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Will You Survive the Regulators?

Who Owns the Patients?

Medical Technology: Doing the Right Thing in a Society of Perverse Incentives

Integration: Will You Survive the Regulators?

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Long before President Clinton and Hillary Rodham Clinton picked up the banner of health care reform, the public was demanding broad, affordable access to health care without sacrificing the intimacy of the private practice model. The industry responded with managed care, the cornerstone of which was shared risk. As preferred provider agreements were succeeded by capitated provider agreements, risk-sharing became risk-shifting, which providers still accepted in return for access to the insurers' growing pools of patients.

The economics of managed care, with its emphasis on cost containment through "gatekeepers" and utilization review, leads to integration (i.e., formation of a single organization or network of affiliated organizations that provide patients access to a continuum of coordinated health services from primary care through tertiary care). Providers integrate to gain economies of scale which enhance bargaining power and secure market share. Integration, however, doesn't just happen; it is accomplished through transactions — among physicians, among hospitals, and between physicians and hospitals. Currently there is a frenzy of consolidation and market positioning. Providers are divesting, acquiring, going public and filing for tax-exempt status. The activity is centered in California and a few other states with high percentages of health maintenance organization (HMO) enrollment, but the trend will soon spread to every corner of this country — if the regulators allow it.

It appears that our nation's regulators are confused by or at odds with the trend towards integrated delivery of health care. They don't understand it, or they don't want it. In either case, they have not clarified or will not clarify their positions. And so, there is today a struggle to maneuver through this minefield in the regulatory landscape of health care. The problem is probably worse on the not-for-profit side than on the for-profit side, so this article will focus only on tax-exempt integrated delivery systems.

Friendly Hills and Facey Rulings

On February 8, 1993, the Internal Revenue Service (IRS) issued an exemption from federal income taxation to the Friendly Hills Healthcare Foundation. On March 31, 1993, the IRS again issued an exemption to the Facey Medical Foundation. Both letter rulings recognized that among the assets to be acquired for cash or to be donated were medical records, covenants not to compete, HMO contracts and other intangible assets generally categorized as goodwill. The rulings also recognized that the prices to be paid by

the foundations for each entity included remuneration to the physician-owners for these intangible assets.

Clearly, in reviewing and approving the Friendly Hills and Facey applications, the IRS considered the "community benefit standard," the prohibitions under 501(c)(3) against private inurement and private benefit and provisions of the Medicare antifraud and abuse statute. What remains unclear is how future transactions can benefit from the Friendly Hills and Facey rulings.

Community Benefit Standard

Under the "community benefit standard,"[1] a hospital must promote the health of a class of persons broad enough to benefit the community as a whole and must operate to serve a public rather than a private interest. For Friendly Hills and Facey, the following commitments were all viewed favorably by the IRS:

- An open medical staff
- Operation of an emergency room open to the public, accepting paramedic runs and providing care to everyone without regard to ability to pay
- Admission of indigent emergency room patients for inpatient care
- Participation in fee-for-service programs and managed care initiatives of Medicare and Medi-Cal
- Community governance with no more than 20 percent of the board being comprised of interested persons, including medical group physicians
- Covenants not to compete that do not preclude departing physicians from practicing in the geographical service area
- The conduct of significant programs of medical research, health education or charitable care

Private Inurement and Private Benefit

How the IRS viewed the transactions with respect to private inurement and private benefit is more ambiguous. Under section 501(c)(3), two activities are specifically prohibited. The first is private inurement, which applies to insiders including physicians, and the second is private benefit. Payment by an exempt organization for goods, services, facilities or financing in excess of fair market value or provision of goods, services, facilities or financing by an exempt organization for less than fair market value constitutes private inurement or private benefit. There is no minimum threshold for inurement. Any private inurement will result in revocation of the organization's exempt status, whereas an incidental level of private benefit can be tolerated. It follows, then, that any payment to insiders in excess of fair market value by an applicant for exempt status would be cause for denial of exempt status.

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The Friendly Hills and Facey applications both contained representations that all assets acquired and all rental fees paid under any lease were at or below fair market value, and both applications were approved. The approvals should imply that the IRS concurred with the applicants' representations that the prices paid did not exceed fair market value and, therefore, that the prices paid did not constitute private inurement. They should, but they don't. In fact, each ruling specifically denies that the IRS is making such a determination.

Medicare Antifraud and Abuse Statute

To further limit the utility of these determination letters as guideposts for future transactions, both rulings were conditioned, and remain conditioned, upon the applicant not being found to be in violation of the antikickback provisions of the Medicare antifraud and abuse statute. The antikickback statute provides criminal penalties for individuals or entities that knowingly and willfully solicit, receive, offer or pay remuneration in order to induce business reimbursable under Medicare or state health care programs. For the IRS to condition exempt status on the results of subsequent actions, that may or may not be agreed to by a sister agency, exposes applicants, underwriters and bondholders alike to substantial risks. Yet, the inclusion of the condition in the determination letters should not have come as a complete surprise. More than one year earlier, the IRS's Chief Counsel, in General Counsel Memorandum 39862, linked revocation of exempt status with violation of Medicare antifraud and abuse laws and, by implication, with violation of any other federal statute.

Do these transactions violate the antikickback statute? Several months before issuing the first determination letter, the IRS requested the Office of the Inspector General's (OIG) views on the applicability of the antikickback statute to a Friendly Hills or Facey-type acquisition of a physician practice, specifically an acquisition wherein the selling physicians would continue to treat patients in an employee or exclusive

contractor capacity. (Importantly, "a safe harbor" from prosecution under the antikickback statute was proposed only for the sale of physician practices when occurring as a result of retirement or some other event that removes the physician from the practice of medicine or from the service area. Among comments received by the OIG on the proposed "safe harbors" was a request by several hospitals that their practice of buying physicians' practices, like Friendly Hills or Facey, for fair market value and then retaining the physicians be afforded the protection of a "safe harbor." The OIG flatly declined to do so.)

In fact, two months before the Friendly Hills ruling was issued, a letter from the OIG to the IRS stated that "when attempting to assess the fair market value 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."[2] The letter continued that "any amount paid in excess of the fair market value of the hard assets of a physician practice would be open to question."[2] Specific items that "would raise a question as to whether payment was being made for the value of a referral stream"[2] included payment for: goodwill; the value of an ongoing business unit; covenants not to compete; exclusive dealing agreements; patient lists; and patient records.

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Most of these intangible assets were openly identified and paid for in both Friendly Hills and Facey and were clearly cited in the determination letters. What can we interpret from this? Did the IRS simply ignore the OIG's letter? After all, the IRS has historically recognized the appropriateness of ascribing value to and paying for intangibles even by an exempt organization.[3] Obviously, the letter was not ignored, but apparently the IRS was not inclined to withhold exempt status in anticipation of a possible indictment of these transactions by the OIG. The IRS was willing only to withhold an unqualified exemption in deference as much to their own prior policy statements as to the OIG's letter. Clearly, there is a "point of tension" between the two agencies on this issue and an apparent conflict between health law and tax law.

Prospects for Safe Passage

Is there, then, no safe passage through this minefield? I believe there is. First, the OIG never stated that payment for the intangible assets of a physician's practice violates the antikickback statute. It stated only that payments for such assets "would raise a question" of possible violation. Secondly, the OIG is unlikely, at least at this time, to pursue enforcement against nonabusive arrangements and transactions. I believe that an abusive arrangement is one: where more than fair market

value is paid; where referrals and charges to Medicare and Medicaid programs are caused to increase; and where the physician's economic condition, currently and into the future, improves significantly as a direct result of the transaction or arrangement. Thirdly, an independent appraisal by a qualified and experienced valuator is strong evidence that an arrangement or transaction is not abusive, at least with regard to the price of exchange, and has always been considered a prerequisite for a successful filing with the IRS.

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On a cautionary note, however, the OIG also stated that "[w]hen considering the question of fair market value ... the traditional or common methods of economic valuation do not comport with the prescription of the antikickback statute" and "[t]he requirements ... for determining fair market value under the safe harbor regulations ... do not replicate the requirements under the Internal Revenue Code."[2] It has been my experience that the traditional methods of valuation used by the IRS for income, gift and estate tax purposes also do not comport with the requirements of the exempt branch of the IRS. Required are a newly developed standard of value and methodologies for valuation that reflect the IRS's requirements, at least as we currently understand them, and which are more likely to pass muster with the IRS than traditional valuation approaches. Such procedures disregard the actual or prospective tax-exempt status of the acquiror. They disregard any benefit conferred upon the acquiror as a consequence of its current or proposed relationship with the physician group. And they set aside the common practice of deducting market rates of physician compensation from income in favor of deducting actual, post-transaction compensation from income. I believe that this kind of analysis, while including the value of intangibles, will not only result in a favorable ruling by the IRS but will also be deemed nonabusive by the OIG.

Finally, the OIG makes no mention of managed care provider agreements or capitated patients in its list of "questionable" assets. Nor does the OIG state that the universe of questionable assets is limited only to those listed. But when I discussed the OIG's intentions with regard to Friendly Hills with an associate counsel at the OIG, pointing out that the network was over 90 percent capitated and that the price paid was only 76 percent of the appraised value, his comment was, "Speaking as a prosecutor, that fact pattern sounds pretty much bomb-proof. I wouldn't want to try that case."

Capitation is the key. Acquisitions of capitated group practices and independent practice associations (IPAs) are more likely than acquisitions of fee-for-service practices to survive regulatory scrutiny if more than tangible assets are acquired. Capitation economically discourages overutilization. Therefore, referrals by capitated practices and IPAs to hospitals and ancillary service units are not likely to increase as a consequence of integration. Also, the capitation of senior patients (and soon of Medicaid patients as well) means that federal and state programs cannot be charged more, even if utilization does increase. I believe, therefore, that the Friendly Hills and Facey exemptions will stand.

Stacked upon the obstacles to integration discussed above are antitrust regulations, state corporate practice of medicine laws and the civil servants who interpret and enforce them. Given the powers wielded by these minions of the public trust, the only solution available to providers intent on remaining viable into the next century is to hire experienced legal and financial advisors. Nevertheless, until a coordinated interagency position paper on integrated delivery systems emerges from Washington, providers will be forced to retain some risk in structuring transactions despite the best efforts of all involved. ■

References

1. Revenue Ruling 69-645, 1969-2 C.B. 117.
2. Letter to IRS from HHS IG reprinted in: *Health Law Reporter*. 1993; 2(8):224-245.
3. Revenue Ruling 76-91, 1976-1 C.B. 149.

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