

BUYING, SELLING, MERGING AND VALUATION: REGULATORY ISSUES¹

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- I. Federal Anti-Kickback Statute (42 U.S.C. § 1320a-7b). The principal fraud and abuse issue raised by transactions involving the purchase, sale or merger of medical practices and health care providers is whether any portion of the purchase price is actually a disguised payment from the buyer to pay for referrals from the seller, or is a discounted price from the seller to induce referrals from the buyer.
- A. General Prohibition. The federal Anti-Kickback Statute prohibits knowing and willful solicitation, receipt, offer or payment of any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, in return for referrals or in return for arranging, recommending, leasing or ordering of any item or service covered in whole or in part by Medicare, Medicaid or other Federal health care program. The federal Anti-Kickback Statute is a criminal statute, violations of which are punishable by a \$50,000 civil monetary penalty per violation, and by criminal penalties of up to five (5) years in prison and/or a \$25,000 fine. Providers who violate the Anti-Kickback Statute may also be excluded from participating in the Medicare/Medicaid programs. 42 U.S.C. § 1320a-7a.
- B. The One Purpose Rule. Federal appellate cases hold that all payments which are intended, even in part, to induce a referral for an item or service covered by the Medicare, Medicaid or other Federal health care programs are prohibited by the Anti-Kickback Statute. This principle is referred to as the “one purpose” rule, meaning that the remuneration violates the law if even one purpose of the remuneration is to induce referrals (even if it is not a primary purpose of the arrangement). See, e.g., United States v. Katz, 871 F.2d 105 (9th Cir. 1989); United States v. Greber, 760 F.2d 68 (3d Cir.), cert. denied, 476 U.S. 988 (1985) (holding that payment of a consulting fee to physicians who referred patients for Holter monitoring was illegal remuneration if “a purpose of the fee was to induce the ordering of services” , even if the fee was fair market value for actual services rendered); United States v. McClatchey, 217 F.3d 823, 834 (10th Cir. 2000) (holding that the “one purpose” rule is not an overly broad interpretation of the Anti-Kickback Statute). However, at least one appellate court has recognized that the mere hope for or expectation of referrals collateral to a legitimate motive for the financial arrangement does not rise to the level of an improper purpose. Id. at 834; United States v. LaHue et al., 261 F.3d 993 (10th Cir. 2001).
- C. Scienter Requirement. The clear trend in federal appellate courts is to interpret the “knowing and willful” language of the Anti-Kickback Statute to require the government to prove that a party offered, paid, solicited or received the remuneration with the knowledge that his or her conduct was unlawful. See United States v. Starks, 157 F.3d 833 (11th Cir. 1998); United States v. Davis, 132 F.3d. 1092 (5th Cir. 1998); Hanlester Network v. Shalala, 51 F.3d 1390 (9th Cir. 1995). The Hanlester court, which was the first to address the scienter element of the Anti-Kickback Statute, concluded that to demonstrate that a defendant “knowingly and willfully” violated the Anti-Kickback Statute, the government must prove that the defendant knew the Anti-Kickback Statute “prohibits offering or paying remuneration to induce referrals,” and that the defendant engaged in the “prohibited conduct with the specific intent to disobey the law [i.e., the Anti-Kickback Statute]” Id. at 1400. Relying on Supreme Court precedent, the Hanlester court construed the latter requirement to mean that the government would have to “prove that defendants knew their conduct was unlawful.” Id. at 1400. Other federal appellate courts have

¹ This outline is a general survey of the law, and does not constitute legal advice.

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declined to follow the Hanlester court's definition of "willful," but still require a heightened standard of scienter. For example, the Eleventh Circuit concluded that the government is required to prove that the defendant was acting with the knowledge that its conduct was unlawful. See Starks, 157 F.3d at 838-39. The Eighth Circuit concluded that "a heightened *mens rea* standard should only require proof that [the defendant] knew that his conduct was wrongful, rather than proof that [the defendant] knew it violated a 'known legal duty.'" See United States v. Jain, 93 F.3d 436, 441 (8th Cir. 1996). However, the Jain court also held that "good faith" is a defense to charges under the Anti-Kickback Statute. Id. at 440. Thus, the government must prove both an intent to induce referrals (not merely a hope, desire or expectation of referrals apart from a legitimate motive for the transaction) and knowledge that the transaction was unlawful (or at least wrongful in the Eighth Circuit). To establish a violation of the Anti-Kickback Statute the government therefore has to prove that the parties intended at least one purpose of the arrangement to be to induce referrals.

- D. Practice Acquisition Safe Harbor. The Secretary of Health and Human Services is authorized to create "safe harbor" exceptions that define business transactions which will not subject the parties to penalties under the federal Anti-Kickback Statute. 42 U.S.C. §1320a-7b(3)(E). Pursuant to that authority, the Office of Inspector General ("OIG") has promulgated two safe harbors for practice acquisitions, one of which protects practitioner-to-practitioner transactions and the other of which protects certain practitioner-to-hospital or other entity transactions. 42 C.F.R. § 1001.952(e)(1) and (2); 56 Fed. Reg. 35964, 35965 (1991). The original practice acquisition safe harbor did not include standards for acquisition of physician practices by hospitals, HMOs, practice management companies, insurers, management services organizations, integrated delivery systems or other types of purchasers. The second practice acquisition safe harbor is now potentially available to protect transactions by these entities, but is of limited utility because it only applies to practice acquisitions in Health Professional Shortage Areas ("HPSAs") where the acquisition is a transitional means for the buyer to try to recruit a new physician within one year to take over the practice.
1. Practitioner-To-Practitioner Safe Harbor. To satisfy the practitioner-to-practitioner safe harbor, the following requirements must be met:
 - a. The sale must be to another practitioner;
 - b. The period from the date of the first agreement pertaining to the sale to the completion of the sale is not more than one year. (This does not mean, as had been the case under the original practice acquisition safe harbor, that all payments to the seller have to be made within one year from the agreement to sell. In other words, installment sales of more than one year duration can potentially meet safe harbor standards).
 - c. The seller cannot be in a professional position to make referrals to or otherwise generate business for the purchasing practitioner after one year from the date of first agreement pertaining to the sale (i.e., the selling physician must retire, cease to practice or relocate within one year of the commencement of the transaction). See 42 C.F.R. §1001.952(e)(1)(ii).
 2. Practitioner-To-Other Entity Safe Harbor. To satisfy the practitioner-to-other entity safe harbor, the following requirements must be met:
 - a. The period from the date of the first agreement pertaining to the sale to the completion date of the sale is not more than three years.
 - b. The practitioner who is selling his or her practice will not be in a professional position after completion of the sale to make or influence referrals to, or otherwise generate

business for, the purchasing hospital or entity for which payment may be made under Medicare, Medicaid or other Federal health care programs.

- c. The practice being acquired must be located in a HPSA, as defined in Departmental regulations, for the practitioner's specialty area.
- d. Commencing at the time of the first agreement pertaining to the sale, the purchasing hospital or entity must diligently and in good faith engage in commercially reasonable recruitment activities that:
 - (1) May reasonably be expected to result in the recruitment of a new practitioner to take over the acquired practice within a one year period; and
 - (2) Will satisfy the conditions of the practitioner recruitment safe harbor in accordance with 42 C.F.R. § 1001.952(n).

3. Goodwill. In a letter dated December 22, 1992, D. McCarty Thornton, the OIG's then Associate General Counsel questioned the legality of a physician selling the goodwill of his/her practice to a hospital, particularly where the physician would thereafter continue to practice in affiliation with, and refer to, the hospital. Mr. Thornton opined that where there is such a continuing relationship between the buyer and a seller after the sale of a practice, payment by the buyer for goodwill or other intangibles (e.g., covenants not to compete, assembled work force, patient lists, patient records, or exclusive dealing arrangements) raises "grave questions of compliance with the antikickback statute." These arrangements, he indicated, may be "merely sophisticated disguises to share profits of business at a hospital with referring physicians, in order to induce physicians to steer referrals to the hospital."

More recently, the OIG has retreated somewhat from Mr. Thornton's position, and it is now generally believed that payment for goodwill by hospitals may be appropriate, as long as the amount paid is not in excess of the fair market value of the practice as a going concern (without regard to the value of existing or future referrals from the seller to the buyer). To negate any inference that the purchase price includes payment for referrals, the value of intangibles should be determined by an independent valuator or appraiser using recognized valuation methodologies based on reasonable economic and market assumptions.

4. Valuation Issues.

- a. Fair Market Value. The Anti-Kickback Statute does not define or specify any standard for valuing transactions to avoid an adverse inference that the transaction may be intended to induce referrals. In OIG advisory opinions, however, the OIG has generally looked favorably upon independent appraisals of "fair market value in arm's length transactions." See e.g., OIG Adv. Op. 03-15 (OIG approves reintegration of medical group and hospital where transfer of assets to hospital and price paid by hospital for real estate were pursuant to independent appraisals of fair market value in arm's length transactions).
- b. Valuation Standard. The definition of "fair market value" generally used for valuation purposes by appraisers and accountants is the following: "The price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arms-length in an open and unrestricted market, when neither is under any compulsion to buy or sell and when both have reasonable knowledge of the relevant facts." International

Glossary of Business Valuation Terms,

<http://bvfls.aicpa.org/Resources/Business+Valuation/Tools+and+Aids/Definitions+and+Terms/International+Glossary+of+Business+Valuation+Terms.htm#investmentvalue> .

- c. Valuation Methods. There are three basic approaches to valuation of on-going businesses: income approach, asset approach, and market approach. The American Medical Association has published two publications dealing with medical practice valuations. See, Internal Revenue Service Business Valuation Guidelines (“Guidelines”)³; See, Buying & Selling Medical Practices: A Valuation Guide (AMA Department of Practice Development Resources, 1990). See also, Mark O. Dietrich, Medical Practice Valuation Guidebook (Windsor Professional Information, 2001/2002).
- (1) Income approach is defined by the Guidelines “as a general way of determining a value indication of a business, business ownership interest, security, or intangible asset using one or more methods that convert anticipated economic benefits into a present single amount.” The income approach may involve:
 - (a) Discounted cash flow approach – combines the organization’s estimated free cash flows, terminal value, and the value of assets not required for operations, e.g., cash and short-term investments.
 - (b) Discounted earnings approach – takes debt-free earnings for a given number of years and capitalizes them to estimate the current value of the organization.
 - (c) The discounted cash flow or earnings are multiplied by a capitalization rate (a market multiple) that reflects the relative risk of the business as a going concern.
 - (2) Asset-based approach is defined by the Guidelines as “a general way of determining a value indication of a business, business ownership interest, or security using one or more methods based on the value of the assets net of liabilities.” This approach may involve.
 - (a) Estimate of the value of property and equipment based on replacement cost new, less depreciation.
 - (b) Value of current assets and liabilities at book values.
 - (c) Calculation of the adjusted debt-free net asset value of the organization based on individual asset values and non-interest bearing liabilities.
 - (3) Market approach is defined by the Guidelines as “a general way of determining a value indication of a business, business ownership interest, security, or intangible asset by using one or more methods that compare the subject to similar businesses, business ownership interests, securities, or intangible assets that have been sold.” This approach may:

³ The purpose of the Guidelines is to provide guidelines applicable to IRS Valuation Engineers, Appraisers, Valuation Specialists and others engaged in valuation practice relating to the development, resolution and reporting of issues involving business valuations and similar valuation issues.

- (a) Look for comparable transactions. There is much room for disagreement regarding what is “comparable.”
 - (b) Public company transactions may not be comparable because they may not be the same business line (or may involve multiple business lines), different size transactions command different multiples (larger transactions generally are accorded higher multiples), and may reflect differences in marketability (there is no ready market for the stock of small medical practices).
 - (c) Many appraisers rely on the *Goodwill Registry* for medical practice transaction comparables. The *Goodwill Registry* is published by the Health Care Group, Plymouth Meeting, PA. The *Goodwill Registry* should only be used as a benchmark and not as determinative of actual value since many transactions listed may not be comparables (e.g., divorce court valuations, minority interest transactions, older transactions).
 - (d) Transactions in different regions of the country with different payor rates and payor mixes may not be comparable.
- d. Income Approach. The principal issue with the income approach is how to value future cash flows without taking into account in an impermissible way the volume or value of existing and future referrals between the seller and the buyer. See, e.g., *Settlement Agreement* between PharMerica, Inc. and the OIG dated March 29, 2005. In that case, PharMerica paid \$7.2 million to purchase a Pharmacy Services Agreement (“PSA”) from Hollins Manor I, LLC, an operator of nursing homes and assisted living facilities. The PSA gave the holder of the contract the exclusive right to provide pharmacy services to residents of HMI’s nursing homes and assisted living facilities for a period of seven years. The OIG alleged that the transaction was tantamount to a purchase of referrals from HMI. The OIG demanded a \$200,000 civil monetary penalty, \$21.6 million in damages and a 10 year exclusion from federal health care payment programs. The matter ultimately settled for \$5.975 million and a corporate integrity agreement. It is not stated in the settlement agreement whether PharMerica had obtained a fair market valuation of the PSA; but it appears that the OIG would, in any event, have viewed this case as involving a payment principally for Medicare/Medicaid referrals. Factors that may influence the analysis and result may include:
- (1) Whether the seller is in a position to refer to the buyer post-transaction;
 - (2) If so, whether the arrangement is exclusive or whether there are providers other than the buyer who have the opportunity to service the seller’s patients; and
 - (3) The extent to which Medicare/Medicaid business is implicated.

A too literal reading of the Anti-Kickback Statute could lead one (incorrectly) to conclude that one should never use the cash flow method for valuing fair market value in a transaction between health care entities, since that method, by definition, takes into account future cash flow from potential business generated between the parties. This is particularly problematic where the seller is in a position to continue to refer to the buyer post-transaction. On the other hand, some expert appraisers have argued cogently that, even taking the health regulatory

considerations properly into account, the income approach to valuation is generally preferred. See, Mark O. Dietrich, CPA/ABV and Reed Tinsley, CPA, CVA, Identifying Appropriate Business Valuation Approaches Under Stark And the AKS, *The Health Lawyer*, Vol. 19, No. 2 (Dec. 2006)

e. Other Income Approach Issues.

- (1) Under or overcoding will affect valuation. A coding review may be advisable in connection with the valuation.
 - (2) If the seller is a practitioner who will be employed by the buyer post-transaction, then the available cash flow to the purchaser will be reduced by the amount of the seller's on-going compensation and will reduce the value of the transaction.
 - (3) Payment for a noncompete may double count cash flow since the income approach already assumes that cash flow will remain with the purchased practice. In addition, state laws varying regarding the enforceability of noncompetes.
 - (4) Revenue growth rate assumptions can have a significant impact on the valuation. Medicare revenue growth for physicians varies by specialty, and in general has not kept up with inflation over the last decade. Accordingly, absent utilization or payor mix changes (or adding new sources of revenues), revenue growth for many practices has been flat or declining (in real dollar terms).
 - (5) Need for capital investment (e.g., for information technology, communications systems or new space or equipment) will reduce value under an income approach.
 - (6) Small practices are inherently riskier than large practices (because they are dependent on the health, availability and performance of only a few practitioners who have fewer resources to respond to market conditions), and so, in general, will command a lower market multiple. An exception to this rule may be concierge practices, to the extent that they are saleable.
5. Earnouts. Earnouts or other arrangements where the amount of the purchase price paid to the seller varies based on revenues of the practice after the sale are particularly suspect under the Anti-Kickback Statute if the seller continues to be in a position to refer, since such arrangements provide incentive to the seller to make such referrals to maximize the purchase price.
6. Nonproviders. Purchasers that are not in a position to receive referrals from the acquired practice (e.g., a venture capital sponsored or publicly traded MSO/practice management company) have less legal exposure under the federal Anti-Kickback Statute than buyers that are themselves providers (e.g., hospitals) or affiliates of providers.
7. Advisory Opinions. The Health Insurance Portability and Accountability Act of 1996 requires the Secretary of the Department of Health and Human Services, in consultation with the Attorney General, to issue advisory opinions regarding the applicability of the Anti-Kickback Statute to particular financial arrangements. However, advisory opinions are not available to address fair market value issues or whether an individual is a *bona fide* employee of an entity. See 42 C.F.R. § 1008.6(b).

- II. Stark Law. The federal Ethics in Self-Referral Act, the so-called Stark Law (42 U.S.C. §1395nn) applies to practice acquisitions to the extent that payment of the purchase price creates a “financial relationship” between a physician or group of physicians and an entity that provides (or will provide) “designated health services” to Medicare and Medicaid patients.
- A. General Rule. Under the Stark Law, if a physician (or his or her immediate family member) has a “financial relationship” with an entity, the physician may not refer Medicare/Medicaid patients to the entity for “designated health services”, and the entity receiving such a referral may not bill for such services. Violation of the Stark Law is punishable by a \$15,000 civil monetary penalty, and by exclusion from the Medicare and Medicaid programs. Circumvention schemes (i.e., violation of the intent but not necessarily the letter of the Stark Law) are punishable by a \$100,000 civil monetary penalty.
1. “Designated health services” include:
 - a. clinical laboratory services,
 - b. physical therapy;
 - c. radiology services, including MRI, CT, ultrasound, PET and nuclear medicine;
 - d. radiation therapy services,
 - e. durable medical equipment and supplies;
 - f. parenteral and enteral nutrients, supplies and equipment;
 - g. outpatient prescription drugs;
 - h. prosthetics, orthotics and prosthetic devices and supplies;
 - i. home health services;
 - j. occupational therapy; and
 - k. inpatient and outpatient hospital services.
 2. Isolated Transactions. The Stark Law expressly excepts isolated transactions between a physician and a provider of designated health services from the self-referral prohibition. See 42 U.S.C. §1395nn(e)(2)(B) and (C), referred to in 42 U.S.C. §1395nn(e)(6); 42 U.S.C. § 411.357(f). The statute specifically identifies a one-time sale of property or purchase of a physician’s practice as examples of isolated transactions.
 - a. Transaction. The Stark II regulations define a “transaction” as: “an instance or process of two or more persons or entities doing business. An isolated transaction means one involving a single payment between two or more persons or entities or a transaction that involves integrally related installment payments provided that—
 - (1) The total aggregate payment is fixed before the first payment is made and does not take into account, directly or indirectly, the volume or value of referrals or other business generated by the referring physician; and

- (2) The payments are immediately negotiable or guaranteed by a third party, secured by a negotiable promissory note, or subject to a similar mechanism to assure payment even in the event of default by the purchaser or obligated party." 42 C.F.R. § 411.351.
- b. Isolated Transaction Exception. The isolated transaction exception is an exception only for compensation arrangements; it does not apply to investment interests. To qualify under the isolated transaction exception, the amount of remuneration involved in the transaction must be consistent with the fair market value of the practice acquired, and may not take into account the volume or value of referrals to the entity by the referring physician or other business generated between the parties. In addition, the price must be paid pursuant to an agreement which would be commercially reasonable even if no referrals were made between the parties. Finally, there can be no additional transactions between the parties (e.g., any other sale or contracting for post-acquisition services) for 6 months after the isolated transaction, except for transactions which are specifically excepted under other Stark Law exceptions (e.g., the bona fide employment or personal services exception), and except for commercially reasonable post-closing adjustments that do not take into account (directly or indirectly) the volume or value of referrals or any other business generated by the referring physician. 42 C.F.R. § 411.357(f)(3).
- c. Fair Market Value. As noted above, to meet the isolated transaction exception, the transaction must be consistent with fair market value. "Fair market value" is defined at 42 C.F.R. § 411.351 to mean "value in arms-length transactions, consistent with general market value." General market value, in turn, is defined to mean "the price that an asset would bring as a result of *bona fide* bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, ... on the date of acquisition of the asset... Usually the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of the acquisition... where the price... has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals."
 - (1) As discussed in Section I.D.4.d. above, the typical income approach to valuation inherently considers future cash flows regardless of source of the income. To meet the Stark Law definition of fair market value, the valuator or appraiser will need to adjust the valuation to assure that anticipated post-transaction business between the parties is not taken into account. This may present a particular challenge where part of the practice being sold includes ancillary services, such as laboratory, imaging or other DHS services, particularly if the seller will continue to be in a position to refer to the buyer post-transaction.
 - (2) To the extent that the Stark Law definition of fair market value contemplates valuation based on comparable transactions in the "particular market at the time of the acquisition", this may present a challenge to the valuator or appraiser since there may be no contemporary transactions in the market, and for the reasons discussed in Section I.D.4.c.(3) above, other transactions may not, in fact, be comparable.
 - (3) Stark Law advisory opinions from CMS are not available on fair market value issues. See 42 C.F.R. § 411.370(c)(1).

- d. Installment Sales. The final Stark II regulations permit installment sales to be considered isolated transactions as long as the payments are “integral” to the transaction (i.e., not payment for other items, services or referrals) and are guaranteed to be made even in the event of default. Under proposed Stark I regulations installment sales would have been completely prohibited because, in an installment sale transaction, the seller may have an incentive to refer to the buyer to assure that the buyer has sufficient future cash flow to meet its installment payment obligations. Note also that if the installment note is secured by collateral (i.e., if a security interest is granted to the seller), then the note becomes an “investment interest” in the buyer for Stark Law purposes. This is because an “ownership or investment interest” is defined under 42 C.F.R. § 411.354(b)(1) to include certain debt instruments such as “loan, bonds, and other financial instruments that are secured by an entity’s property or revenue or a portion of that property or revenue.” In this regard, as noted above, the Stark Law isolated transaction exception only protects compensation arrangements; it does not protect investment interests. If buyer is another medical practice and the note is secured, the seller may be able to rely on the in-office ancillary services exception to protect the investment interest. Otherwise, if the installment note is secured and an ownership interest in the buyer is created thereby, the parties may have difficulty identifying another Stark Law exception that will permit the seller to refer Medicare/Medicaid business to the buyer post-transaction.
3. Sales of Lab or other DHS Service. The isolated transaction exception will not protect the sale by a medical group of a clinical laboratory, imaging center, or other DHS services to a hospital (or other DHS entity) if the value of the lab or other DHS service is based upon the anticipated continuing referral volume from the selling medical group. Some argue that such a transaction may, however, be protected by the indirect compensation arrangements exception to the Stark Law. Whether that exception applies depends on whether that exception looks to the purchase price relationship between the hospital and medical group or the compensation relationship between the medical group and its physicians in determining whether compensation reflects the volume or value of referrals to the hospital. There is lack of consensus among the health lawyers on this issue.
- a. 42 C.F.R. § 411.354(c)(2)(ii) instructs that there is an “indirect compensation arrangement” if “the referring physician...receives aggregate compensation from the person or entity in the chain in which the physician...has a direct financial relationship that varies with, or otherwise reflects, the volume or value of referrals or other business generated by the referring physician for the entity furnishing the DHS [i.e., the buyer]...” Where a medical group is the seller, generally the only entity with which the referring physicians will have a direct financial relationship is their own medical group. The physicians will have only an indirect financial relationship with the buyer defined by the purchase price. 411.354(c)(2)(ii) goes on to say “[i]f the financial relationship between the physician... and the person or entity in the chain with which the referring physician has a direct financial relationship is an ownership or investment interest, the determination whether the aggregate compensation varies with, or otherwise reflects, the volume or value of referrals or other business generated by the referring physician for the entity furnishing the DHS will be measured by the *nonownership or noninvestment interest closest to the referring physician.*” In this regard, two points should be noted. First, the referring physicians will generally have both an investment and compensation relationship with their medical group. So, arguably, the clause cited immediately above would not apply, since it can be construed only to apply where the referring physician’s financial relationship is only a direct investment or ownership interest. Second, even if it applies where the direct financial arrangement

consists of both an investment interest and compensation arrangement with the referring physician, the nonownership/noninvestment interest *closest to the physician* can still be construed to be the direct compensation relationship between the selling medical group and its physicians. The Stark regulations do not say (or do not say clearly) that you have to look up the chain to the purchase price transaction in this instance --where there is a direct compensation relationship at the same level as the investment interest. The argument can therefore be made that so long as the selling group's compensation relationship with its physicians does not take into account or otherwise reflect the volume or value of DHS referrals to the hospital relating to the DHS service sold to the hospital, then the indirect compensation arrangements exception applies. Arguments, however, can be fashioned to the contrary, and to prohibit the payment of a purchase price for a DHS service to which the seller will continue to refer post-transaction. In any event, if both the purchase price and the physician's compensation from the selling medical group reflect the volume or value of actual or anticipated referrals to the buyer for DHS services, then this exception clearly would not apply.

4. Investment Interests. If the acquisition transaction involves the distribution of equity (or secured debt) in the buyer to the selling physician as part of the transaction consideration, referrals by the seller post-transaction may be prohibited unless the investment meets an applicable investment interest exception. The Stark Law regulations define an "investment interest in an entity" to include both direct and "indirect" investment interests - - i.e., an investment interest in an entity that holds an ownership or investment interest in any entity that furnishes designated health services. See 42 C.F.R. §411.354(a) and (b)(5). Thus, for example, a physician's investment interest in a laboratory holding company will be deemed to be an investment interest in the laboratory itself. In contrast, if a laboratory holding company enters into a joint venture with a physician, the physician's investment interest in the joint venture entity would not involve an indirect investment interest in the holding company's laboratory subsidiary, as long as the joint venture entity does not have any investment interest in the laboratory subsidiary.
 - a. Ownership or investments interests do not include the following interests, which are considered compensation arrangements potentially protected by the isolated transaction exception:
 - (1) An interest in a retirement plan;
 - (2) Stock options and convertible securities *received as compensation* until the stock options or convertible securities are exercised or converted to equity;
 - (3) An unsecured loan subordinated to a credit facility; or
 - (4) An "under arrangements" contract between a hospital and an entity owned by one or more physicians or medical groups providing DHS under arrangements with the hospital. 42 C.F.R § 411.354(3).
 - b. Investment Interest Exceptions. The only available investment interest exceptions are for ownership interests in a group practice (i.e., the in-office ancillary services exception), a publicly traded company or a mutual fund with \$75 million in stockholder equity, rural entities, and a whole hospital (and not in a discrete portion or service of a hospital). See 42 C.F.R. § 411.355(b); 411.356. There is no Stark Law exception for

small privately held entities that is comparable to the Anti-Kickback Statute safe harbor for investments in small entities. *Compare* 42 C.F.R. § 1001.952(a)(2).

5. Other Exceptions. The Stark Law may also affect the post-acquisition relationship between the parties. Post-acquisition issues may include assuring compliance with the Stark Law employment, personal services, space and equipment rental, and in-office ancillary services exceptions.

III. Tax Exemption Considerations

1. Private Benefit. A Section 501(c)(3) organization must serve public rather than private interests.⁴ There is a presumption that when a medical practice is acquired by an exempt hospital, a private benefit flows to the physicians either because of the acquisition itself or the continuing relationship with the hospital.⁵ However, this is only a presumption and the organization may serve private interests as long as the private benefit is incidental to the organization's exempt purpose.⁶ The IRS has explained that private benefit is "incidental" if it is:

- a. A "necessary concomitant" of the public activity;⁷ and
- b. Insubstantial in relation to the public benefit resulting from the activity.⁸

For example, a 501(c)(3) hospital may benefit a physician who is employed by the hospital after the hospital acquires the physician's practice, as long as that benefit is incidental to the public benefit provided by the hospital.⁹

2. Inurement. The net earnings of a 501(c)(3) organization may not "inure in whole or in part to the benefit of private shareholders or individuals."¹⁰ This is different from private benefit in that the inurement proscription applies only to "insiders" but unlike private benefit, there is no de minimis exception to the inurement proscription.
 - a. Insiders. The inurement proscription is applied to "insiders" who have a personal and private interest in the organization's activities and could cause the organization to confer a prohibited private benefit.¹¹ The IRS' Exempt Organizations Handbook focuses on whether an individual possesses control over the organization to determine whether that

⁴ Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii).

⁵ See "Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook" (for FY 1996) ("1996 CPE") at p. 227.

⁶ Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii).

⁷ See, e.g., Better Business Bureau v. United States, 326 U.S. 279 (1945); St. Louis Union Trust Co. v. United States, 374 F.2d 427 (8th Cir. 1967); Orange County Agricultural Society v. Comm'r., 893 F.2d 529 (2d Cir. 1990).

⁸ PLR 9231047 (May 5, 1992).

⁹ "Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook," 19th ed. (1995 for FY 1996) ("1996 CPE"), at pp. 385-386. See also "Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook," 17th ed. 91993 for FY 1994) ("1994 CPE") at pp. 228-231.

¹⁰ Treas. Reg. 1.501(c)(3)-1(c)(2).

¹¹ Id. At 1.501(a)-1(c). See also 1996 CPD at p. 386; American Campaign Academy v. Comm'r., 92 T.C. 1053, 1066 (1989); Sound Health Association v. Comm'r., 71 T.C. 158, 185 (1978).

individual is an “insider”.¹² The 1996 CPE states that the private benefit prohibition applies “to all physicians, either individually or as part of a medical group that sells assets to a tax exempt organization and all physicians who subsequently perform services for the exempt organization,” and notes that benefits to the physician(s) from such arrangements must be balanced against benefits to the public.¹³

- b. Medical Staff Members. In a 1987 General Counsel Memorandum, the IRS took the position that “all persons performing services for an organization have a personal and private interest and therefore possess the requisite relationship necessary to find private benefit or inurement.”¹⁴ A 1991 General Counsel Memorandum confirmed that physicians on the medical staff of an exempt hospital are presumptively “insiders” for purposes of the inurement proscription, regardless of whether they are employed by the hospital.¹⁵ There appears to have been some relaxation of this strict rule of inclusion in 2000 when the IRS began to apply a facts and circumstances test in order to determine whether the physician has the opportunity to make use of the organization’s income or assets for personal gain based upon his or her relationship.¹⁶
3. Acquisition of Practices. To avoid inurement or private benefit, the 1994 CPE requires an exempt hospital which acquires for-profit private practices from physicians and thereafter employs those physicians to:
 - a. Obtain an appraisal to show that the purchase price does not exceed fair market value;¹⁷
 - b. Enter into employment or independent contractor agreements with all or most of the selling physicians in order to retain the goodwill value of the practices;
 - c. Pay the selling physicians on the same compensation scale (adjusted for experience and specialty) as the other physicians employed by the hospital (or affiliate) and, if necessary, provide evidence that the selling physician’s reputation and experience justify a higher salary;¹⁸
 - d. If necessary, enter into fair market value leases with the physicians for any assets retained by them (although the IRS prefers that the hospital (or affiliate) purchase all of

¹² The IRS has stated that directors and officers of 501(c)(3) health care organizations (and other individuals who are in a position to influence or control such organizations) should be bound by conflict of interest policies requiring those individuals to (i) disclose conflicts and (ii) not participate in matters in which the individual is interested. See Exempt Organization Continuing Professional Education Technical Instruction Program Textbook, 20th ed. (1996 for FY 1997) (“1997 CEP”), Chapter C “Tax-Exempt Health Care Organizations Community Board and Conflicts of Interest Policy,” pp. 17-29.

¹³ 1996 CPE at p. 386.

¹⁴ GCM 39670 (June 17, 1987). See also GCM 39498 (April 24, 1986).

¹⁵ GCM 39862 (November 22, 1991).

¹⁶ See, Exempt Organization Continuing Professional Education Technical Instruction Program Textbook (FY 2000) (“2000 CPE”), Physician Incentive Compensation.

¹⁷ 1994 CPE at 232.

¹⁸ Id. At 220-221 and 232.

the assets to clearly establish the hospital's control over the practice and the selling physician's lack of control);¹⁹ and

- e. If tax-exempt bonds are used to finance practice acquisitions, complete an extensive questionnaire.²⁰

Many of these principles are generally applicable to transactions between any form of exempt entity, and any form of taxable entity.

The 1996 CPE notes that a tax-exempt entity's purchase of the stock of a for-profit medical practice may confer a private benefit on the selling physician if the exempt organization fails to make a downward adjustment to the value of the stock to account for the exempt organization's assumption of the burden of corporate level tax which would have been paid by the selling physician if the transaction had been structured as an asset purchase.

4. Modern Health Care Services Exemption Revocation. In April of 1994, the IRS terminated the exempt status of Modern Health Care Services, Inc. (a/d/a LAC Facilities, Inc.), a Miami-based health care company, based, in part, on the company's practice acquisition activities. The revocation was based on the following:
 - a. Overvaluation of acquired physician practices;
 - b. Unreasonably high physician compensation following practice acquisition;
 - c. Subsequent sale of practices to their prior physician-owners; and writing off of the physicians' debt to the hospital;
 - d. Excessive executive compensation;
 - e. Amendment of retirement plan by the officers to permit their receipt of lump-sum payments;
 - f. Expenditure for a partnership owned by insiders; and
 - g. Personal expenditures (spouses' travel, alcohol, country club meals, etc.) constituting private inurement.

The IRS indicated that the company had acquired a physician practice for \$6 million, and, post-acquisition, increased compensation for the acquired physicians from \$1.375 million to \$2 million. The IRS reappraised the value of this practice at \$2 million. In addition, the company purchased other medical practices from insider physicians for \$17.4 million, and within a couple of years sold the practices back to some of the same physicians for a \$4.5 million installment note. That installment note was then written down by the parties to \$253,000. The IRS concluded that these transactions resulted in prohibited inurement/private benefit to the physicians whose practices were acquired. See Technical Advice Memorandum, Modern Health Care Services, Inc., 94 TNT 216-38 (November 3, 1994).

¹⁹ Id. At 216.

²⁰ Processing Exemption Applications with Tax Exempt Bond Issues, Internal Revenue Manual, Supplement 76G-33.

5. Intermediate Sanctions. In general, the IRS has been reluctant to use the draconian penalty of revoking the tax exempt status of an organization to remedy inurement/private benefit transactions. Starting September 14, 1995, the IRS has had the authority to impose "intermediate sanctions" in such circumstances. Section 4958 of the Internal Revenue Code ("Code") imposes a two-tier excise tax on "disqualified persons" engaging in "excess benefit transactions" with "applicable tax-exempt organizations." The first-tier tax is 25 percent of the amount of "excess benefit;" the second-tier tax imposed if the excess benefit transaction is not corrected within a specified procedural period, is 200 percent of the amount of excess benefit. Code Sections 4958(a)(1), 4958(b). This tax is imposed on the disqualified person, not the exempt organization. Thus, if compensation or other transactions with disqualified persons are determined to be excessive, the result for the disqualified person is either repayment of the tax of 25 percent of that amount or payment of taxes of 25 percent and 200 percent of the excess amount.
- a. If the excise tax is imposed on a disqualified person, an excise tax of 10 percent of the excess benefit amount, up to an aggregate maximum of \$10,000, is also imposed on "organization managers" who participate in an excess benefit transaction, knowing that it is an excess benefit transaction, unless their participation is not willful and is due to reasonable cause. Code Section 4958(a)(2).
 - b. If an excise tax is imposed on disqualified persons or organization managers, a penalty equal to the amount of the tax may also be imposed for repeated or willful and flagrant violations.
 - c. The legislative history makes clear that the excise tax may be imposed instead of revocation of tax exemption or, in extreme cases, intermediate sanctions may be imposed along with the ultimate sanction
 - d. Rebuttable Presumption of Reasonableness. 26 C.F.R. 53.4958- 6 (a).
 - (1) In general. Payments under a compensation arrangement are presumed to be reasonable, and a transfer of property, or the right to use property, is presumed to be at fair market value, if the following conditions are satisfied --(1) The compensation arrangement or the terms of the property transfer are approved in advance by an authorized body of the applicable tax-exempt organization (or an entity controlled by the organization with the meaning of 53.4958- 4(a)(2)(ii)(B)) composed entirely of individuals who do not have a conflict of interest with respect to the compensation arrangement or property transfer; (2) The authorized body obtained and relied upon appropriate data as to comparability prior to making its determination; and (3) The authorized body adequately documented the basis for its determination concurrently with making that determination.
 - (2) For purposes of the rebuttable presumption, an authorized body means --(A) The governing body (i.e., the board of directors, board of trustees, or equivalent controlling body) of the organization; (B) A committee of the governing body, which may be composed of any individuals permitted under State law to serve on such a committee, to the extent that the committee is permitted by State law to act on behalf of the governing body; or (C) To the

extent permitted under State law, other parties authorized by the governing body of the organization to act on its behalf by following procedures specified by the governing body in approving compensation arrangements or property transfers. For a decision to be documented concurrently, records must be prepared before the later of the next meeting of the authorized body or 60 days after final action of the authorized body is taken. 26 C.F.R. § 53.4958(c)(3)(ii).

- (3) For purposes of the rebuttable presumption, a member of the authorized body does not have a conflict of interest with respect to a compensation arrangement or property transfer only if the member --(A) Is not a disqualified person participating in or economically benefitting from the compensation arrangement or property transfer, and is not a member of the family of any such disqualified person, as described in section 4958(f)(4) or 53.4958-3(b)(1); (B) Is not in an employment relationship subject to the direction or control of any disqualified person participating in or economically benefitting from the compensation arrangement or property transfer; (C) Does not receive compensation or other payments subject to approval by any disqualified person participating in or economically benefitting from the compensation arrangement or property transfer; (D) Has no material financial interest affected by the compensation arrangement or property transfer; and (E) Does not approve a transaction providing economic benefits to any disqualified person participating in the compensation arrangement or property transfer, who in turn has approved or will approve a transaction providing economic benefits to the member.
- (4) An authorized body has appropriate data as to comparability if, given the knowledge and expertise of its members, it has information sufficient to determine whether, under the standards set forth in 53.4958-4(b), the compensation arrangement in its entirety is reasonable or the property transfer is at fair market value. In the case of compensation, relevant information includes, but is not limited to, compensation levels paid by similarly situated organizations, both taxable and tax-exempt, for functionally comparable positions; the availability of similar services in the geographic area of the applicable tax-exempt organization; current compensation surveys compiled by independent firms; and actual written offers from similar institutions competing for the services of the disqualified person. In the case of property, relevant information includes, but is not limited to, current independent appraisals of the value of all property to be transferred; and offers received as part of an open and competitive bidding process.

6. Valuation Issues and The Carracci Case

- a. Fair Market Value. In Revenue Ruling 59-60, 1959-1 C.B. 237, the IRS defined fair market value for exempt organization purposes essentially as it is defined for general accounting purposes. See Section I.D.4.a. above. The hypothetical buyer component of the definition of fair market value prohibits the specific or unique characteristics of a particular buyer from being taken into account in developing the assumptions used in conducting the valuation analysis. See e.g., *United States v. Cartwright*, 411 U.S. 546, 551 n.13(1973). Thus, for example, when an exempt hospital acquires a physician's practice, the practice is required to be valued on an after-tax basis as if it were being purchased by a taxable buyer, even though a tax exempt buyer will not pay taxes. On the other hand, "the valuation method must take into account, and correspond to, the

attributes of the entity whose assets are being valued.” See *Carracci v. Comm’r*, No. 02-60912 (5th Cir. July 11, 2006, revised July 31, 2006).

- b. Carracci Case. In *Carracci*, the 5th Circuit Court of Appeals overturned a Tax Court decision finding that the Tax Court erred as a matter of law in the methodology used to value assets transferred from a tax exempt to a taxable organization, and in finding that the transaction involved excess benefits warranting intermediate sanctions and potential revocation of tax exemption. The *Carracci* case involved a sale on October 1, 1995 (two weeks after the retroactive effective date of the of Section 4958—the Intermediate Sanctions Statute) of the assets of three home health agencies in rural Mississippi that were controlled by the Carraccis to three taxable entities owned and controlled by the Carracci’s. The consideration for the sale was assumption of the liabilities of the agencies—no other consideration changed hands. 97% of the patients of the home health agencies were Medicare beneficiaries, and the agencies had been operating at a loss for seven years under then current Medicare reimbursement methodology. Under that methodology the agencies would, at most, be paid their actual costs. However, historically .7% of Carraccis costs were disallowed assuring that the agencies would be operated at a loss. The Carraccis retained an experienced tax attorney, who in turn arranged for two independent appraisals of the assets of the agencies. Both appraisers concluded that the value of the liabilities exceeded the value of the tangible and intangible assets of the agencies since the agencies had never been profitable and needed capital investment to keep them operating. The purpose of the for-profit conversion was to raise needed capital from potential investors.
- (1) The IRS audited the transaction and issued a deficiency notice to the Carraccis finding an excess benefit of \$18.5 million (based on an IRS asset valuation), \$256 million excise tax liabilities under Section 4958, penalties of over \$8 million, and grounds for revoking the tax exempt status of the agencies. The Carraccis appealed.
 - (2) Fortunately for the Carraccis, the IRS had made numerous blunders in its handling of the case, and so the 5th Circuit concluded that the burden of proof (which normally rests with the taxpayer to establish that the assessment is incorrect) shifted to the IRS to prove the correctness of its assessment. The IRS could not meet that burden.
 - (3) The court found that the valuation approach used by the Tax Court was erroneous as a matter of law and fact. The Tax Court used a market approach looking at the market value of invested capital using publicly traded companies as the benchmark for comparison. The 5th Circuit found that such a valuation methodology was inappropriate for a company, like Sta-Home, that had no invested capital. It found that the IRS and Tax Court also erred in assigning significant value to intangible assets of the agencies (i.e., workforce-in-place, licenses, CONS, patients) since the agencies had no history of profitable operations. These intangible assets were deemed unprofitable assets that do not contribute to fair market value. Citing Rev. Rul. 59-60, the 5th Circuit reminded the IRS that it is required to assign zero value to unprofitable intangible assets. The 5th Circuit further found that the IRS erred in selecting valuation comparables. The comparables were all publicly traded companies with invested capital. The agencies were not. All but one of the comparables were profitable and none was financially distressed. The comparables all served different populations in different markets, with other service lines and different

payor and case mixes. None were anything like 97% dependent on Medicare reimbursement. The 5th Circuit also took the IRS to task over the qualifications of its valuation expert, finding that the valuator did not possess any special knowledge of home health and failed to consider the unique Medicare reimbursement circumstances faced by these home health agencies—which made it impossible to profit from their Medicare business. In contrast, the 5th Circuit noted with approval the qualifications and conclusions of the Carraccis' valuation expert who was a recognized authority on the home health care industry and spent significant time on the ground researching the Carraccis' home health business in rural Mississippi.

c. Some Lessons from the Carracci Case.

- (1) Select a qualified appraiser with particular expertise and experience with medical group transactions.
- (2) Properly take into account third party payor methodologies and rates in determining the valuation.
- (3) To the extent that the valuation is based on a market approach, search for true comparables and rigorously analyze those comparables.
- (4) An exempt buyer should avail itself of the process under the Intermediate Sanctions regulations for the rebuttable presumption of reasonableness.

IV. HIPAA/Privacy. A seller is permitted under the HIPAA privacy regulations to share patient identifying information (protected health information or "PHI") with the buyer pursuant to a business associate agreement. See 45 C.F.R. § 160.103 (definition of business associate); 45 C.F.R. §§ 164.502(e) and 164.504(e). This is because a business associate, such as a buyer, is allowed to use PHI for "health care operations" purposes of the seller if seller is a "covered entity" for HIPAA purposes. Medical group practices are "covered entities." "Health care operations" is defined in 45 C.F.R. § 164.501 to include "Business management and general administrative operations of the entity, including, but not limited to: ... (iv) The *sale, transfer, merger, or consolidation* of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity *and due diligence related to such entity.*"

V. State Law Issues. State laws also affect the structure of purchase and merger transactions among health care providers and practitioners. These state laws include:

A. Restrictions on covenants not to compete.

B. Corporate Practice or Medicine. The corporate practice of medicine doctrine, which generally prohibits lay organizations from directly employing physicians, continues to apply in many states.

C. Licensure and Certificate of Need. Every state has licensure requirements that must be satisfied before a provider can operate, and many states continue to have certificate of need laws.

D. State Antitrust Laws.

- E. Fiduciary Duty Issues. A frequently overlooked but important aspect of a practice acquisition, particularly when a large group is being acquired, is the fiduciary duties of those in control of the seller. One fiduciary duty relates to dividing the proceeds of the sale within the group itself. Care must be used when amounts are distributed disproportionately, particularly if existing stockholder agreements do not contemplate a major transaction such as a sale, and only deal with current compensation issues. A second fiduciary duty issue relates to dividing the purchase price between two or more entities, such as a professional corporation and a real estate partnership, when the ownership arrangements of the two organizations are not identical. This latter issue may be addressed by a fairness opinion rendered by an independent appraiser or valuator.