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Fair Market Value in Health Care Transactions

Why and when do we need it?

Health care is one of the most highly regulated industries in the United States. Stark, anti-trust, anti-kickback, fraud and abuse, HIPAA, intermediate sanctions, excess benefits, and false claims are just some of the words that are dreaded by many health care providers.

In this article we will explain the role that fair market value (FMV) plays in the health care industry: why we need it and when we need it.

Whenever anything of value is exchanged among health care providers or between a nonprofit organization and a third party person or business, the value of the exchange may need to be at fair market value or the parties may face civil or even criminal penalties.

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FMV and government health care reimbursement

Both for-profit and nonprofit health care providers that accept payments from government programs (such as Medicare or Medicaid) must be careful that exchanges between them and other providers (for example, of money, space, or services) are at FMV. If not, the providers could be excluded from these programs and subject to the *Anti-Kickback Statute* (42 U.S.C. §1320a-7b) and the *False Claims Act* (31 U.S.C. § 3729). Both carry civil penalties and the *Anti-Kickback Statute* carries criminal penalties as well.

According to the Office of the Inspector General (OIG) of the U. S. Department of Health and Human Services, the main purpose of the *Anti-Kickback Statute* is "to protect patients and the federal health care programs from fraud and abuse by curtailing the corrupting influence of money on health care decisions." Most of the time this influence involves one provider giving something of value to another provider for less than or more than FMV to induce the referral of Medicare or Medicaid patients.

For example, a hospital may want a medical group to refer patients to the hospital. To induce the referrals, the hospital makes one of the physicians a medical director and pays the physician a hefty fee. If the fair market value of the physician's services does not equal the fees paid, or if the services are not really necessary to support the hospital's programs and services, the payment would be illegal under the statute. In fact, even if the services were necessary and paid at FMV, the intent to induce referrals could be enough to violate the *Anti-Kickback Statute*.

Once the providers are in violation of the statute, the U.S. Department of Justice usually asserts that any filed Medicare or Medicaid claims are false claims under the theory that if the referrals were illegal then any medical claims are illegal. So the provider winds up in violation of two laws (*Anti-Kickback Statute* and *False Claims Act*).

Violations of the *Anti-Kickback Statute* are punishable by up to five years in prison, criminal fines up to $25,000, and administrative fines up to $50,000 per violation, plus up to three times the prohibited remuneration received, and exclusion from federal health care programs (such as Medicare and Medicaid).

Violators of the *False Claims Act* are subject to civil penalties of $5,500 – $11,000 plus three times the amount of damages the government sustains because of the act of that person. These penalties apply to each false claim; for example, if a health care violator submits 1,000 claims, it could cost $11 million (1,000 claims x $11,000) plus three times actual damages. In addition, providers risk exclusion from Medicare and Medicaid.

FMV and nonprofit organizations

In addition to the *Anti-Kickback Statute* and the *False Claims Act*, nonprofit organizations can have other problems if they violate FMV. Internal Revenue Code (IRC) section 501(c)(3) grants a tax exemption to nonprofits only if "no part of the net earnings of [the organization] inure to the benefit of any private shareholder or individual."

A nonprofit that violates this prohibition can have its exempt status revoked. In the medical directorship example, if the payment was not at FMV, a nonprofit hospital could lose its nonprofit status whether or not there was any referral of patients. Loss of nonprofit status would cause the hospital to pay taxes on its earnings and lose its ability to issue tax-exempt bonds.

Because revocation of nonprofit status might be excessive punishment and not in the public interest, Congress passed IRC Section 4958, the Excess Benefit Transaction Rule, also frequently referred to as "intermediate sanctions" since the ultimate sanction is revocation of nonprofit status.

Civil penalties for violators of Section 4958 are imposed on the manager involved in the decision and the person who benefited from the decision. An excise tax equal to 25 percent of the surplus benefit (in excess of FMV) is imposed on the person who benefited. If the excess is not corrected (repaid), an additional excise tax equal to 200 percent of the excess benefit is imposed. In addition, an excise tax of 10 percent, up to $10,000, can be imposed on the nonprofit manager involved.

FMV and physicians

Not only can physicians be involved in *Anti-Kickback Statute*, *False Claims Act*, and IRC Section 4958 issues, they can also be involved in transactions that fall under the Stark law.

The Stark law applies only to physicians who refer Medicare and Medicaid patients for designated health services (DHS) to entities which they (or an immediate family member) have a financial relationship. Unless the

transaction meets the specific requirements of one or more closely defined exceptions, it is prohibited.

DHS include many ancillary physician services, such as clinical laboratory services, outpatient prescription drug services, physical and occupational therapy, and imaging services (for example, MRI, CT, ultrasound). Other examples include durable medical equipment and supplies, home health services, inpatient and outpatient hospital services, radiation therapy, parenteral and enteral nutrient equipment and supplies, and prosthetics, orthotics, and prosthetic devices and supplies.

Like the A*nti-Kickback Statute*, Stark was enacted to prevent economic incentives from having an impact on referrals — this time involving physicians and DHS. In fact, if the government can also convince a jury that the doctor acted with the requisite intent, a physician in violation of Stark they may also be in violation of the *Anti-Kickback Statute*.

A simple example of a Stark violation would be when a physician is directly compensated for Medicare or Medicaid patient referrals made for DHS (that is, they are paid each time they make a referral). A more subtle example is where a physician's compensation (which may be a fixed amount) is in excess of FMV in exchange for DHS referrals.

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Under Stark, the person who caused the illegal claim is subject to civil monetary penalties of up to $15,000 per service billed and exclusion from Medicare and Medicaid participation. Any physician or entity entering into a scheme to circumvent the law could face civil penalties of up to $100,000 and exclusion from Medicare and Medicaid.

So, if a physician referred 1,000 DHS services, the penalty would be up to $15 million (1,000 services x $15,000 per service) and exclusion from Medicare and Medicaid. In addition, the physician could also face penalties under the *Anti-Kickback Statute* as well as the *False Claims Act*.

Fair market value

None of these laws prevent bona fide business transactions so long as they are within the definition of fair market value. The problem is that providers feel financial pressure to engage in transactions outside the definition in order to circumvent the objective of these laws, which is to eliminate money from influencing medical decisions. Many states have similar laws.

Any exchange of value with health care providers receiving payments under federally funded programs and/or between nonprofits (including nonprofit management) and others may require a FMV determination. These transactions may include:

- Joint venture arrangements
- Payments to physicians for clinical or administrative services
- Business acquisitions or dispositions
- Call coverage arrangements
- Space rental agreements
- Equipment leases
- Management services agreements
- Income guarantees
- Practice support payments
- Payments to physicians for presenting on continuing medical education topics
- Block time (or "per click" or per day) leasing arrangements
- Providing anything of value at no cost (staff, space, computers, etc.)

Violations

Every day providers engage in transactions that either purposely or inadvertently violate these laws. Many transactions are designed to be sufficiently complex so as to prevent detection. Other transactions may look like they comply in form, but they do not comply in substance. This is typically the case, as in our medical director example, where there may be no business purpose to the transaction other than to influence patient referrals.

Providers and their advisors should not be looking for ways to circumvent these laws; there are no loopholes. However, a transaction, properly structured and supported, could be compliant, whereas the same transaction, not properly structured, would not be.

Providers should seek competent legal advice from attorneys who specialize in health care law and, when necessary, from appraisers and other consultants who understand the issues unique to health care transactions.

Resources

Author

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- Anne Clifford is a health care senior consultant specializing in health care business valuation.