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A Balanced Approach to Valuation of Physician Practices

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The Hospitals and Health Systems Practice Group published an article on fair market valuation issues in physician practice acquisitions in the May 2011 issue. Recognizing that there are issues on which reasonable valuators can differ in the valuation process and to benefit our membership and to further discussion, we are pleased to publish the following article, which presents another viewpoint on the topic.

Introduction—Framing the Practice Intangibles Issue

Throughout the United States, physician practice acquisition activity has increased significantly, driven largely by ongoing uncertainties resulting from healthcare reform, declining reimbursement from Medicare, and a desire by hospitals and health systems to bolster integrated delivery models and achieve greater physician alignment and integration, to enhance patient care and reduce costs. With the increase in acquisition activity, appraisers have been challenged to find a solution to a valuation conundrum where the regulatory framework for practice acquisition may seem to be contradictory to the real world considerations that drive fair market value (FMV) and the acquisition process. Recently there have been several articles written on this topic, and from these articles it is clear that even highly qualified, healthcare-focused appraisers have divergent positions on how to properly value physician practices.[1]

The central argument among appraisers regarding physician practice valuation is whether or not intangible value (i.e., value in excess of the value of tangible assets) can exist in the absence of a positive income stream that *fully* supports the intangible value. The continuum of positions on this subject include the most conservative valuation practitioners arguing "no positive income stream, no intangible value," and the most aggressive practitioners arguing that significant intangible value can, and does, exist regardless of the level of projected income (or loss) of the practice. It is our position that the correct stance lies somewhere in between, and the focus of this article is to address the deficiencies in the arguments held at either end of the spectrum, while advocating a well-reasoned middle ground.

Regulatory and Case Law Environment

As a prelude to any substantive discussion on the appropriate methodologies for physician practice valuation, we must first appreciate the underlying

regulatory environment governing appraisals in the healthcare industry. Transactions in the healthcare industry are subject to much greater restrictions than those found in other industries, and appraisers must develop their analyses in a manner that comports with these regulations. This is a result primarily of three key federal laws: (1) the Anti-Kickback Statute;[2] (2) the "Stark" Law;[3] and (3) the Internal Revenue Service doctrine regarding "private inurement" or "private benefit."[4] Each of these key laws requires compensation paid under most compliant transactions to be consistent with FMV, which is often specifically defined, and can vary depending on the particular regulation. For example, as discussed in greater detail below, the Stark definition of FMV varies from the traditional definition used in other industries. Other laws may impact healthcare transactions as well, such as the False Claims Act[5] or various state laws. Furthermore, each of the key laws above is supplemented by advisory opinions and other commentary and guidance provided by the government agencies charged with carrying out the particular laws, as well as case law interpreting the laws. For example, the Office of Inspector General (OIG) has issued guidance to hospitals stating compliant transactions with physicians will generally have compensation consistent with FMV, and when compensation is not consistent with FMV, it may be evidence of an improper inducement.[6]

Several recent federal court cases have interpreted or involved the FMV standard under the Stark Law. The facts of these cases are often complex and will not be recited here. However, the cases illustrate a few themes about how the complexities of the Stark Law have been handled. In particular, courts have stated that an arm's-length negotiation between the parties to a transaction does not, by itself, mean that compensation is consistent with FMV.[7] Further, while the complex Stark regulations have been explained by CMS in lengthy commentary and guidance provided concurrently with issuance of the regulations, courts have been mixed in their willingness to rely on CMS guidance and commentary to interpret the meaning of the regulations.[8] Finally, the government (including both OIG and the U.S. Department of Justice) has signaled that it is willing to litigate the issue of FMV when it disagrees with the parties' determination of FMV, and a few recent cases have involved testimony from competing valuation experts.[9]

The Key Definition—"Fair Market Value"

The term "fair market value" is a widely recognized and well-defined term of appraisal practice, first formally defined in the Internal Revenue Service Revenue Ruling 59-60, and further refined in the International Glossary of Business Valuation Terms published in 2001. The International Glossary definition is currently accepted by the prevailing professional organizations for business valuation including the American Society of Appraisers, National Association of Certified Valuation Analysts, American Institute of Certified Public Accountants, Institute of Business Appraisers, and the Canadian Institute of Chartered Business Valuators. The International Glossary defines fair market value as:

> [T]he 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 compulsion to buy or sell and when both have *reasonable knowledge of the relevant facts. (emphasis added)*

In the healthcare industry, fair market value is a specifically defined term in the Stark Law and regulations as follows:

> [T]he value in arm's-length transactions, consistent with the general market value. 'General market value' means the price that an asset would bring, as the result of *bona fide bargaining* between *well-informed* buyers and sellers who are *not otherwise in a position to generate business* for the other party; or the compensation that would be included in a service agreement, as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement. (emphasis added)[10]

CMS provided additional clarity with the following guidance in the commentary to the Stark II Phase II regulations, stating that, *"Moreover, the definition of 'fair market value' in the statute and regulation is qualified in ways that do not necessarily comport with the usage of the term in standard valuation techniques and methodologies."* The guidance goes on to qualify this statement with an example hinting at the possible inapplicability of a market approach, by stating, *"For example, the methodology must exclude valuations where the parties to the transactions are at arm's-length but in a position to refer to one another."*[11]

OIG has also voiced concerns regarding the proper interpretation of fair market value in healthcare, stating:

> When considering the question of fair market value, we would note that the traditional or common methods of economic valuation do not comport with the prescriptions of the anti-kickback statute. Items ordinarily considered in determining the fair market value may be expressly barred by the anti-kickback statute's prohibition against payments for referrals. *Merely because another buyer may be willing to pay a particular price is not sufficient to render the price paid to be fair market value*. The fact that a buyer in a position to benefit from referrals is willing to pay a particular price may only be a reflection of the value of the referral stream that is likely to result from the purchase.
>
> Accordingly, when attempting to assess the fair market value (as that term is used in an anti-kickback analysis) attributable to a physician's practice, *it may be necessary to exclude from consideration any amounts which reflect, facilitate or otherwise relate to the continuing treatment of the former practice's patients*. This would be because any such items only have value with respect to the on-going flow of business to the practice. It is doubtful whether this value may be paid by a party who could expect to

> benefit from referrals from that ongoing practice. Such amounts could be considered as payments for referrals. Thus, *any amount paid in excess of the fair market value of the hard assets of a physician practice would be open to question*.[12] (emphasis added)

OIG's cautionary statements on physician practice valuation are reminiscent of the famous words used by Justice Potter Stewart as he tried to explain his position on obscenity, stating "I shall not today attempt further to define the kinds of material I understand to be embraced. . . . but I know it when I see it. . . ."[13] Whereas government guidance is rarely straightforward and explicit in its intent, the Stark regulations do make clear that regulators will consider a range of methods of determining FMV, and the appropriate method will depend on the nature of the transaction.[14] Each of the concepts found in the definitions of FMV above influences the selection and application of the valuation approach(es) used by the appraiser to value a physician practice.

Overview of Business Valuation

There are three generally accepted approaches to valuing a business or business interest, which can broadly be defined as follows:

- Income Approach—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 future economic benefits into a single present amount.
- Market Approach—A general way of determining a value indication of a business, business ownership interest, security, or intangible asset using one or more methods that compare the subject to similar businesses, business ownership interests, securities, or intangible assets that have been sold.
- Asset (or Cost) Approach—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 or cost of the assets.

No single valuation approach is appropriate in all situations, and when considering the relevance of each approach in arriving at a final conclusion of value, the appraiser must consider many factors. According to Rev. Ruling 59-60, Section 3.01, *"A determination of fair market value, being a question of fact, will depend upon the circumstances in each case. No formula can be devised that will be generally applicable to the multitude of different valuation issues . . . Often, an appraiser will find wide differences of opinion as to the fair market value of a particular stock. In resolving such differences, he should maintain a reasonable attitude in recognition of the fact that valuation is not an exact science. A sound valuation will be based upon all the relevant facts, but the elements of common sense, informed judgment and reasonableness must enter into the process of weighing those facts and determining their aggregate significance."*

This is further supported by the IRS CPE Texts on Medical Practice Valuation, of which the 1996 text states the following:

> The factual assumptions upon which a valuation is based should be reviewed carefully to ensure that they are realistic, and if the valuation uses the income approach, it should be confirmed, if possible, by the cost and market approaches. Requiring that multiple approaches be used is consistent with the statement in Revenue Ruling 68-609, *supra*, that the formula [income] approach may be used for determining the fair market value of intangible assets of a business only if there is no better basis therefore available.

Though one valuation approach may be found to be more appropriate in a particular situation, advocating a single approach to the exclusion of the others is not consistent with the standards of professional appraisal practice.

Thesis—Excluding Approaches Outright is Flawed and Unnecessarily Limiting

Recent articles regarding physician practice valuation argue that the Income Approach is the *only* valid methodology in determining a practice's value and that the use of the Cost Approach has no supportable argument. This is simply incorrect. As indicated above, a competent appraiser will consider all approaches, and no one valuation approach will be appropriate in all circumstances. Professional appraisal practice is by necessity a process that requires application of financial theory combined with sound judgment and commercial reasonableness. Too often, appraisers try to focus on absolutes in an attempt to create defensible positions devoid of subjectivity. Not only does this render the appraisal process impotent, but this also undermines the economic reality of the hypothetical negotiation the appraiser is attempting to replicate under the FMV standard.

As suggested at the beginning of this article, the heart of the valuation issue for physician practices is the identification and assignment of value to intangible assets. An intangible asset is defined by the International Glossary as "nonphysical assets such as franchises, trademarks, patents, copyrights, goodwill, equities, mineral rights, securities, and contracts (as distinguished from physical assets) that grant rights and privileges and have value for the owner." We will use the term "intangible asset" as separate and distinct from "goodwill," the latter being a specific category of unidentified intangible asset that derives its existence from the surplus income above and beyond reasonable returns on identifiable assets.

According to *Valuing a Business,*[15] there are multiple characteristics that give rise to the value of an intangible asset. In this text, Dr. Pratt states, "there should be a specific bundle of legal rights (and/or other natural properties) associated with the existence of the intangible asset. For an intangible asset to have quantifiable value it should possess certain additional attributes such as:

- It should generate some measureable amount of economic income to its owner. This economic benefit may be in the form of an income increment *or a cost decrement* (emphasis added).
- It should enhance the value of other assets with which it is associated; the other assets may include tangible personal property, real estate, or other intangible assets."

It is important to note that this definition specifically draws reference to the creation of income (Income Approach) or the avoidance of cost (Cost Approach). Moreover, Pratt's text goes on to suggest that certain intangible assets lend themselves to the use of the Cost Approach, and the chapter dedicates two pages of text to the use of this approach for intangibles. According to Pratt's text, "The cost approach provides a systematic framework for estimating the value of an intangible asset based on the economic principal for substitution.

A prudent investor would pay no more for a fungible intangible than the cost that would be incurred to replace the subject with a substitute of comparable utility or functionality."[16]

From the above it should be clear that multiple characteristics may give rise to the existence of intangible value. Why then is there such disagreement among appraisers as to the existence and means by which to quantify intangible value in physician practices? In our opinion there are three primary sources of ongoing confusion:

Issue 1—Ambiguity in the Healthcare Regulations

As discussed, the regulatory environment for healthcare is highly complex, and includes provisions that may be contrary to standard valuation techniques used by appraisers. For many appraisers, the fear of regulatory risk has led to a desire for rule-based decision-making that eliminates the possibility of having their judgment impugned. Examples of rule-based decision-making include comments such as "physician practices have no value beyond tangible assets," or "the income approach is the only method to value physician practices." Regrettably, this mindset undermines the valuation process by eliminating its most important aspect—thoughtful analysis. Valuation analysis necessarily requires analytical thinking. As quoted earlier, "*No formula can be devised that will be generally applicable to the multitude of different valuation issues . . . valuation is not an exact science. A sound valuation will be based upon all the relevant facts, but the elements of common sense, informed judgment and reasonableness. . . . "*

Though OIG and other regulatory bodies warn that any value in excess of tangible assets is subject to challenge, it is unlikely that there will come a time where the valuation methods used by an appraiser will be prescribed in a one-dimensional framework. Until further clarification is given, it is important that appraisers continue to explore multiple approaches and support each with legitimate and reasonable assumptions.

Issue 2—Despite Contrary Claims, IRS CPE Texts Clearly Contemplate Use of the Cost Approach

Among the guidance relied upon by healthcare focused appraisers is the IRS CPE texts, which addressed the issue of FMV from the IRS perspective. We agree that these texts contain informative guidance for the valuation of physician practices, but care should be used to consider these texts holistically, including their context, time period, and purpose. Unfortunately, some appraisers in the healthcare industry have selectively used these texts to support their narrow views on valuation. A summary of guidance found in these texts is listed below:

- "Under the Service's current published rulings, the FMV of the assembled assets that comprise an entity as a going concern may include the value of the entity's intangible assets. Intangible assets include medical records, covenants not to compete, HMO contracts, other contracts, trademarks and trade names, and goodwill."
- "In general FMV is determined within the framework of the business enterprise's *worth to the most likely hypothetical purchaser, which in this situation, is assumed to be a commercial health care corporation." (emphasis added)*
- The IRS requests that "the valuation provide all recognized approaches for estimating value, including the income approach, market approach and cost approach."
- The IRS found the discounted cash flow (DCF) method to be the most relevant approach to valuing the transfer of operating assets to an applicant, but cautioned that when using the DCF "the analysis must be based on reasonable assumptions as to the amount and time of the cash flows and must use a reasonable discount rate. In any event, the results of the cash flow approach should be tested against other methods such as price-to-earnings and price-to-book value methods."[17]
- "The last method for estimating value, the cost approach, measures value by determining the cost to replace or reproduce and asset, less an allowance for physical deterioration or obsolescence. . . Intangible assets, if any, are typically not valued under this method *unless their value can be estimated reasonably*. However, *the cost approach can be used as a valuation method for computer software, patient records and files, and assembled workforce.*"[18]
- "A well trained, organized and efficient work force is a valuable asset in any business." The use of the cost approach is based on the premise that for a potential buyer to re-create the particular practice it has to hire and train a similar work force.
- "The concept of an integrated delivery system, and the Service's understanding of it, *is evolving*. Therefore, each future case will bring the Service greater sophistication and, with it, a better understanding of the tax and non-tax issues involved."

A key take-away from the above is that the IRS recognized that its position on practice valuation was *evolving*, and appraisers should be open to the reality that such an evolution is continuing to this day. Whereas these texts remain informative fifteen years later, appraisers must also consider the vast body of knowledge that has been created since their publication. It should also be clear from the above that the IRS recognized that all three valuation methodologies should be explored and considered in the valuation of a physician practice. There is no "one size fits all" in valuation. Moreover, the IRS gives specific reference and credence to the idea that intangible assets such as workforce-in-place may be valued under the Cost Approach, which will be explored further below.

Issue 3—Lack of Understanding of Financial Theory and Misapplication of Valuation Principles

We have seen several opinions from experienced appraisers indicating a very narrow understanding of the real world drivers of FMV and the financial theory used to support valuation models. The following is a discussion of some of the more salient opinions and the counter arguments to each.

Income Approach for Physician Practices

As described earlier, the Income Approach estimates value by drawing reference to the future economic benefits expected to be generated by the business. This is typically accomplished through the use of a DCF model that projects the earnings of the business over a discrete period, frequently five years, then discounts these cash flows to present value at a risk-adjusted rate of return. Though an examination of the financial theory behind this approach is beyond the scope of this article, there are essentially two key elements in the DCF model: (1) the projected cash flow; and (2) the rate of return used to discount the cash flow to present value. As with all valuation methods, these two core components are subject to significant manipulation by appraisers, and small changes in underlying assumptions can result in material changes in the indicated value. The IRS recognized the ease of manipulation of cash flow assumptions and discount rates by the appraiser in the CPE texts, specifically cautioning that "the analysis must be based on reasonable assumptions as to the amount and time of the cash flows and must use a reasonable discount rate . . . In any event, the results of the cash flow approach should be tested against other methods such as price-to-earnings and price-to-book value methods."[19]

One position being advocated currently is that a physician practice can only have intangible value if there is a supportive level of positive cash flow (i.e., value determined using a discounted cash flow model). The authors do not agree with this position, largely due to the fact that this is an oversimplification of valuation theory and incongruent with the actual financial model observed for physician practices.

The primary challenge in applying the Income Approach to physician practices is the business model and mechanism for physician earnings. Most independent physician practices pay 100% of the available profit (i.e., cash flow) to their owners in the form of compensation including salaries, benefits, bonuses, and/or distributions.[20] When valuing a physician practice, post-acquisition compensation must be accounted for in the valuation model. Accordingly, there are only three mechanisms by which a practice using this business model will generate sufficient future profit to support a value under the Income Approach:

- The model assumes the physicians take a pay cut, and the reduction in pay creates a profit;
- The model assumes the physicians take a pay freeze, and the business will achieve growth and attain cost efficiencies that will result in a profit; or
- The model assumes the practice's ancillaries are carved out and valued separately, and the resulting loss associated with the professional practice is "ignored."

Each of these three mechanisms has questionable economic reality and is subject to manipulation on the part of the appraiser. From a practical standpoint, advocating the Income Approach as the only means to value a physician practice is tantamount to saying that physician practices have no value beyond tangible assets. Though this may be true in some cases, especially for smaller practices, it is difficult to argue that larger physician groups have no value beyond their furniture and equipment.

One of the arguments advanced by the "DCF only" appraisers is that no rational investor would pay for an asset that generates no income. This is an oversimplification, and a more correct position would be that no investor would pay for an asset that generates no *economic benefit*. As previously mentioned, this economic benefit may be in the form of income *or* a cost decrement. Mathematically, the avoidance of a loss is equally as valuable as the attainment of income in the same magnitude, and would result in the same value under an income approach. In many cases the value of a physician practice may not stem from the income it generates, but the losses that might otherwise be avoided by a purchaser looking to start or expand a physician practice. There are also valid and commercially reasonable non-financial motivations for these acquisitions, which include community need, anticipated physician shortages, development of an Accountable Care Organization, etc.

Though a legitimate expectation of positive cash flow would certainly support intangible value, there are at least as many arguments against using the DCF method/Income Approach for physician practice valuation as there are for it. And while we are not aware of any regulatory guidance specifically mandating the use of the Income Approach to value practices, we are aware of regulatory guidance cautioning against the use of the DCF method in certain settings, as mentioned previously.[21] By advocating the use of DCF only, one argues that other methods for valuation are either inapplicable, overly risky, and/or in violation of regulatory guidance. This is simply not correct.

Asset (or Cost) Approach Generally

The Asset or Cost Approach is recognized as a valid and appropriate methodology for physician practice valuation in the 1996 IRS CPE text, which explains that the concept behind this approach is that a purchaser has the immediate use of an accumulation of assets that allows the purchaser the ability to walk into a business and operate it immediately. This text specifically details the use of the Cost Approach to value assembled workforce, stating, "*A well trained, organized, and efficient work force is a valuable asset in any business . . . The use of the cost approach is based on the premise that for a potential buyer to re-create the particular practice it has to hire and train a similar workforce; that hiring/training process has identifiable costs—for recruitment, orientation, training and lost salary—that form the basis of the valuation process.*" The text continues, "*Medical Practices have going concern value.*

The buyer of an existing practice purchases a turnkey operation and receives immediate value from the assembled workforce and other assets needed to operate the business." The authors agree.

Appraisers frequently identify and value intangible assets in physician practices. These include, among others, workforce-in-place, trade names, and patient charts. It has been argued that there is a continuum of risk as it pertains to these intangible assets, with the most "risky" intangible asset in a physician practice being the workforce.[22] We believe this is contrary to logic and reality, and in fact, the physician workforce is often the most valuable asset of a practice and the most difficult to replace or recreate. Because a discussion of the application and risks of valuation methodologies to each of the intangible assets listed above is beyond the scope of this article, the authors will focus on the specific issue as it applies to the asset of workforce-in-place.

Workforce-in-Place

A well trained, organized, and efficient workforce is a valuable asset in any business. This is particularly true for service-centric businesses, such as physician practices, where the vast majority of value is derived from human capital. Assignment of value to the workforce-in-place is not a violation of the concepts of FMV, commercial reasonableness, or valuation theory, and as previously demonstrated the IRS CPE text makes specific reference to the value of this asset and suggests the Cost Approach is the preferred method for its appraisal. Though proponents of the "DCF only" approach rightfully disclaim that workforce may have no value "when no legal right exists," this is rarely the case in physician practice acquisitions. Regrettably, the article offers no valuation technique for the scenarios where legal rights do in fact exist. The authors agree that in order for the workforce to have assignable value, it must be secured by a valid legal or contractual right. This is nearly always the case in physician practice acquisitions where the employment contracts signed by the physicians include non-competition, non-solicitation, and/or claw-back clauses, among other rights. As described further below, it is our position that the value of the workforce-in-place is tantamount to ascribing value to those key protections found in the physicians' post-transaction employment contracts. Like the other intangible assets described above, the value associated with the workforce-in-place may already be manifest in physician compensation in some instances. We will explore that concept further in the next section.

In the estimation of the FMV of workforce-in-place, a valuator can draw reference to current wages and benefits, third-party recruiting surveys, and discussions with the subject physician practice and potential buyer (most often a hospital or health system) regarding historical hiring and training practices. Consideration can be given to the historical turnover and retention rates experienced at the subject physician practice, as well as the potential for ongoing turnover due to the age of the individual. We believe that the conceptual framework for assigning value to the workforce-in-place is equally valid and appropriate for both physician and non-physician staff.

Adding up the items discussed above results in the unadjusted value of each physician member of a particular workforce-in-place. In order to arrive at the FMV of the workforce, various adjustment factors can be applied to account for historical turnover rates, excess staffing, proximity to retirement, and other obsolescence factors that may reduce the unadjusted values. Like the DCF Method, care must be used to ensure that the assumptions underlying the cost approach are reasonable and consistent with the FMV standard. When properly applied, the assignment of value to workforce-in-place is a valid and defensible approach for physician practices.

Compensation Offset

A challenge with applying the Cost Approach to physician practices is that, unlike the Income Approach, the Cost Approach does not have a direct mechanism by which to account for post-acquisition compensation of the physicians. Generally, the post-acquisition compensation for physicians must be accounted for in the business value. This was affirmed in *Derby v. Commissioner,*[23] where the Tax Court concluded that the "intangible assets functioned as leverage in the negotiations and that their transfer resulted in an increase in the total [compensation] received in the transaction." In simpler terms, the same economic benefit cannot be manifest in both purchase price and post-acquisition compensation.

Under the Income Approach, increases in post-acquisition compensation can be incorporated into the projection model directly, which will translate into a reduction in forecasted profits for the business and hence, a reduction of value under this approach. The Cost Approach is unaffected by these changes. Because the Cost Approach does not specifically account for these changes, increases in compensation must be accounted for through a supplemental calculation.

To determine the compensation offset, the difference in the historical compensation and the proposed compensation is determined over the initial employment period, typically three to five years. The sum of this increase in compensation, adjusted for present value as appropriate, is then offset against the intangible value previously determined. In some instances the post-acquisition compensation is sufficient to eliminate all of the intangible value that might otherwise be paid, in which case only the value of the tangible assets will be paid.

Concluding Remarks

In summary, the authors advocate the following position on practice valuation:

- The appraiser should consider all three approaches to valuation in each assignment. There are usually few, if any, comparable market transactions and therefore, reliance can be placed on the Income and Cost Approaches to valuation in forming conclusions.
- When applying the DCF method, no consideration should be given to any of the synergistic benefits to the buyer such as provider based billing, shared overhead, etc. However, the organic opportunities that exist for the practice in the absence of a transaction such as expected growth, cost containment, etc. can be considered.

- When applying a Cost Approach, value should be assigned only to the intangible assets that stem from a legal or contractual right, or that could be separated from the business. When assigning values to these assets, care must be taken to support each value with a thorough investigation into the actual existence of the asset. For example, there is no value to a covenant not to compete if no such covenant was executed, etc. It is our belief that for physician practices, the value of the physician non-compete is equal to the value of the physician workforce-in-place. Though an Income Approach is commonly used to value non-competes outside of healthcare, this method can only be performed by drawing direct reference to the patient volumes that would be lost in the absence of the covenant. The authors believe this presents a potential violation of the prohibition on payment for referrals.[24] Absent consideration of lost referrals under an income approach, the value secured by the covenant is appropriately measured by the continued and secured employment of the physicians (i.e., the workforce value).
- Post-acquisition compensation *must* be considered in the valuation regardless of the approach used to value the practice. However, as described above, it may be more appropriate to account for changes in compensation as a separate calculation as opposed to building it directly into the DCF model. Most employment contracts are for a period of two to five years, and building a change in compensation into the DCF model necessarily assumes that the initial employment contract rate/terms will continue into perpetuity. This does not comport with economic reality and may unduly penalize value under an Income Approach. Our suggestion is to hold compensation at current levels for the physicians in the DCF (oftentimes measured as a rate per work relative value unit). To the extent the compensation rate is increased post-acquisition, the intangible value of the practice should be reduced accordingly, whether such intangible value is found under a Cost or Market Approach.

Over the coming months, there is likely to be continued discussion and debate regarding the correct methodologies for valuing physician practices. While multiple opinions regarding valuation will be advocated by appraisers, attorneys, physicians, and buyers, the authors believe the most defensible position is a *balanced position*. What should be obvious for this article and others is that most physician practices do have value, and a supportable position will be one that is based on sound logic, informed judgment, and the economic realities of the current marketplace.

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1 *See White Paper: Assessing Intangible Value in a Physician Practice Acquisition*, Mark O. Dietrich, Gregory D. Anderson, Carol Carden, J. Gregory Endicott, W. James Lloyd, Todd Sorensen, Reed Tinsley, and Kathie L. Wilson, published in the *Hospital & Health Systems Rx* Newsletter, (AHLA, May 2011). Contrast with: *Valuing Physician Medical Practices*, Douglas R. Ayres, Stephen J. Diagostino, and Thomas J. Thieme, published in *Valuation Strategies* (May/June 2011), and *The Cost Approach to Fair Market Value—and the Inclusion of Intagible Assets—for Physician Practices*, Kameron H. McQuay, published in *The Value Examiner* (July/August 2011).

2 42 U.S.C. § 1320a-7b(b).

3 42 U.S.C. § 1395nn.

4 *See Treas*. Reg. 53.4958 *et seq.*

5 31 U.S.C. §§ 3729-3733.

6 *See* "OIG Supplement Compliance Program Guidance for Hospitals" 70 Fed. Reg. 4858, at 4866 (January 31, 2005).

7 *U.S. ex rel. Kosenske v. Carlisle HMA, Inc.*, 554 F.3d 88 (3d Cir. 2009).

8 Contrast the *Kosenske* case, where the court cited and relied on the CMS commentary to the regulations, with *U.S. ex rel. Singh v. Bradford Regional Medical Center*, No. 04-186 (W.D. Pa. Nov. 10, 2010), where the commentary was ignored by the court, and the trial in *U.S. ex rel. Drakeford v. Tuomey Healthcare System, Inc.*, No. 3:05-CV-02858-MJP, (S.C.), where arguments concerning the CMS commentary made in support of a summary judgment motion were apparently rejected by the trial court.

9 Both the *Tuomey* and *Bradford* cases (cited above) have involved the use of competing valuation experts on opposite side of the case.

10 42 CFR § 411.351.

11 69 Fed. Reg. at 16107 (March 26, 2004).

12 Excerpt from Letter from D. McCarty Thornton (Associate General Counsel, Inspector General Division) to T.J. Sullivan (Office of the Associate Chief Counsel, IRS) dated December 22, 1992.

13 *Jacobellis v. Ohio*, 378 U.S. 184, 197 (1964).

14 69 Fed. Reg. at 16107 (March 26, 2004), referring to original discussion at 66 Fed. Reg. at 944 (January 4, 2001).

15 Pratt, Valuing a Business: The Analysis and Appraisal of Closely Held Companies, Fifth Edition (New York, McGraw-Hill, 2008), pg. 366.

16 *Id.*, page 369.

17 We note that "price-to-earnings" and "price-to-book" are not recognized valuation methods.

18 *See* Gordon V. Smith and Russell L. Parr, Valuation of Intellectual Property and Intangible assets, p. 232 (1989).

19 As referenced above, price-to-earnings and price-to-book are not recognized valuation methods, but may be categorized as variations of the Market Approach.

20 The mechanism for payment is frequently dictated by the organizational structure and tax implications.

21 *See* OIG Advisory Opinion 09-09, where OIG stated that its "conclusion might be different if the valuation of the respective contributions of the investors included intangible assets" and that it "might be concerned if the valuation were based on a cash flow analysis of the [entity] as a going concern."

22 Mark O. Dietrich, et al. *Assessing Intangible Value in a Physician Practice Acquisition*, February 2011, page 3.

23 Derby v. Commissioner, T.C. Memo. 2008-45.

24 *See* for example, *U.S. ex rel. Singh v. Bradford Regional Medical Center*, No. 04-186 (W.D. Pa. Nov. 10, 2010), which states: "There really is no dispute that the amount of the non-compete payments was arrived at by considering the amount of business [Bradford] would receive from the doctors. Although Defendants do not explicitly state that they 'took into account' the anticipated referrals from [the doctors] in arriving at the non-compete amount, a review of their briefs shows that Defendants implicitly concede that the value of the doctors' anticipated referrals was a part of the negotiations."

Hospital-Physician Relationships in the Post-Reform World: Does One Size Fit All?

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Introduction

Integrated delivery systems widely used in the 1990s were primarily developed to foster managed care contracting positions of institutional and physician providers. Organizations such as physician-hospital organizations and independent practice associations were developed in hopes of gaining advantage in contract negotiations. Some effort was made to show that such organizations and affiliations achieved some level of clinical and/or financial integration to pass antitrust scrutiny from the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ). However, with passage of the Patient Protection and Affordable Care Act (ACA),[1] new models of integration will be required to focus primarily on enhanced coordination of care across the full continuum (primary care, acute care, long term care, and palliative care) to improve the quality of care and patient outcomes while at the same time controlling the cost of healthcare. This article reviews some of the pilot programs contemplated by the ACA and models currently being used and developed by providers and payors to secure long-lasting relationships that are mutually beneficial and designed to achieve the objectives of coordination of care, improved quality, and reduced costs.

Section 3021 of ACA states that selection of innovative payment and service delivery models should "give deference to models that also improve the coordination, quality, and efficiency of health care services." While previous integration strategies were mostly defensive aimed at maintaining or expanding market shares, new integration strategies can create value for high-performing provider organizations by responding to patients and payors who are demanding accountability and demonstrated results. The ACA contains many pilot projects, such as accountable care organizations (ACOs), patient-centered medical homes, bundled payment programs, and gainsharing arrangements. In addition, providers continue to utilize more traditional forms of integration, such as physician employment, physician practice subsidiaries, and co-management agreements.

The Medicare Shared Savings Program and Other CMS Initiatives

ACOs typically involve a core group of medical and institutional providers and suppliers that accept responsibility for providing or arranging care for a defined group of patients under a payment arrangement that allows net profits payments to participants for achieving reduced costs and improved or enhanced quality of care. Section 3022 of ACA required the U.S. Department of Health and Human Services (HHS) to establish by January 1, 2012, the Medicare Shared Savings Program. On April 7, 2011, the Centers for Medicare & Medicaid Services (CMS) released draft regulations related to the Shared Savings Program.[2] These regulations were intended to provide the framework for an accountable care model whereby providers would take on some of the responsibility, and receive some of the reward, for reducing Medicare costs for defined populations. The Shared Savings Program was designed to provide: (1) a mechanism for the delivery of integrated and coordinated care by providers and suppliers, (2) measurable improvements in quality of care, (3) lower costs to the Medicare program, and (4) performance incentives to achieve the stated goals.

The Shared Savings Program is intended to incentivize providers, organized into ACOs, consisting of primary care physicians, specialists, and other healthcare providers and suppliers, with reducing overall Medicare costs incurred by patients who have been assigned to the ACO. If the ACO is successful in reducing costs, Medicare would share a percentage of the savings with the ACO. If Medicare costs for patients assigned to the ACO increased, however, the ACO could be responsible for a portion of the increased costs.

Reaction to the draft regulations was strongly negative. Industry groups generally believed the draft regulations placed too much risk on the ACOs, without giving them the tools they would need to ensure they could actually reduce costs. Additionally, potential participants felt the cost of starting up an ACO outweighed any potential gain that could be realized by participating in the program. High-profile healthcare institutions like the Cleveland Clinic, Mayo Clinic, Intermountain Healthcare, and Geisinger Health System, thought to be the model for the ACA's ACO demonstration project, indicated they had so many concerns about the draft regulations that they doubt they would participate.[3] In addition, provider groups such as the American Hospital Association, American Medical Association, and the Medical Group Management Association weighed in with detailed comments and concerns about the draft regulations.

On October 20, 2011, CMS issued an interim final rule concerning the Medicare Shared Savings Program.[4] At the same time, CMS and the HHS Office of Inspector General issued a series of waivers from the fraud and abuse laws,[5] and the FTC and DOJ issued revised antitrust guidance concerning ACOs.[6] The Center for Medicare and Medicaid Innovation (CMMI) also announced the testing of an "Advance Payment ACO Model," which is designed to provide selected participants with advance payments to invest in infrastructure necessary for ACO operations.[7] CMS will recoup the advance payments from the shared savings generated by the ACO.

The agencies sought to address stakeholder concerns and provide a flexible approach to accountable care, foster a better understanding of the requirements for participation, and indicate how enforcement agencies will view ACO activities in governmental

and commercial programs. The preamble to the interim final rule also describes the options that commenters suggested and should be instructive to other types of accountable care programs.

Previously, on May 17, 2011, CMS announced the Pioneer ACO Program.[8] The Pioneer ACO is an initiative out of CMMI, and it differs significantly from the Shared Savings Program under Section 3022 of ACA. Pioneer ACOs must have at least 50% of their total revenues derived from outcomes-based contracts and sufficient primary care physicians to assign at least 15,000 beneficiaries (not including beneficiaries aligned through specialists). The core payment arrangement is based on escalating shared savings and losses and a transition to population-based (i.e., capitated) payment in the third year (50% fee for service plus monthly payment of ACO's projected fee for service revenue as a per-member per-month payment). The Pioneer performance metrics will be the same as those contained in the *final* Shared Savings Program regulation (where CMS substantially simplified the quality metrics).

CMS also recently released information concerning the Bundled Payments for Care Improvement Initiative (Bundled Payment Initiative).[9] Section 3023 of ACA authorized the Bundled Payment Initiative. On August 23, 2011, CMS released requests for applications to participate in the Bundled Payment Initiative. The Bundled Payment Initiative provides four different payment models that providers will test and develop. CMS hopes to design a new payment system based on services delivered across an episode of care to replace the current system of separate fee-for-service payments. The goal of the Bundled Payment Initiative is to increase efficiency, improve quality of care, and lower costs through the coordination of care across settings. There are three retrospective models, under which providers would be paid under a Medicare fee-for-service system, but at a discounted price, and one prospective model. A provider would use historical data to establish a target price for an episode of care (such as cardiac bypass surgery). If total payments are less than the target, the provider would be eligible to share in the savings. There are different models for an inpatient stay, an inpatient stay and post-acute care for a minimum number of days following discharge, and a period of time beginning with discharge and ending no later than thirty days after discharge.

The Development of Commercial ACOs

Negative initial reaction aside, some of the elements of the Medicare Shared Savings Program are likely here to stay. Both Medicare and commercial insurers are continuing to look for ways to control costs and are looking to providers to partner with them in meeting those goals. Commercial insurers already have begun to implement ACO-like programs in some of the nation's largest markets. One recent trend is for commercial insurers to seek to set up ACO-like relationships with hospitals and health systems and physician groups. As more and more insurers move to this model, hospitals and physician groups that are not prepared may find themselves at a competitive disadvantage. These models, like the Medicare Shared Savings Program, will require providers to monitor and report quality data and control costs. Physician integration and buy-in to the goals and objectives of these programs are critical to successful implementation of commercial ACOs.

Commercial ACO programs are designed to increase access to quality patient care, provide better care coordination, and lower medical costs. Examples of performance goals include reducing readmission rates and unnecessary emergency room visits. In some cases, a team of clinical care coordinators and health coaches manage the ACO pilot programs, and these positions are often funded by the payor. The success of the ACO is dependent on information, clinical collaboration, and consultation. CIGNA has developed a Collaborative Accountable Care Model that involves a large primary care physician group, a multi-specialty group, and an integrated delivery system or physician-hospital organization. There are rewards for improving quality, cost efficiency, and patient experience and ensuring that care is delivered in the right setting.[10]

Related to the ACO model is the Patient Centered Medical Home (PCMH). ACOs and PCMHs are not necessarily competing models and could merge into a single model over time. PCMHs are the primary means by which patients are placed into the delivery system. They ensure a conscious and comprehensive series-of-care encounters that are coordinated by a team of primary care providers.

The National Committee for Quality Assurance has established a program to recognize PCMHs that meet its standards.[11] These standards describe clear and specific criteria about organizing care around patients, working in teams, and tracking care over time. The PCMH is designed to operate much like a gatekeeper with the goal of structured, proactive, and coordinated care rather than episodic treatments for illnesses by paying for not just face-to-face encounters but also consultations and administrative services required to coordinate care.

Because of this continued industry trend, it is important for hospitals, health systems, and other interested providers to consider how these trends will affect their businesses. Going a step further, many providers have begun to take steps to position themselves to be able to react to any future changes, both to the Medicare system of payment and to the increasing demands of commercial insurers to participate in ACO-like reimbursement models. Nearly any model will require greater cooperation and closer integration between hospitals and physicians. Hospitals and health systems that have begun to better integrate with their physicians will undoubtedly be better positioned to adapt and respond to changing market pressures.

Physician Integration Models for Achieving the Goals of Accountable Care

There is no one-size-fits-all model for the physician integration needed to accomplish the goals of accountable care. Any physician integration model must be tailored to the culture, goals, and market in which a particular hospital and its medical staff operate. Market conditions and the structure and independence of the physician community will be key considerations in selecting the model of integration best suited to accomplish the stated goals. Just because one model works for one system does not mean that it will work for all systems.

Direct Employment

Direct employment of physicians is the most common model of hospital-physician integration. The upside of employment is that it allows a lot of flexibility to the physician and the hospital in structuring the relationship (such as compensation) and gives the hospital or health system a high-degree of control over the relationship. It also allows for the hospital to subsidize the practice of a physician or a specialist that the community otherwise might not be able to support. The major downsides to employment are that it does not allow physicians to share in ancillary revenue and it removes control of the day-to-day operations of the physician's practice from the physicians. The traditional independence enjoyed by physicians can make it difficult for employment to spur true engagement. Physicians have been trained to be individual leaders and they come to meetings as leaders and not participants. Physicians and hospital administrators also solve problems in different ways. Hospital administrators are accustomed to taking data and using it to come up with alternatives. To address these issues, goals and objectives for the relationship must be stated clearly upfront.

Group Practice Subsidiaries

One alternative to direct employment are so-called group practice subsidiaries or hospital-operated group practices. The benefits of these organizations is that they operate almost like self-contained group practices, and allow the physicians practicing in them to maintain some control over their practices, while providing the physicians with the benefits of being closely affiliated with a hospital or health system. These entities can be set up to incorporate several groups or different specialties, and allow the physicians, with some limitations, to generally structure their compensation relationships among each other as they choose and to have input in other key decisions. These organizations often are governed by a board of directors with both hospital and physician representation.

Physician Co-Management

Another alternative form of integration is physician co-management. A contractual relationship is created whereby the physician or physicians group is compensated for various administrative and management services provided to the hospital, typically involving a particular service line such as cardiology or orthopedics. Regardless of form, these arrangements are intended to increase the physician's connection to the hospital and align the physician and the hospital's interests by providing leadership of a program through development and enforcement of clinical guidelines and teaching of other physicians and support staff. Physician leadership is key to clinical performance improvement.

Development of Health Information Technology Infrastructure

Before any system of providers is ready to travel down the road to accountable care, it must invest in the information technology infrastructure needed to provide detailed cost and quality data. To meaningfully implement an ACO-like model, the hospital or health system must be able to track and control cost and quality data. Many ACA provisions emphasize the importance of health information technology and the reporting of achievements in quality and clinical and cost effectiveness of various initiatives and strategies. For example, HHS is authorized to incorporate into the existing Physician Quality Reporting Initiative reporting and incentive payments related to electronic prescribing and meaningful use of electronic health records. HHS also is directed to develop a national strategy for the improvement of care, including the use of data to improve quality, efficiency, transparency, and outcomes, and the improvement of research and dissemination of "best practices" to improve patient safety and reduce medical errors, preventable readmissions, and healthcare-associated infections.

Legal Impediments to Hospital-Physician Integration

The Stark Law

The Stark Law prohibits a physician from referring a Medicare patient for certain "designated health services" to an entity with which the physician, or a member of the physician's immediate family, has a financial relationship unless an exception applies.[12] A financial relationship includes an ownership interest or a compensation arrangement. The Stark Law and regulations promulgated pursuant to the Stark Law contain a number of exceptions, such as bona fide employment relationships and personal services agreements. These exceptions contain many elements and requirements that can be difficult to meet and therefore do not provide a great deal of latitude in the ways hospitals can compensate physicians. There appears to be tension between the government's encouragement of pay-for-performance initiatives and the Stark Law's direct prohibition on payments based on the volume or value of referrals.

In the preamble to the Stark II Phase III regulations, CMS stated that payments based on preventative care or quality measures or other quality measures could pass muster under the personal services agreement exception. Of course the payments must be at fair market value and meet the other requirements of the relevant Stark exception. With respect to pay-for-performance or other incentive payments that relate to cost or volume of services, the options are more limited. Pay-for-performance or other incentives may be permissible if paid to employed physicians or through use of the "shared risk" exception, but great care should be paid to the regulatory requirements when structuring such payments.

Federal Anti-Kickback Statute

The federal Anti-Kickback Statute prohibits the knowing and willful solicitation, offer, payment, or acceptance of any remuneration for referring an individual for a service or item covered by a federal healthcare program or purchasing, leasing, ordering, or arranging for or recommending the purchase, lease, or order of any good, facility, service, or other item reimbursable under a federal healthcare program.[13] The Anti-Kickback Statute is an intent-based statute, and the courts have struggled to define the correct standard of intent. Some courts have adopted the restric-

tive "one purpose" test, which provides that if one purpose of the payment is to induce referrals, the statute is violated, notwithstanding other legitimate bases for the payment.[14]

The Anti-Kickback Statute contains a statutory exception for payments made to bona fide employees and a "safe harbor" also has been adopted for employees. Amounts paid to bona fide employees do not constitute "remuneration" and therefore do not constitute a violation of the Anti-Kickback Statute. OIG has suggested that payments in excess of fair market value to employees will not be protected by the safe harbor.

The Civil Money Penalties Law

In 1986, Congress enacted the Civil Money Penalties Law (CMP Law) as part of the Social Security Act.[15] Under the CMP Law, it is illegal for a hospital to make a payment to a physician "as an inducement to reduce or limit services provided with respect to individuals who are entitled to Medicare and Medicaid benefits and who are under the care of the physician." Under the CMP Law, both the hospital and the physician are subject to penalties under such circumstances.

In 1999, OIG issued a Special Advisory Bulletin outlining its concerns with "gainsharing programs." Gainsharing typically refers to a program in which a hospital gives a physician a share of any reduction in the hospital's costs attributable in part to the physician's efforts. OIG stated that such programs violate the CMP Law.

In subsequent advisory opinions, OIG has somewhat relented from the position announced in the Special Advisory Bulletin, but the opinions may not be relied upon by other parties and gainsharing programs still risk violation of the CMP Law.

Fraud and Abuse Waivers

ACA authorized the HHS Secretary to waive the fraud and abuse laws as necessary for the implementation of ACOs. On October 20, 2011, CMS and OIG issued guidance that included five specific waivers: (1) a pre-participation waiver; (2) a participation waiver; (3) a patient incentive waiver; (4) a shared savings distribution waiver; and (5) a compliance under the Stark Law waiver. The waivers apply only to the Shared Savings Program and participating ACOs. The waivers are self-implementing, and no application is required. The waivers are more flexible than anticipated and provide opportunity for creative arrangements. The waivers apply only to the Stark Law, Anti-Kickback Statute, and the CMP Law, and do not, for example, apply to the Internal Revenue Code or the antitrust laws.

Antitrust Issues

DOJ and FTC issued a proposed Antitrust Policy Statement applying to collaborations (not including mergers) among otherwise-independent providers that seek to participate in the Shared Savings Program.[16] The proposed Policy Statement describes a "safety zone" for certain providers that participate in the Shared Savings Program. To fall within the safety zone, independent ACO participants that provide a common service must have a combined share of 30% or less for each common service in each participant's primary service area, whenever two or more participants provide that service to patients from the primary service area.

The revised Antitrust Policy Statement issued on October 28, 2011, eliminated the requirement that an ACO participant that has a share of 50% or more for any common service that two or more participants provide in the same primary service area must obtain a letter from one of the antitrust enforcement agencies advising the reviewing agency has no present intent to challenge or recommend challenging the ACO. The revised Antitrust Policy Statement also provides that rule-of-reason analysis will be provided to ACOs that meet CMS eligibility requirements. The eligibility requirements are sufficient to support a finding of adequate clinical integration such that joint negotiation of prices with a commercial plan would not constitute unlawful price-fixing.

Conclusion

ACA and the current market for healthcare services, coupled with economic pressures associated with ever-rising healthcare costs, have forced providers and payors to evaluate different models for the delivery of care. The days of sole reliance on fee-for-service appear to be gone, and the focus is turning to payment for care based on quality, efficiency, and outcomes. To succeed in this environment, hospitals and physicians must be able to align their interests and provide coordinated care focused on quality and transparency.

Numerous strategies are available to providers prepared to work together to secure these goals. However, it remains incumbent on Congress and the regulatory agencies to remove the regulatory barriers to achieving the goals of accountable care: delivering care that is integrated and patient-focused.

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1 Pub. L. No. 111-148, 124 Stat. 119 (2010).
2 76 Fed. Reg. 19528-19654 (Apr. 7, 2011).
3 Model ACO Health Centers Skeptical of Proposed Rule, The Commonwealth Fund, May 6, 2011, *available at* www.commonwealthfund.org.
4 76 Fed. Reg. 67802-67990 (Nov. 2, 2011).
5 76 Fed. Reg. 67992-68010 (Nov. 2, 2011).
6 76 Fed. Reg. 67026-67032 (Oct. 28, 2011).
7 76 Fed. Reg. 68012 (Nov. 2, 2011).
8 Center for Medicare & Medicaid Innovation, Pioneer ACO Model, *available at* http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco/.
9 Center for Medicare and Medicaid Innovation, Bundled Payments for Care Improvement, *available at* http://innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html.
10 Collaborative Accountable Care: CIGNA's Approach to Accountable Care Organizations, *available at* http://newsroom.cigna.com/knowledgecenter/aco.
11 *See* National Committee for Quality Assurance, Guidelines: Physician Practice Connections. Patient Centered Medical Home, *available at* www.ncqa.org.
12 42 U.S.C. § 1395nn.
13 42 U.S.C. § 1320a-7b(b). A kickback violation may also serve as a basis for liability under the federal False Claims Act.
14 *See United States v. Katz*, 871 F.2d 105 (9th Cir. 1989); *United States v. Greben*, 760 F.2d 668 (3d Cir.), *cert. denied* 474 U.S. 988 (1985).
15 42 U.S.C. § 1320a-7a(a).
16 76 Fed. Reg. 21894-21902 (Apr. 19, 2011).

The Incremental Transition Toward Accountable Care: The Bundled Payments for Care Improvement Initiative

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On August 23, 2011, the Centers for Medicare & Medicaid Services (CMS) announced the Bundled Payments for Care Improvement Initiative (Initiative) as the latest in a series of efforts authorized by the Patient Protection and Affordable Care Act to improve health and the quality of care and lower costs.[1] Under the Initiative, hospitals, physicians, and other providers will be eligible to enter into agreements with Medicare through which they will receive a single negotiated payment for services provided during an episode of care. By bundling payments for all of the discrete services furnished during an episode into a predetermined lump sum, the Initiative is designed to align the incentives of those involved in the patient's care and thereby improve the quality and efficiency of care. The Initiative is being administered by the Center for Medicare and Medicaid Innovation (Innovation Center); deadlines for applying to participate in the program are fast approaching, and in the case of one, have already passed.[2]

Prior Bundled Payment Projects

While the Initiative represents an entirely new effort to improve care through bundled payment, it draws on the experience gained in prior Medicare demonstration projects. Specifically, the Initiative is informed by three bundled payment demonstrations: the Medicare Participating Heart Bypass Center demonstration, Medicare Cataract Surgery Alternate Payment demonstration, and the Medicare Acute Care Episode (ACE) demonstration.[3] The Participating Heart Bypass Center demonstration yielded savings for Medicare and resulted in cost efficiencies for participating providers without decreasing the quality of patient care. Although comparatively small in terms of provider participation, the Cataract Surgery Alternate Payment demonstration provided insight into the use of bundled payments for high-volume services and also yielded savings for Medicare. While the ACE demonstration is still in progress, preliminary results indicate that both participating providers and Medicare have realized savings by arrangements through which CMS and participating providers agree to a particular discount for cardiac and/or orthopedic inpatient procedure hospitalizations.

The Initiative's Request for Application (RFA) also cites two gainsharing demonstrations as providing theoretical support: the Physician Hospital Collaboration demonstration and the 2005 Deficit Reduction Act Medicare Gainsharing demonstration.[4] While the final evaluations of these demonstrations have not yet been released, preliminary findings indicate that participating providers improved clinical outcomes (potentially resulting in savings for Medicare) and that participating hospitals realized savings as a result of increased efficiency.

Bundled Payment Models

The Initiative provides for four broadly defined payment models, which, as described below, contain general parameters concerning the episode of care for which bundled payment will be made and the methodology through which payment will be determined. Providers may apply for and participate in one or more of the models. The clear intent of the Innovation Center is to promote a flexible approach through which providers may, within the guidelines of each model, propose definitions for episodes of care (i.e., the clinical conditions and services that may be grouped together for payment purposes), payment arrangements with Medicare (i.e., the discount to be offered Medicare), and arrangements among participating providers (i.e., the allocation of payment by and between those who provide care). Furthermore, as described in the RFA, the Innovation Center seeks proposals of a wide scope that affect a broad range of conditions, reach many Medicare beneficiaries, offer significant savings to Medicare, are designed to be scalable and replicable by similar providers, are able to be implemented quickly, and that potentially already involve participation by other payers.[5] Unlike the demonstrations that preceded it, the Initiative provides participants with latitude to make comprehensive changes to the way they receive payment.

Models 1, 2, and 3 involve a "retrospective" bundled payment arrangement, while Model 4 is premised on a "prospective" bundled payment arrangement. Retrospective arrangements are those in which traditional Medicare fee-for-service payment is made at a negotiated discount and then total payment for a particular episode of care is reconciled against a predetermined target price. In a prospective arrangement, a single negotiated payment is paid as a lump sum in lieu of traditional fee-for-service payment.

Model 1 defines the episode of care for which bundled payment will be made as an inpatient stay in a general acute care hospital. Medicare will make payment to participating hospitals at an agreed upon discount of the rates established under the Inpatient Prospective Payment System. Physicians will be paid separately for their services under the Medicare Physician Fee Schedule. Cost savings below the negotiated discount may be shared by providers. If, however, payment to the provider is in excess of aggregated historical payment beyond an established risk threshold, the difference must be repaid by the provider.

Under Model 2, the episode of care is defined to include both the inpatient stay and post-acute care delivered after discharge, with the episode ending either a minimum of thirty or ninety days after discharge, depending on applicant preference. Model 3 limits the episode of care to post-acute care provided after discharge, with the episode beginning upon discharge from the inpatient stay and ending no sooner than thirty days after discharge. In both Models 2 and 3, the target price for an episode of care will be discounted from an amount based on the provider's historical fee-for-service payments for the episode, and payments will be made at the usual fee-for-service rates. If, on reconciliation, the aggregated fee-for-service payments are less than the predetermined target price, Medicare will pay the difference to the provider. If payments exceed the target price, the difference must be repaid by the provider.

Like Model 1, Model 4 defines the episode of care to include only the inpatient stay; however, as described above, Model 4 features a prospectively determined bundled payment that will be made to the hospital for both inpatient hospital and physician services. Practitioners would be required to submit "no-pay" claims to Medicare for services included in the episodes of care and would be paid by the hospital out of the bundled payment. As noted in the RFA, this approach is essentially an expansion of the ACE demonstration described above.

Gainsharing Arrangements

The Initiative also permits applicants to include gainsharing arrangements (i.e., arrangements through which a portion of the cost savings gained from efficiency improvements are shared with those who provided the care) in their proposals. Gainsharing arrangements have previously been declared to be violations of the Civil Monetary Penalties Act and may implicate the Anti-Kickback Statute and the physician self-referral prohibitions of the Social Security Act.[6] However, pursuant to amendments made by the Patient Protection and Affordable Care Act, the Secretary of the U.S. Department of Health and Human Services has waiver authority with respect to the fraud and abuse laws in Titles XI and XVIII of the Social Security Act in order to test certain payment models, including those contemplated by the Initiative.[7]

In order to be included in a bundled payment proposal under the Initiative, gainsharing arrangements must meet several criteria as set forth in the RFA.[8] In general, such arrangements will be permitted only to the extent that care is not inappropriately reduced, quality of care is not diminished, utilization and referral patterns are not inappropriately changed, and the risks of fraud, waste, and abuse are appropriately guarded against.

Discussion

For providers wary of the upfront capital costs, unclear long-term returns, and regulatory uncertainty associated with accountable care organizations, the Initiative presents an interesting opportunity to make a foray into accountable care. Nevertheless, it seems clear that the providers best positioned to take advantage of the Initiative are those who have taken some of the steps that are required for participation in more organizationally demanding initiatives, such as the Medicare Shared Savings Program. An organization's investment in care coordination and its risk bearing capability would seem to be important in the decision to apply for participation in the Initiative. In addition, an organization's degree of institutional knowledge (i.e., understanding of the patterns of care provided to its patients and the costs associated therewith) would appear to be critical to the process of making a proposal under the Initiative that will ultimately prove beneficial. Providers who have experience with cross-provider improvement efforts and who may have already entered into arrangements that involve accountability for entire episodes of care would seem to be particularly well suited to benefit.

The Initiative's RFA makes clear that the Initiative is only the first in a series of activities focused on care episode redesign. The RFA also indicates that additional prospective payment models are on the horizon and that the concepts of episode payments and gainsharing may be extended to the chronic care setting.[9] Taken as a whole, and in the context of the various other efforts spearheaded by the Innovation Center, the Initiative provides a strong indication that the transition toward more accountable care will take many forms and ultimately be driven by provider innovation.

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1 The Center for Medicare and Medicaid Innovation hosts a website for the Initiative that contains, among other resources, a General Fact Sheet, a Frequently Asked Questions document, and the Request for Application (RFA). *See* www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html. For further information concerning each of the bundled payment models discussed herein, please review the RFA. *See* http://innovations.cms.gov/documents/payment-care/BundledPayments-Request_for_Application_v4.pdf.

2 The deadlines by which providers must submit application materials vary depending on which bundled payment model or models the provider seeks to participate in. Providers that seek to participate in Model 1 were required to submit a nonbinding letter of intent by October 6, 2011. Final applications must be received by November 18, 2011. For Models 2, 3, and 4, the letter of intent must be submitted by November 4, 2011, and final applications must be received by March 15, 2012.

3 RFA at 4.

4 *Id.*

5 *Id.* at 7.

6 *See, e.g.*, U.S. Department of Health and Human Services, Office of Inspector General, Special Advisory Bulletin, Gainsharing Arrangements and CMPs for Hospital Payments to Physicians to Reduce or Limit Services to Beneficiaries (July 1999), *available at* http://oig.hhs.gov/fraud/docs/alertsandbulletins/gainsh.htm.

7 *See* Patient Protection and Affordable Care Act, Section 3021, Pub. L. No. 111-148, 124 Stat. 119 (codified at 42 U.S.C. § 1315a(d)(1)).

8 *See* RFA at 24.

9 *Id.* at 5.

Social Media and Mobile Devices in Healthcare: Managing the Times of Change

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The Internet has evolved over the last several years into a living mechanism for people all over the world to instantly share information, review data, transmit audio/pictures/video, collaborate on ideas, and connect to others across the world through various forms of social media. Right now, the most interesting and important impact is that mobile and social media invite us to participate in the online world more than ever before. Both ordinary people and healthcare providers are constantly involved in two-way interactive communication involving mobile phones and social media that allow any individual, be it patient/doctor/nurse/administrator, to interact, share, respond, and market healthcare information in avenues never before realized. This evolution of both the use of mobile devices and the use of the Internet via social media has impacted the healthcare industry as well. Healthcare providers/facilities, medical device companies, pharmaceutical companies, insurance companies, and government agencies charged with providing healthcare services all must deal with the ever-growing use of mobile phones and the interaction with social media in their respective niches to take advantage of the opportunities these technologies offer, while avoiding or minimizing their liabilities.

Growth in Social Media/Internet for Healthcare-Related Uses

Americans are utilizing the Internet as a tool to locate information on a specific disease or medical problem. A review of the Pew Poll recently showed 66% of American adults look online for health information on a specific disease or medical problem.[1] More than sixty million Americans exchanged medical experiences online with each other in 2010.[2] A simple Google search reveals numerous healthcare blogs (DiabetesMines, HealthMatters, NYT HealthBlog), health social networks (PatientsLikeMe, Organized Wisdom, DailyStrength), and hospital Twitter accounts, Facebook pages, and YouTube channels. It is estimated that by 2015 more than 500 million people worldwide will be expected to be using mobile healthcare applications.[3] As of November 2010, there were approximately 17,000 applications aimed at consumers versus providers/facilities relating to healthcare.[4]

The health information people acquire online has a significant impact on their health-related decisions, with 60% saying this information affected a decision about how to treat an illness or condition. These numbers are especially striking because Americans only turned to two sources more frequently than the Internet for information or assistance in dealing with health or medical issues:

(1) Health professionals, such as doctors, and

(2) Friends and family members.

Interestingly, because the goal of transparency continues to take front and center in healthcare, the current data available for consumers regarding hospital and physician reviews does not seem to be actively used. A separate study found that hospital and doctor review sites have not yet become healthcare decision-making tools for most consumers and, in fact, only 6% of American adults are aware of the Centers for Medicare & Medicaid Service's Hospital Compare tool.[5]

Despite the low numbers of consumers utilizing various hospital and physician review sites, the evidence is clear that consumers are using other Internet sites and social media sites to obtain healthcare information, discuss healthcare issues, and seek treatment options. In contrast, healthcare providers are using social media to market new services, educate consumers on current health issues, and connect to a previously untapped market.

Even with the emergence of social media as the leading outlet for healthcare providers and consumers to exchange information, it is important that healthcare providers adopt policies that protect their interests in this age of change. Given that the use of social media by healthcare providers can create a number of legal problems, any entity engaging in social media should have a basic social media policy. The most common concern is controlling and safeguarding valuable protected health information. Some essential related concerns include data security and confidentiality, including violations of the Health Insurance Portability and Accountability Act (HIPAA)/Health Information Technology for Economic and Clinical Health (HITECH) Act regulations; harm to a healthcare provider's reputation; violations of securities laws; public relations; re-posting of harmful material; and employment law issues including harassment. Rich and relevant content is the most critical factor in successful social media policies. As a suggestion, all healthcare providers using social media need to clearly establish social media content rules that might include a sample of the following:

- Policy should dictate healthcare provider vision, mission, and goals;
- Policy should define healthcare provider social media sites—what are they?;
- Policy should include a disclaimer as to medical advice;
- Policy should dictate posts by others not affiliated with provider are their own opinion and not attributable to hospital;
- Policy should have a reservation by provider to review, edit, remove postings;
- Policy should contain common sense rules to adhere to including:

  - No posts from minors without parents permission;
  - Users should check copyright policies of material before publishing;
  - Respect others;
  - No foul language;
  - Do not post personal information;
  - Do no friend patients;
  - Do not advertise business, services, or events; and
  - Avoid spamming;
- Policy should dictate time, hours, and email/contact for person responsible for oversight of provider social media sites;
- Policy should require transparency with posting information;
- Policy should not violate HIPAA/HITECH and local privacy laws;
- Policy should have decision analysis regarding posts on a social media site to respond, remove, or keep posts by third parties;
- Policy should contain a non-disclosure agreement about the healthcare provider that prohibits any disclosure of information that is proprietary or confidential;
- Policy should contain a prohibition on posting information that is defamatory, obscene, discriminatory, or harassing to anyone, particularly the hospital's patients, clients, affiliates, or the Board of Directors, employees, or any person/entity; and
- Policy should contain a prohibition from offering any kind of medical advice on social media so as to avoid the creation of a physician-patient relationship while using social media.

Simply adopting a good social media policy is not enough. Healthcare providers must be educated on the social media policy as well. It cannot be overstated that education is a key component to not only comprehension of the social media policy, but also to reducing a healthcare provider's exposure to liability when using social media as a tool in today's healthcare market.

Cell/Smart Phone Usage in Healthcare

Mobile phones, including smart phones, are common place amongst healthcare providers. Look no further than the Pew study, which found a whopping "83% of American adults own some kind of cell phone—and these devices have an impact on many aspects of their owners' daily lives."[6] It should be no surprise that, according to the Pew study, text messaging and picture taking continue to top the list of ways that Americans use their mobile phones—three quarters of all cell owners (73%) use their phones for each of these purposes. According to the study, other relatively common activities include sending photos or videos to others (54% of cell owners do this) as well as accessing the Internet (44%).[7] Usage of smart phones also has grown in the healthcare industry. A new generation of physicians is embracing mobile technology, not only with smartphones, but also with tablet computers. A recent study by QuantiaMD found "a significant group of 'Super Mobile' doctors now use both devices,

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and they are far more likely to use mobile technology in clinical settings to access decision tools, learn about new treatments, look up reference material, and handle patient information."[8] In fact, the QuantiaMD study found that from their survey of 3,800 physicians, the following trends are taking place:

- Physicians are adopting mobile technology at a very high rate; this transcends practice settings and years of practice;
- Physicians' strong interest in tablet devices indicates this technology will soon command the physician market; there is also strong interest in tablets from healthcare institutions;
- "Super Mobile" physicians who own both smartphones and tablets are accessing online resources at significantly higher rates across a broad range of core professional activities;
- Healthcare institutions are beginning to adopt mobile technology for their physicians and show strong interest in moving forward;
- Access to Electronic Medical Record data tops the physician wish-list for how they want to use mobile technology; and
- Physicians are concerned about how they can be reimbursed for patient care and professional consulting activities when using mobile technology.[9]

As the use of cell/smart phones continues to grow, with physicians using mobile/smart devices to communicate with other physicians, nursing staff, and patients, there is an underlying concern regarding the security of protected health information. This concern is compounded by the fact that recent action by the new director of the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) indicated a trend toward greater HIPAA enforcement. As of September 30, 2011, OCR has investigated and resolved more than 14,527 cases by requiring changes in privacy practices and other corrective actions by the covered entities (CEs). Corrective actions obtained by OCR from these CEs have resulted in change that is systemic and that affects all the individuals they serve. According to the data, OCR has successfully enforced the HIPAA Privacy Rule by applying corrective measures in all cases where an investigation indicates noncompliance by the CE.

In addition, OCR reported that in another 7,548 cases, investigations found no violation had occurred. However, in the rest of the completed cases (36,334), OCR determined that the complaint did not present an eligible case for enforcement of the Privacy Rule. To summarize, since the compliance date in April 2003, HHS has received more than 64,126 HIPAA Privacy complaints. According to HHS/OCR, more than 91% of complaints received (over 58,409) have been resolved either through investigation and enforcement (over 14,527); through investigation and finding no violation (7,548); or through closure of cases that were not eligible for enforcement (36,334).[10]

It is interesting to note that from a review of the HHS/OCR data, the compliance issues investigated most, in order of frequency, are:

1. Impermissible uses and disclosures of protected health information;
2. Lack of safeguards of protected health information;
3. Lack of patient access to their protected health information;
4. Uses or disclosures of more than the Minimum Necessary protected health information; and
5. Complaints to the covered entity.[11]

Based on the increased enforcement of HIPAA Privacy Rules, and now with the advent of the HITECH Breach Notification Rules, it is paramount that healthcare providers understand the unique risks involved in the use of cell/smart phones in every practice to protect themselves from potential liability. The use of these devices presents numerous risks including:

- Authentication;
- Encryption;
- Wi-Fi Connection;
- Faulty conversation;
- Incomplete conversation or text message;
- Autocorrect problems with content of emails/text messages;
- Potential violations of HIPAA/HITECH—through failures of the administrative safeguards;
- Potential for de-identified information to become re-identified for possible HIPAA/HITECH violation;
- Applications might contain faulty conversions for medications;
- Applications might contain faulty definitions for medications; and
- How text messages are entered in the medical records could create issues of patient care or potential liability.

To address these issues, healthcare providers and facilities should devise policies that address these concerns as well as create administrative, physical, and technical safeguards that are HIPAA compliant so as to decrease liability. To that end, policies to decrease potential exposure to HIPAA/HITECH violations via use of cell/smartphones by healthcare providers might include the following:

- Enforce a restriction on the use of personal cell phones/electronic communication devices by healthcare providers during work hours;
- Provide a safe location for healthcare providers to use cell phones/electronic communication devices in private space away from all patients, common patient care areas, and common work areas;
- Provide a specific time window for healthcare providers to use cell phones/electronic communication devices, e.g., during lunch or break periods;
- Require personal cell phones/electronic communication devices to be turned off and stored during working hours;
- Require any cell phones/electronic communication devices utilized by healthcare providers be issued and authorized by the hospital/facility/group organization and only be used for

business purposes or other uses consistent with healthcare provider business or in furtherance of patient care;

- Require that any use of cell phones/electronic communication devices to record or take still or video pictures of the facility, employees, patients, or property is strictly prohibited and such activity could subject the offending individual to immediate termination; and
- Require that cell phones/electronic communication devices used by patients or public at large be limited to a private space away from all patients, common patient care areas, and common work areas.

Conclusion

In today's healthcare market, both social media and mobile/smart phones play a growing role for disseminating information related to healthcare services. Healthcare providers are in a difficult position. While people are using mobile/smart phones and social media at an ever-increasing rate, the multiple legal and regulatory schemes potentially applicable to healthcare providers create unique challenges for them. Despite these hurdles, healthcare providers should venture cautiously into social media and carefully consider how to control the use of cell/smart phones by providers. Healthcare providers can take many proactive steps to mitigate the regulatory risk, and these steps can be integrated into an entity's existing compliance program.

1 *See* www.pewinternet.org.
2 *Id.*
3 *Id.*
4 *Id.*
5 Tara Lagu and Peter K. Lindenauer, Putting the Public Back in Public Reporting of Health Care Quality, 304 J.A.M.A. 1711-1712 (2010), *see* http://jama.ama-assn.org/content/304/15/1711.extract.
6 *See* www.pewinternet.org/Reports/2011/Cell-Phones/Key-Findings.aspx.
7 *Id.*
8 Mary Modahl, *Tablets Set to Change Medical Practice*, QuantiaMD (June 15, 2011), www.quantiamd.com/q-qcp/QuantiaMD_Research_TabletsSetToChangeMedicalPractice.pdf.
9 *Id.*
10 *See* HHS Enforcement Highlights *at* www.hhs.gov/ocr/privacy/hipaa/enforcement/highlights/index.html.
11 *Id.*

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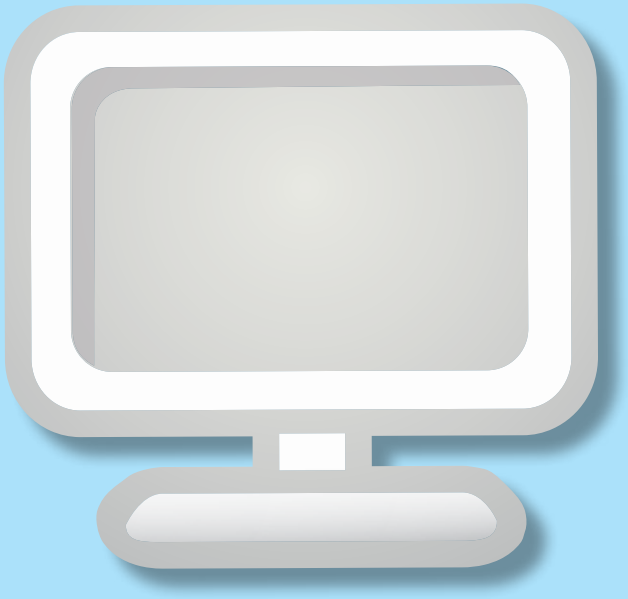

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