earnings. In fact, there is no prohibition on using this valuation method.

There is no prohibition on any particular health care entity earning a high profit margin (as long as there is no fraud and abuse contributing to that income, of course).

Let's assume that, for purposes of the subject valuation, excess earnings are defined as excess above the median profit margin level for that health care industry segment. Based on that excess earnings definition, half of all of the entities in the industry segment may earn excess earnings (i.e., half of the health care entities will earn income above the median level, and half of the health care entities will earn income below the median level).

All Health Care Valuations Should Be Performed on a Before-Tax Basis

In order to adjust for the fact that some health care industry acquirers are tax-exempt and some health care industry acquirers are for-profit entities, some analysts ignore income taxes altogether—and perform all valuations on a pretax basis.

Some analysts erroneously believe that this procedure prevents the tax-exempt entity from paying more than fair market value for a target health care entity. This objective is certainly appropriate. However, there is no regulatory requirement that all health care property (or services) valuations be performed on a pretax basis—or on an after-tax basis, for that matter.

Typically, if the property (or services) valuation variables are derived in a consistent basis, then the subject health care property (or services) should have one fair market value—whether the variables are measured on a pretax basis or an after-tax basis. That is, the valuation can be performed with all valuation variables (discount rates, capitalization rates, pricing multiples, income metrics) derived on a pretax basis.

Alternatively, the valuation can be performed with all valuation variables derived on an after-tax basis. The fair market value conclusion should be about the same.

There is no regulatory (or theoretical) preference—or prohibition—for performing health care property (or services) valuations on a pretax basis compared to an after-tax basis.

There Should Be No Goodwill Included in the Health Care Valuation

Some analysts erroneously believe that audit and regulatory authorities do not allow the inclusion of either an individual practitioner's goodwill or an

entity's institutional goodwill in a health care property transfer valuation. These analysts may conclude that any goodwill value includes the value of prohibited patient referrals or the value of excess (and suspicious) earnings.

There is no legislative or regulatory prohibition on the health care entity (tax-exempt or otherwise) paying for the goodwill of a target health care entity. There is no prohibition on including the value of goodwill in the health care property valuation.

Goodwill can be measured many different ways. But, goodwill is basically the value of the health care entity's ongoing business operations in excess of the value of the entity's tangible assets. For a successful going-concern business operation, the analyst would expect the health care entity to have some amount of goodwill.

The goodwill value should not include future prohibited transactions or expected post-acquisition synergies or economies of scale. But, if the target entity's historical results of operations indicate a positive goodwill value, then that goodwill value should be included in the health care property transfer valuation.

Typically, the goodwill value is included in the asset-based approach valuation analysis of the target entity value. And, that goodwill value may be measured in either the asset accumulation method or the adjusted net asset value method of the asset-based approach to business enterprise valuation.

There Should Be No Patient Relationships Value Included in the Health Care Valuation

Often the analysts who exclude goodwill value will also exclude the value of any patient relationships-related intangible asset from the health care valuation. This procedure (or lack of performing a procedure) is particularly important when the analyst uses the asset-based business valuation approach (and, specifically, the asset accumulation method) to value the health care property transfer.

First, the statutory and regulatory prohibition relates to any health care provider (tax-exempt or otherwise) paying for patient referrals to the acquirer entity. Second, there is no prohibition of a health care acquirer paying for the current patient relationships (not the patient referrals to the acquirer) of the target health care entity.

In virtually any industry or profession, a good part of the value of a target business relates to the income earned from the entity's current customer (in this case, patient) relationships. The value of these current patient relationships is often measured based on the expected future income from the current patients returning to the current health care services provider. Such a value does not (and should not) include the expected future income from the future referrals of current patients to the acquirer health care entity.

No Health Care Entity Can Pay Reasonable Compensation over $1 Million per Individual

Some analysts erroneously believe that there is an arbitrary dollar amount (say, $1 million per year) of reasonable compensation above which health care regulatory authorities will not accept. These analysts may also erroneously believe that there are arbitrary "ceilings" on fair market value compensation for different professional positions—for example, a chief executive officer, chief medical officer, chief research officer, operating room director, emergency room director, and the like.

There are no such arbitrary limits on the fair market value level of compensation—either in the relevant statutes or in the relevant regulations.

There are numerous factors that an analyst should consider in assessing the fair market value of a health care entity executive or professional compensation. Likewise, there are numerous factors that an analyst should consider in assessing the fair market value compensation-related contract terms for health care entity contractors.

All of these factors are consistent with the overarching consideration with regard to the fair market value of either employee or contractor compensation: the compensation should be commensurate with the compensation levels paid to similarly qualified individuals performing similar functions at similar organizations.

The Analyst Should Not Use For-Profit Organizations as Comparables in a Compensation Analysis

Some analysts erroneously believe that for-profit business entities do not provide meaningful guidance with regard to the fair market value compensation assessment of a tax-exempt entity employee or contractor. As mentioned above, the general regulatory guidance with regard to fair market value compensation is that the analyst should consider comparable individuals in comparable situations at comparable organizations.

First, with respect to providing empirical evidence regarding market-derived compensation levels, tax-exempt health care entities and for-profit

health care entities are comparable in at least one important respect. Both types of health care entities are subject to the Medicare fraud and abuse statutes and regulations. Therefore, ignoring income tax status considerations, neither type of health care entity may seek reimbursement for employee or contractor compensation expense in excess of fair market value compensation levels.

Second, health care entities and many related industry entities are comparable in at least one other important respect. That is, they all compete for the same pool of executive and professional talent. Health care providers, insurance companies, pharmaceutical companies, research institutes, universities, and other organizations all are competing to recruit the same pool of executive, technical, and professional talent. In addition, when a health care entity employee or contractor decides to change jobs, he or she can interview with all of these related-industry entities.

Employers will recruit—and compensate—the most talented employees (even if that means recruiting an employee from a related industry). Likewise, the employees will interview with—and work for—the highest-paying employers (even if that means working for an employer in a related industry).

In a fair market value compensation analysis, the analyst should consider the "big picture" with regard to compensation paid by competing employers and compensation received by competing employees. With regard to the supply and demand for executive, technical, and professional talent, comparable organizations can be (1) either for-profit or not-for-profit and (2) in related industries.

A Services Supplier Cannot Earn Excess Profits on a Fair Market Value Services Contract

Like the fair market value of employee and contractor compensation, the general rule with regard to the fair market value of supplier contract price is that it should be supported by empirical market data. That is, the subject health care entity contract price should be comparable to prices paid by comparable entities for comparable contract services.

Like employees offering employment services, service providers are free to offer their services to both for-profit entities and tax-exempt entities. Likewise, service providers are free to offer their services to entities in related industries. Accordingly, for-profit entities and related industry entities may provide a source of empirical data for assessing the fair market value of market-derived contract services prices.

Further, there is no statutory or regulatory prohibition that an efficient services provider cannot earn a profit margin (even a high profit margin) providing services to a health care entity. Rather, the services providers must charge fair market value prices for the services they provide to the health care entity. Excess earnings methods and profit split methods may have certain applications in health care property valuation circumstances.

However, neither of these methods is used to measure the fair market value price for professional, administrative, technical, or other contract services provided to a health care entity.

Analysts Should Only Consider Data from For-Profit Acquirers in Health Care Property Valuations

Some analysts erroneously believe that they should only consider valuation variables extracted from empirical data with regard to for-profit buyer transactions. Such valuation variables may include discount rates, capitalization rates, pricing multiples, and so forth.

These analysts erroneously believe that this procedure will prevent the subject health care entity (particularly a tax-exempt entity) from paying more than fair market value for property or services. Presumably, this belief is based on the erroneous premise that tax-exempt buyer transactions (related to property or services) include some amount of price premium associated with the buyer's tax-exempt status.

In other words, this belief is based on the misconception that tax-exempt entities generally pay more than a fair market value price for purchased property or services.

It is possible that any buyer (health care or otherwise, tax-exempt or otherwise) could occasionally pay more than fair market value for property or services. Likewise, it is possible that any buyer could occasionally pay less than fair market value for property or services.

However, there is no empirical evidence to indicate that any class of buyer (and particularly health care buyers or tax-exempt buyers) consistently pays more than (or less than) fair market value for property or services. Therefore, there is no empirical or theoretical reason to exclude a tax-exempt health care property or services transfer from the analyst's data gathering or valuation analysis.

Paying a Fair Market Value Price Is the Same as Having a Commercially Reasonable Purpose

To comply with the relevant federal statutes and regulations, health care entities (and their legal counsel) often ask the analyst to opine that a pending transfer is both:

1. priced at fair market value and
2. commercially reasonable.

Some analysts erroneously believe that proving one of these propositions (i.e., that the transfer is priced at fair market value) also provides the second of these propositions (i.e., that the property or services transfer is commercially reasonable and has a valid business purpose). That analyst belief is incorrect.

A property or services transfer could be priced at fair market value—and still there is no valid business purpose for the proposed transfer. In other words, that transfer would not be commercially reasonable. Likewise, there could be a perfectly valid business purpose for the health care entity to enter into the property or services transfer—yet the transfer could be priced at above fair market value.

In other words, that transfer could still be commercially reasonable (even though it was not priced at a fair market value price).

Each of these two opinions (i.e., fair market value price and commercially reasonable purpose) deserves its own individual consideration and analysis. Each of these two transfer transaction opinions can be reached by the analyst independently of the other opinion.

Analyst Misconceptions Summary

This section considered 10 common misconceptions with regard to health care transfer fair market value analyses. Each of these analyst beliefs is considered a misconception when it is compared to the professional guidance provided by the relevant statutory authority and regulations.

There are, of course, valid analyst beliefs with regard to health care fair market value valuations.

First, in the valuation of any health care property transfer, the analyst should understand the transfer transaction. For example, the analyst should understand if a pending transaction will be the purchase of the entity assets or of the entity equity.

Second, in the property transfer valuation, the analyst should consider both the payment price and the payment terms. For example, the analyst should investigate if there is any seller financing. And, the analyst should investigate whether the property purchase price will be paid in cash at the closing—or whether there will be a series of payments over a time period. If there are payment terms, then the analyst should assess whether those terms are at fair market value.

Third, the analyst should consider if there are several contracts being entered into as part of the property transfer. For example, the analyst should consider whether there are earn-out provisions to the property transfer transaction. And, the analyst should consider whether there are employment agreements, noncompete agreements, intellectual property licensees, lease transfers, or other agreements that are part of the overall transaction. If so, the analyst should assess the fair market value of the total (multi-contract) transaction.

Fourth, the analyst should consider whether the transaction includes both a property transfer and a services transfer. And, the analyst should consider the direction (i.e., from whom to whom) of both the property transfer component and the services transfer component. Both components of the transfer have to be at fair market value if the total transaction is considered to be a fair market value transaction.

Finally, this section considered both analyst misconceptions and analyst correct perceptions with regard to the fair market value analysis of a entity property transfer or services transfer.

Summary and Conclusion

This discussion focused on the role of fair market value valuations with regard to a health care entity property and services transfers. In particular, this discussion considered the regulatory implications of a health care property or services transfer when one participant is a tax-exempt entity.

Analysts who performs valuations of health care property or services transfers should be aware of the various regulatory requirements with regard to such fair market value valuations. Analysts should be familiar with the regulatory environment with regard to private inurement, excess benefit transactions, intermediate sanctions excise tax penalties, and other regulatory issues.

Robert Reilly is a managing director of the firm and is resident in our Chicago practice office. Robert can be reached at (773) 399-4318 or at rfreilly@willamette.com.