Hospital/Physician Affiliations: The Good, The Bad, and the Ugly

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Presented by:
Almeta E. Cooper, Esq.
Associate Vice President and General Counsel
The Ohio State University Medical Center

Anthea R. Daniels, Esq.
Calfee, Halter & Griswold LLP

I. Overview

When a hospital and a physician or physician group decide to affiliate, the work has just begun. Because such transactions are highly regulated by a vast number of agencies and regulatory schemes the stakes for noncompliance are high. Both physicians and hospital administrators may be at risk for making sometimes unintended missteps. While both physicians and hospital administrators are likely to know that financial transactions should be done with “fair market value” in mind, there is much more to be considered when creating a compliant hospital/physician affiliation. Deciding how much to pay for the affiliating entity, how to structure the purchase for tax and regulatory purposes while creating a worthwhile deal are just some of the challenges. As the title to this paper suggests, even well-intentioned parties can end up with a deal that could deviate wildly from the regulators’ expectations. Issues to consider will be outlined below along with their regulatory schemes, which will be supplemented with current opinions and case law to further guide the reader in facing some of the concrete issues they may encounter in actual practice.

II. Fair Market Valuations and Purchase Price Issues

When entering into various arrangements, ranging from employing a new physician to purchasing an entire physician practice, hospitals are faced with many regulatory roadblocks which must be navigated with care to ensure a compliant result. Below are the various federal laws and regulatory schemes as well as some recent case law and pieces of official guidance, all of which should be used to help guide those facilitating this complicated process.
a. Stark Law

Certain of the Stark Law exceptions and the AKS safe harbors contain requirements that the compensation relationship subject to the exception/safe harbor be “commercially reasonable.” The following is a list of the Stark Law exceptions (all found at 42 C.F.R. 411.357) that contain a requirement that the financial relationship between the physician and the provider of designated health services (“DHS”) be commercially reasonable:

- Rental of office space;
- Rental of equipment;
- Bona fide employment relationship;
- Isolated transactions;
- Group practice arrangements with a hospital;
- Fair market value compensation; and
- Indirect compensation arrangements.

In each of these exceptions, the regulation requires that the compensation would be “commercially reasonable even if no referrals were made between the parties.” The fair market value exception is the only exception to use different language, requiring that the arrangement be “commercially reasonable (taking into account the nature and scope of the transaction) and furthers the legitimate business purposes of the parties.”

“Commercially reasonable” is not defined in the Stark Law regulations. However, CMS has issued regulatory guidance stating that commercially reasonable means that an arrangement is “a sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of potential referrals.” CMS has further clarified that “an arrangement will be considered ‘commercially reasonable’ in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential DHS referrals.”

Finally, CMS has provided some guidance as to how parties can establish that an arrangement is commercially reasonable. For instance, CMS has said that “with respect to determining what is ‘commercially reasonable,’ any reasonable method of valuation is
acceptable, and the determination should be based upon the specific business in which parties are involved, not business in general. In addition, we strongly suggest that the parties maintain good documentation supporting valuation.” CMS has also stated that, “for example, a commercially reasonable method of establishing fair market value (and general market value) for the rental of office space can include providing us with a list of comparables. We would also find acceptable an appraisal that the parties have received from a qualified independent expert.” CMS has also stated that the commercial reasonableness of a medical equipment lease could be based on “cost plus reasonable rate of return on investment on leases of comparable medical equipment from a disinterested lessor.”

B. Anti-Kickback Statute

Unlike the Stark Law exceptions, the AKS safe harbors use the term “commercially reasonable” in different contexts. The following is a brief summary of each safe harbor (all found at 42 C.F.R. 1001.952) that contains the “commercially reasonable” language:

- **Space rental.** The safe harbor requires that the space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

- **Equipment rental.** The safe harbor requires that the equipment rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

- **Personal services and management contracts.** The safe harbor requires that the services contracted for do not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

- **Sale of practice.** The safe harbor requires that the purchasing hospital or entity of a practice from a practitioner who is retiring or moving from a health professional shortage area must diligently and in good faith engage in commercially reasonable recruitment activities to recruit a new practitioner to take over the acquired practice.

- **Price reductions offered by contractors with substantial financial risk to managed care organizations.** The safe harbor requires that the managed care agreement must, among others, specify a methodology for determining payment that is commercially reasonable and consistent with fair market value established in an arms-length transaction.
• **Fair market value ambulance replenishing.** The receiving facility and the ambulance provider must make commercially reasonable payment arrangements in advance for the replenishing of ambulance supplies.

The regulatory commentary issued with the safe harbors provides very limited guidance as to what constitutes commercial reasonableness. The OIG has described a commercially reasonable arrangement as one where the “space and equipment leased or services purchased have intrinsic commercial value to the lessee or purchaser.” The purpose behind the requirement has been described as “intended to preclude safe harbor protection for health care providers that surreptitiously pay for referrals...by renting more space or equipment or purchasing more services than they actually need from referral sources.” Furthermore, OIG has stated that a commercially reasonable business purpose means “that the purpose must be reasonably calculated to further the business of the lessee or purchaser.”

C. Other Uses

Fair market value is used in other federal regulatory contexts. For instance, the use of fair market value of compensation is a requirement for many tax-exempt organizations. The IRS has defined fair market value as “the price at which the property would change hands between a willing buyer and a willing seller when the former is not under any compulsion to buy and the latter is not under any compulsion to sell, both parties having reasonable knowledge or relevant facts.” The IRS has further stated that “a determination of fair market value, being a question of fact, will depend upon the circumstances in each case.” Although this revenue ruling from 1959 related to regulations regarding estates, it has been cited favorably in numerous rulings since then, including those relating to nonprofit hospitals.

D. Stark Self-Referral Disclosure Protocol (“SRDP”)

The Patient Protection and Affordable Care Act (“PPACA”)\(^1\) has already changed many aspects of health care and will cause many more changes in the future. One of the most relevant changes to the discussion of anti-kickback/Stark issues is the creation of the CMS Voluntary-Self-Referral Disclosure Protocol (“SRDP”), as Centers for Medicare and Medicaid Services (“CMS”) was required to create this program under section 6409 of the PPACA.\(^2\) According to CMS’s website, the goal of this program is to set forth a process to enable providers of services and suppliers to self-disclose actual or potential violations of the Stark statute.\(^3\)

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3. Supra note 2.
For those familiar with the anti-kickback self-reporting process through the Office of Inspector General, CMS essentially adopted the same approach. The SRDP requires health care providers of services or suppliers to submit all accurate information related to the issue in order to allow CMS to analyze the actual or potential violation of Stark. It is important to note that this is not a process under which an entity is seeking an advisory opinion from CMS. When submitting information to enter the SRDP process, CMS will likely be assuming there is an actual violation by the submitting entity. This process is meant to encourage forthrightness and quick resolution of the Stark issues and is not meant for the entity to use to test the waters.

Procedurally, the PPACA requires CMS, as part of the U.S. Department of Health and Human Services, to inform providers and suppliers how to report possible Stark violations to the Agency. Disclosures should include all relevant information and must be submitted electronically to 1877SRDP@cms.hhs.gov. In addition, the disclosing party must submit an original and 1 copy by mail to the Division of Technical Payment Policy.

While many may be wary of self-reporting, the SRDP does provide an incentive for those who come forward. Section 6409(b) of the PPACA, gives the Secretary of HHS the authority to reduce the traditional amount due in fines if a violation of Stark is found for those who self-report the violation. Additionally, if a party believes they have overpaid a physician or provider in violation of Stark, Section 6402 of the PPACA allows for a 60 day window for reporting and refunding of the Stark-violating overpayments to be tolled while the entity works their way through the SRDP process, allowing the entities a larger window of time to allow for further investigations of what can prove to be highly complicated situations. Self-reporting entities in the SRDP process will not be required to complete the overpayment refund process until a settlement agreement is reached through the SRDP process or when the entity removes itself or is removed by CMS from the SRDP process.

This specific process is only meant to solicit the self-reporting of Stark issues. Those entities who have anti-kickback issues which OIG deals with should initiate the OIG self-disclosure process simultaneously. CMS will coordinate with both the OIG as well as the Department of Justice (“DOJ”); however the type of coordination is vague as the process has only been in place for a little over a year and a half. According to their documents, CMS may conclude that the disclosed matter warrants a referral to law enforcement for consideration under its civil and/or criminal authorities. When appropriate, CMS may use a disclosing entity’s information to

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4 Supra note 2.
7 Id.
8 Id.
9 Supra note 5.
prepare a recommendation to OIG and DOJ for resolution of False Claims Act, civil monetary penalty, or other liability.\textsuperscript{10} Because of these possibilities, the entity’s initial decision of whether to disclose a matter involving non-compliance with Stark should be made carefully.

To date, there have been four settlements which have been published by CMS on their website.\textsuperscript{11} The first, and largest to date, was resolved on February 10, 2011 and involved several violations. A Massachusetts acute care hospital disclosed through the SRDP that it violated Stark by (1) failing to satisfy the requirements of the personal services arrangements exception for arrangements with certain hospital department chiefs and the medical staff for leadership services, and (2) failing to satisfy the requirements of the personal services arrangements exception for arrangements with certain physician groups for on-site overnight coverage for patients at the hospital.\textsuperscript{12} CMS came back with their findings and the parties settled for $579,000.

Throughout the next 12 months, three more institutions self-reported. On November 9, 2011, a critical access hospital in Mississippi disclosed it violated Stark by failing to satisfy the requirements of the personal services arrangements exception for arrangements with certain hospital and emergency room physicians.\textsuperscript{13} The settlement was in the amount of $130,000. Additionally, two settlements have already been reached in 2012.\textsuperscript{14} Both involved hospitals that self-disclosed they violated Stark by exceeding the non-monetary compensation limit for a physician. The first, a settlement for $4,500, was settled by a hospital in Georgia and the second, for $6,700, involved a hospital in California.

This process is an evolving one. It would behoove entities to monitor the reported settlements, their final costs and the benefits of self-reporting. To be able to accurately weigh the risks of disclosure for one’s institution, it may be necessary to analyze the complexity of the compliance issue, any entity that self reports is advised to be prepared to produce an accurate description of the violations. CMS reserves the right to terminate the process with any entity that does not appear to be truthful in providing accurate information. Once your entity is “kicked out” of the process, all you are left with is a very detailed tip to CMS about what is going on at your institution. One must also keep in mind CMS may refer an institution to another agency, such as the OIG, the DOJ or other law enforcement agency.

\textit{E. Cautionary tales from the courtroom}

\textsuperscript{10} \textit{Supra} note 5.
\textsuperscript{12} \textit{Supra} note 11.
While the Stark and anti-kickback regulations have been long established, it is always helpful to have the benefit of a court’s interpretation as well as to observe enforcement activity over time. For academic medical centers and other similar health care organizations, the advantage of learning from the mistakes of similar institutions that have experienced regulatory trouble provides guidance in navigating this complicated body of law. Some cautionary tales follow below.

a. United States ex rel Drakeford v. Tuomey

A significant 2010 judicial decision was issued in United States ex rel Drakeford v. Tuomey. As reported by commentators, an orthopedist filed a qui tam case which was heard by a district court jury; and subsequently U. S. government intervened. Even though a jury verdict was returned in this case, there was no written decision. Thankfully, the transcripts have provided insight as to what occurred at trial and many commentators have spent time examining the core issues.

Tuomey Healthcare System’s main facility is the Tuomey Regional Medical Center, which has 301 beds and is located in Sumter, South Carolina. At issue in the Tuomey decision were alleged violations of the Stark Law as well as the False Claims Act. The jury found Tuomey violated the Stark Law, but not the False Claims Act. However, the U. S. Government has the option to retry the False Claims Act issue if it wishes. The major missteps arose out of the hospital’s handling of the part-time physician employment contracts between two for-profit companies. More specifically, both companies were wholly-owned by Tuomey and they were entities which stood in between the not-for-profit hospital and the referring physicians.

The compensation structure arranged for the physicians included the following: 1) base salary, 2) a productivity bonus of 80% of the amounts collected by Tuomey for the physician’s personally performed services, and 3) an incentive bonus of up to 7% of the productivity bonus if

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20 Id.
21 Supra note 16.
the physician met certain performance targets. While some may immediately recognize that these facts pose a “red flag” at this point, not surprisingly someone involved in the fledgling transaction also saw a problem. This individual warned the hospital that this arrangement allowed the part-time physicians to be paid more than the hospital collected, and thus could be in violation of the law. The orthopedist did not sign the contract and instead filed the qui tam action.

At trial, the government attempted to prove the compensation structure exceeded the fair market value (“FMV”) as well as violated Stark, because the physicians would, in theory, be capable of earning more than 130% of their net collections on the procedures they performed. To combat the allegations, the hospital attempted to show that when determining the compensation structure, they relied upon an independent valuation consultant’s views on the FMV issue.

The jury was not persuaded, and found Tuomey violated the Stark Law. Specifically, the hospital violated Stark II, as the arrangement failed to meet any of Start II’s designated exceptions. Also, the wRVU structure was fatally flawed because a productivity level set at 90% does equate to a 90% conversion factor, which is necessary. Their actual productivity was around 50th-75th percentile, but their compensation was at about the 90th. The government said the wRVU must not exceed the 75th percentile, and if it does, the institution must provide a valid justification, which was not present here. There also were incentives offered to the physicians for the first dollar they earned, in addition to having access to employee benefits usually reserved for full time Tuomey employees, although the participating physicians were part-time.

As a result, Tuomey was ordered to pay $44,888,651.00 plus interest for their violations. While the lower courts did not find a violation of the False Claims Act at this point in time, the False Claims Act issue may be retried by the US government.

There are important lessons to be learned from Tuomey. First, before agreements are entered into, the commercial reasonableness inquiry must always be complete and thorough. Unfortunately, this was not done in Tuomey. It is important to note that Tuomey, under the agreement, would have actually paid the physicians more than the hospital received. Whenever this is the case, an institution needs to examine what is really going on with the arrangement. Practically, the provider should generally make money or at the very least break even if the arrangement is a reasonable and compliant one. Also, although there was a “red flag” prior to the qui tam filing, Tuomey did not alter its course. It was obvious that Tuomey was attempting a relatively novel approach, and the government asserted that on these facts, the institution should have sought an OIG opinion before going forward with it.

22 Supra note 16.
23 Supra note 16.
Relying upon the advice of counsel and outside consultants is only likely to provide a
defense to the hospital when the actual advice provided is reliable and accurate. As Tuomey’s
leadership learned, it could not hide behind an “advice of counsel” defense, especially when they
shopped around for an opinion which coincided with their institution’s desires. Although they
received the advice they were looking for, they did not ensure that the consultant did a thorough
job of examining the proposed compensation schedule.

Since Tuomey’s administration appeared to have been shopping around for a valuation
which would approve the structure they desired, it made it easier for the government to attack
their approach. Whichever consultant a hospital decides to hire to complete the FMV analysis,
the consultant must be able to defend his/her decision and the process used to reach it. Here, the
resulting report from the selected consultant was only 3 ½ pages, and lacked the detail and
analysis to be persuasive to the enforcement bodies.

In conclusion, a $44 million fine plus interest certainly requires for similarly-situated
health systems to take notice. Others can avoid the predicament in which Tuomey found itself.
By seeking outside FMV valuations in good faith and ensuring the consultants are relying upon
appropriate information, throughout the physician contracting process, hospitals can position
themselves to avoid this multi-million dollar disaster.

b. U.S. ex rel. Signh v. Bradford Regional Medical Center

In addition to Tuomey, the recent 2010 decision in U.S. ex rel. Signh v. Bradford
Regional Medical Center can assist those attempting to craft compliant compensation
packages. In Bradford, the court considered whether a fixed compensation package could take
into account the value or volume of referrals or other related business generated between the
contracting parties. The issues the court addressed were whether or not there was an indirect
compensation arrangement exception and if so, if the compensation was still consistent with
FMV.

The hospital in this case, Bradford Regional Medical Center, is a 107-bed acute-care
community nonprofit hospital located in Bradford, Pennsylvania. In addition to an acute-care
hospital, BRMC also has a full service home health division, a 95-bed skilled nursing facility,
and a comprehensive inpatient and outpatient behavioral health program, including one of the
few dual diagnosis units in Pennsylvania, Ohio and New York. Bradford became concerned
when they heard two of their biggest referring cardiologists were exploring whether or not they
wanted to obtain a nuclear camera of their own. If this occurred, their patients would no longer
be referred to Bradford for that service, because the cardiologists would be able to use the
camera in-office. Upon hearing about the proposed venture, Bradford’s CEO asked Bradford’s

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VP of Operations for information regarding the referrals from the two cardiologists in order to determine “what kind of impact could that have” upon Bradford.27 Bradford’s gross revenues from the referrals were approximately $2.7 million and approximately $2.2 million of those were outpatient revenues.28

Bradford’s CEO was concerned about the referring cardiologists acquiring the camera. He met with the cardiologists during the spring of 2001 to discuss a possible “joint venture ‘within the Safe Harbor exception to Stark II’”, according to a letter from the CEO to the cardiologists.29 When the cardiologists went ahead and purchased the camera, Bradford initiated various aggressive strategies which adversely affected the cardiologists, including such actions as creating a policy which stated that any practitioner who has a “financial interest with a competing health care entity that might have a significant impact upon the hospital” would not be eligible for hospital privileges.30 The cardiologists finally caved after extensive negotiations and entered into a Sublease Agreement for the nuclear camera. Under the new arrangement the hospital paid the physicians a fee equal to 10% of the collection for tests performed on the camera.31 Also, while the details of the actual agreement are extremely specific and slightly confusing, it is sufficient enough for the purpose of this paper to state that the payments made to the cardiologists under the sublease took into account the revenues Bradford expected to receive from the referrals of cardiologist patients as well as a non-compete payment.

At trial, the court’s task was to determine whether or not this agreement constituted an indirect compensation agreement. Both the Stark Act and the anti-kickback statutes prohibit a health care entity from submitting claims to Medicare based on referrals from physicians who have a “financial relationship with the entity”, unless an expectation is carved out in the law (also known as a “safe harbor”).32 To prove their case, the plaintiffs would have to demonstrate that the arrangement produced payments to the physicians which exceeded FMV. The court held that while the compensation may have been fair market between these parties, it was nonetheless in violation of Stark. The sublease and the noncompete violated Stark because the payments took into account the “volume or value of referrals generated by the referring physicians”.33

Stark is intended to establish a straightforward test that compensation arrangements, such as those at issue here, should be set at FMV for the work performed or the equipment leased. Inflating compensation to compensate for the physician’s ability to generate other revenues

28 Id.
29 Id. at 607.
30 Id.
32 Id. at 615.
33 Id. at 621.
between the parties, such as referrals, is prohibited. After the Court determined there was an indirect compensation agreement, the court concluded that parties failed to demonstrate that the arrangements met a “safe harbor”.

By reading the opinion, it is evident that the court struggled to determine whether or not a particular arrangement did in fact violate the law. Determining whether an arrangement does not take into account the volume or value of referrals is often not a black and white issue. Frequently the arrangements are convoluted and give courts pause. Going forward, it is prudent for institutions who may become party to these types of agreements to fully understand what is required for FMV under Stark Law.

The FMV determination for this federal regulatory scheme is unlike the traditional determination. In addition to all traditional considerations, Stark requires that an agreement between a willing buyer and a willing seller also be such that the agreement does not allow the parties to be in a position to generate any type of business for the other party. This illegal arrangement may look like enticing the physicians to generate referrals for the institution or the use of a valuation metric which takes into account anticipated or actual referrals when determining compensation.

As Bradford demonstrated, the courts have ruled that noncompetes run afoul of the FMV requirements under Stark if the restrictive covenant takes into account the volume or value of referrals. It is possible to avoid this type of Stark problem by making the physician the institution’s bone fide employee, as this is a “safe harbor”. If the practitioner is the actual employee of the instruction, the compensation has to be consistent with FMV and limits the compensation to only be given for work done by that employee physician for their employer. While not actually defined in Stark, the CMS commentary also indicates a willingness to include “commercial reasonableness” to be a requirement for compensation if the arrangement falls under one of the ten Stark “safe harbors”, such as the bone fide employment exception.

c. Covenant Medical Center’s Record-breaking Settlement

Located in Waterloo, Iowa, Covenant Medical Center (“Covenant”) is a 366-bed, full-service, multi-specialty hospital providing acute, sub-acute and outpatient health care. In 2009, Covenant found themselves in the middle of a Department of Justice (“DOJ”) investigation for

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35 Supra note 34.
36 Supra note 34.
violations of the False Claims Act. According to U.S. Attorney Matt M. Dummermuth of the Northern District of Iowa, "This payment is the largest ever related to claims of health care fraud in the Northern District of Iowa."  

According to the Department of Justice, this settlement resolves allegations that Covenant submitted false claims to Medicare because of the financial relationships with five physicians which violated the Stark Law. More specifically, the allegations focused on violations of Stark II, which does not allow a hospital to profit from any of the referrals of patients which were made by a physician with whom the hospital has an improper compensation arrangement. According to the DOJ’s press release, the Department recognizes an arrangement as improper if a physician is paid above fair market value for their services and that compensation is not commercially reasonable. 

Here, the arrangement did not qualify as commercially reasonable and was not at the levels dictated by a proper FMV assessment. Not only were the five physicians at issue among the highest paid in Iowa, but their salaries put them amongst the high paid in the entire nation. They were making between $719,000 and $1.8 million each. While Covenant attempted to claim they were high producers who were being properly compensated for their high volume of work, the DOJ did not agree. Therefore, any referral coming to the hospital from these physicians who were being improperly compensated was illegal under Stark II. Because of this illegal arrangement, there were False Claims Act issues for the medical center. 

The Justice Department's Civil Division and the United States Attorney's Office for the Northern District of Iowa jointly handled this case while the Office of the Inspector General, Department of Health and Human Services provided investigative assistance. The intent of the Stark Law, according to the DOJ, is to ensure that physicians' medical judgments are not compromised by improper financial incentives and are based solely on the best interests of the patient. Tony West, the Assistant Attorney General for the Department of Justice's Civil Division, stated, "Health care providers must act in the best interests of their patients. The Justice Department will protect patients by pursuing hospitals that have improper financial relationships with physicians." In order to effectuate the goals of Stark, the DOJ is “actively working with our investigative partners to ensure Medicare funds are properly spent, and we will continue to

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40 Supra note 39.
41 Supra note 39.
43 Supra note 39.
44 Supra note 39.
45 Supra note 39.
46 Supra note 39.
Aggressively pursue all types of fraud in order to protect federal health care dollars.

Appropriate application of the Stark law is an ongoing challenge. Each new case and settlement provides additional guidance for those charged with keeping their physician compensation packages in compliance with state and federal laws. As mentioned above, many groups outside of the DOJ acted in concert to solicit this high-value settlement from Covenant Medical Center. With the amount of money at stake which the federal government can obtain from hospitals and medical centers found in violation, it safe to assume that the number of investigations of and settlements with health care organizations will do anything but increase.

III. Allocation of Purchase Price

As will be discussed later in Purchasing Ancillaries, the fair market valuation will allocate a value to each tangible and intangible that is purchased. Often if a hospital is acquiring a physician’s practice, the major and most valuable asset is not the hard assets or medical records, but the intangible “good will” of the practice. Professionals have ways in which the IRS has blessed the valuing of such goodwill as a restrictive covenant, if such jurisdiction permits restrictive covenants as will be discussed later in this outline. The major issue concerning the allocation of the purchase price is the tax ramifications. The “good will” of a practice has the benefit of capital gains tax rather than ordinary income. Thus, it would be afforded a 20% tax rather than the restrictive covenant which is taxed as ordinary income or subject to the Seller’s tax bracket. Hence, a Seller always wants the most placed on the good will and tangibles of the business if possible. All must be sound or it will be subject to IRS scrutiny and audit.

IV. Covenants Not to Compete

Many employers choose to include restrictive covenants not to compete (“noncompetes”) within their employment contracts. For hospitals, they are able to insert such clauses into the employment agreements with physicians or physician groups. This is done with the goal of preserving the investment the hospital makes in the physician, as training a new physician and letting them have access to all of your patients just to turn around and have them leave for the rival hospital a year later would prove to be problematic. When affiliating with a new group of physicians, it is important to examine how to best structure their new noncompetes.

Most noncompetes take the same general form, as most employers want to prevent the same thing: their employee to take their talents and skills obtained from them to their nearby rival competitor by limiting the geographic area they can practice in for a particular period of
time. To adequately protect their interests, employers will seek to control the area where their former employee will be able work after termination of the employment relationship. Most states choose to allow employers to do this, as a covenant imposing a reasonable restraint will generally be held to be a valid exercise of the parties' freedom to contract.\(^\text{48}\) It is now uniformly agreed that in order to be valid, a promise imposing a restraint in trade or occupation must be reasonable.\(^\text{49}\) Generally, the reasonableness of a noncompete turns on the facts of the particular case as of the time the contract was entered into, and the courts, in determining whether and to what extent unreasonable restrictions may be modified, usually take into account various factors, such as the territorial scope and duration of the restraints, as well as the activities which are prohibited.\(^\text{50}\) If the employer can show that the noncompete serves their legitimate business interests, then it will likely be reasonable. Employers run afoul of the “reasonableness” system when they create an area or an amount of time that is beyond what is necessary to protect their interests, such as their investment in their physicians.

States approach this issue in various ways. Some states, as those discussed below, yield to the legislature and allow their noncompetes to be governed by statutes and regulations. In Ohio, as in many other states, the noncompete guidance for employers arises out of the common law. It is well settled in Ohio case law that a noncompetition covenant of reasonable duration and area will be enforced when properly made a part of an employment agreement.\(^\text{51}\) A court may enforce a covenant not to compete to the extent necessary to protect an employer's legitimate interests.\(^\text{52}\) To show that a noncompetition agreement is reasonable, the employer must prove by clear and convincing evidence that the agreement: (1) is no greater than is required for the employer's protection; (2) does not impose undue hardship on the employee; and (3) is not harmful to the public.\(^\text{53}\)

\begin{itemize}
\item \textit{a. Collection of remarkable noncompete state statutes}
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Those states who choose to allow statutes and regulations to control their approach to noncompetes take a similar approach in their treatment of an employer’s ability to control the employee’s professional actions after the employment relationship has been terminated. While most states approach the treatment of restrictive covenants enforced against employees the same regardless of the employee’s actual position or profession, some states choose to carve out specific rules which treat physician noncompetes uniquely.

\(^{48}\) 6 Williston on Contracts § 13:4 (4th ed.)
\(^{49}\) Supra note 48.
\(^{50}\) 61 A.L.R.3d 397 (Originally published in 1975)
\(^{52}\) 39 Ohio Jur. 3d Employment Relations § 77.
\(^{53}\) Supra note 52.
Delaware appears to protect the physician’s right to practice after terminating an affiliation with other physicians comparatively more than most other states, as their legislature drafted a specific statute to protect this situation instead of leaving it to the common law. The Delaware statute explicitly states, “any covenant not to compete provision of an employment, partnership or corporate agreement between and/or among physicians which restricts the right of a physician to practice medicine in a particular locale and/or for a defined period of time, upon the termination of the principal agreement of which said provision is a part, shall be void.”\(^{54}\) (Emphasis added.) Therefore, agreements between physician groups may not include any type of noncompete to govern the physician’s practice of medicine after the agreement is terminated, regardless if the restriction is geographic or time-related. This provision may not affect employment agreements between physicians and non-physician owned hospitals, as the resulting agreement would not be “between and/or among physicians”. However there is currently no case law in Delaware which definitively addresses this issue.

In Idaho, a state which has multiple medically-underserved regions, their legislature established a specific statutory scheme to deal with restrictive covenants for foreign physicians who practice in those areas. Rural and underserved communities in Idaho would be able to apply for the placement of a foreign trained physician after demonstrating that they are unable to recruit an American physician, and all other recruitment/placement possibilities have proven to be inaccessible.\(^{55}\) The “Idaho Conrad J-1 Visa Waiver Program” authorizes the Idaho department of health and welfare to recommend up to thirty foreign trained physicians per federal fiscal year to locate in communities that are federally designated as having a health workforce shortage.\(^{56}\) This triggering designation is done by the Health Resources and Services Administration (“HRSA”).\(^{57}\) If a physician is practicing under a J-1 visa, the employment contract must not prevent the physician from providing medical services in the designated shortage area after the term of employment.\(^{58}\) A noncompetition clause or any provision that purports to limit the J-1 visa waiver physician's ability to remain in the area upon completion of the contract term is prohibited.\(^{59}\) Additionally, it is relevant to note that the contracting party must guarantee the physician a base salary of at least ninety-five percent of step II of the local prevailing wage for the field of practice in the area to be served.\(^{60}\)

Next, Tennessee’s law, while not unique in theory, is unique in its specificity of application, as it goes so far as to discuss restrictive covenants as they relate to a purchase of a

\(^{54}\) Del. Code Ann. tit. 6, § 2707 (West 2011).
\(^{56}\) Supra note 55.
\(^{59}\) Supra note 58.
\(^{60}\) Supra note 39.
physician practice. An agreement entered into in conjunction with the purchase or sale of a healthcare provider's practice may restrict the healthcare provider's right to practice the healthcare provider's profession. However, the duration of the noncompete and the allowable area of the restriction must, as in many states, be reasonable under the circumstances. There shall be a rebuttable presumption that the duration and area of restriction agreed upon by the parties in such an agreement are reasonable.

Finally, Texas has a unique approach. A covenant not to compete relating to the practice of medicine is enforceable in Texas against a person licensed as a physician by the Texas Medical Board as long as the non-compete covenant complies with certain requirements. First, the covenant must not deny the physician access to a list of his patients whom he had seen or treated within one year of termination of the contract or employment. Also, the non-compete must still provide access to medical records of the physician's patients after the physician’s termination, as long as authorization is given by the patient. The non-compete must provide that the physician will not be prohibited from providing continuing care and treatment to a specific patient or patients during the course of an acute illness even after the contract or employment has been terminated. The non-compete must also have a buy-out option of the covenant by the physician at a reasonable price or, at the option of either party, or at a price as determined by an arbitrator. If the physician has a business ownership interest in a hospital or ambulatory surgical center, then none of the noncompete clause requirements are required.

b. Official CMS Noncompete Guidance

In May 2011, CMS released an Advisory Opinion which examined whether or not it was proper to include a non-compete for a physician in a hospital’s recruitment package. This issue arose in September 2007, when CMS issued the Stark II, Phase III regulations. This new segment of the law changed CMS’ previous approach to the permissibility of non-competes in recruitment arrangements. While they were formerly prohibited, CMS was convinced that categorically prohibiting entities from making use of restrictive covenants may actually make it more difficult for hospitals to recruit physicians. CMS reasoned that it was possible that some physician practices would be averse to hiring additional physicians unless they could impose limited, reasonable non-compete clauses. Upon reflection, CMS officials amended 42 C.F.R. Section 411.357(e)(4) to state that physicians and physician practices may not impose on the

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62 Supra note 61.
63 Supra note 61.
65 Supra note 64.
66 Supra note 64.
67 Supra note 64.
68 Supra note 64.
recruited physician any practice restrictions that *unreasonably restrict* the recruited physician’s ability to practice medicine in the geographic area served by the hospital if they are offering “remuneration” to get the physician into their area in the first place, which leaves “reasonable restrictions” in the recruitment agreement permissible.

In 2011, a hospital was requesting guidance as to whether or not a non-compete provision in a recruitment package which included remuneration was proper, as the “Physician Recruitment exception” said that if a hospital offers remuneration to entice a physician to relocate, the agreement must satisfy many requirements, one of which is that a physician practice may not impose practice restrictions on the recruited physician that unreasonably restrict the recruited physician's ability to practice medicine in the geographic area served by the hospital.\textsuperscript{70} The entity requesting the advisory opinion, a hospital and a physician practice plan, wanted to execute a physician recruitment agreement to entice a pediatric orthopedic surgeon to their area, because their area had a documented need. Within the proposed arrangement described by the requesting hospital, the physician would receive an income guarantee loan and moving expense loan (“remuneration”), as well as be subject to a non-competition provision. On its face, the non-competition provision restricted the physician from “establishing, operating, or providing professional medical services at any location within a twenty-five-mile radius from the Hospital for one year following the earlier of the termination or expiration of the Proposed Arrangement”.\textsuperscript{71} The hospital was hoping this provision would be permissible.

CMS answered favorably, as Stark II would have disallowed it, but since CMS changed their approach to this issue after receiving comments of its real-world impacts, the current non-competition provisions will not be categorically prohibit non-competes from recruitment arrangements, as long as they’re “reasonable”.\textsuperscript{72} In reaching their decision, CMS officials said they evaluated several factors to decide whether or not this non-competition provision imposed practice restrictions that “unreasonably restricted” the physician’s ability to practice in the geographic area served by the hospital.\textsuperscript{73} The assessed time period, distance requirement and whether or not the physician would be permitted to practice at certain hospitals within and outside the hospital’s geographic service area within the one year period. They also assessed the hospital’s state and local laws regarding restrictive covenants. Based upon the fact the one year prohibition was reasonable, the 25 mile radius was a reasonable geographic service area for the hospital and the fact that the physician would still be permitted to practice at certain hospitals,

\textsuperscript{70} 42 C.F.R. § 411.357 (2010).
\textsuperscript{72} Supra note 71.
\textsuperscript{73} Supra note 71.
CMS decided the noncompete was permissible as it could not be found to “unreasonably restrict the physician’s ability to practice medicine”.74

V. Purchasing Ancillaries and Loss of Revenue

One tricky issue is negotiating the purchase price for an ancillary medical testing business, such as an imaging center or physical therapy business. Many physician practices provided services ancillary to their medical business as a way to increase revenue. However, in the last several years, Medicare has been reducing the amount that it pays freestanding facilities, such as a physician’s practice, for such services. Thus, Medicare pays more to a hospital which provides the same service. Hence, the trend has been for many physicians to sell these ancillary businesses to a hospital and then either become employed or leased as an independent contractor to the hospital for professional services, or at minimum enter into a management agreement with the hospital to manage the testing facility that was sold to the hospital.

Valuing these ancillary businesses is very tricky especially since most of these deals have a portion of the purchase price allocated to the tangible assets but the greater portion is typically allocated to the intangibles (e.g., goodwill, trade name, restrictive covenant). Thus, if possible and financially feasible, it is advisable to obtain a fair market valuation to not only determine the purchase price, but also the allocation among all of the tangible and intangible assets.

In order to comply with Stark and AKS, fair market value is key. Often, physicians will somehow want to be compensated for the “referrals” that they will make to the testing facility once it is sold to the hospital. However, it is clear that any such arrangement that contemplates in any way the past or future referrals by the Sellers to the hospital will violate both Stark (if the testing facility is a DHS) and AKS since the purchase price would be taking into account the volume or volume of referrals. Lawyers can counsel on these regulatory issues, but unless otherwise trained and credentialed are in no position to offer commentary on whether the purchase price constitutes fair market value. Nevertheless, a lawyer can review the fair market value report for completeness, regulatory commentary and assumption as to their general reasonableness.

Often by giving the physician an opportunity to manage the ancillary business acquired by the hospital, the physician can earn extra income for these management/administrative duties, but not be the owner tied down with capital, billing and collection issues.

VI. Adjusting Revenue and Guaranteeing Compensation

74 Supra note 71.
Many transactions between hospitals and physicians involve guaranteeing a level of compensation usually relying on a third party source such as the Medical Group Management Association’s annual survey of physician compensation. It is broken down by specialty, region of the country and percentiles. Additionally, it is possible to get a valuation to determine what is the proper amount to pay in order to comply with the fair market requirements of Stark, AKS and the IRS. Many transactions, while guaranteeing a first or second year salary, are tying the guarantee to RVU production, or billables, collections or net revenues. Thus, compensation may be adjusted upward or downward based on RVU production. The ability to adjust the compensation downward in the event of decreased revenue or productivity by the physician helps the hospital to ensure that it is paying fair market value to the physician. In the United States v. Campbell, (D.W.J. Jan. 4, 2011 (2011 WL 43013)), the court held that payment by a hospital to a physician must be commensurate with the duties required and the performance of those services must be a prerequisite to the receipt of payment. Otherwise, the payments look like a sham arrangement and a disguise for kickbacks. Thus, hospitals do not typically guarantee a salary for a long period of time since it can easily fall out of fair market value.

VII. Case Study Hypothetical

Anytown Hospital (“Hospital”) is a 400 bed hospital is located in Anytown, USA. It is considering acquiring a four person cardiology practice called Hearts-R-US (“HRU”). HRU’s practice generates revenues in the 50 - 70% of MGMA. The physicians have been experiencing reduced revenues on account of payor sources and decreased reimbursement for ancillary tests. HRU also owns a testing facility located 10 miles from its practice which is jointly owned with a radiologist, who performs all of their readings.

The testing facility is Tests-R-US (“TRU”) and provides echoes and stress tests to Medicare, Medicaid and commercial beneficiaries. TRU leases all of the testing equipment; however they are not capital leases. Three years ago at its peak, the testing facility generated $1 million. Today, it generates about $500,000 and approximately nets $50,000 to each owner. Each member of HRU has earned roughly $400,000 for their professional services.

HRU would like for each physician to be paid by Anytown Hospital a $750,000 guaranteed salary for three years as well be granted a six year agreement. To your surprise, Anytown Hospital has agreed to a purchase price of TRU of $8 million cash on closing. Your Director of Physician Development has inked a LOI with HRU. He comes to you to draft the PSA/employment agreements and make everything “legal.” He also wants you to obtain a FMV valuation under attorney client privilege for both the lab and the professional services. What do you do?

Alternative Hypotheticals:
What if you have a valuation for TestsRUS at $3 million and fair compensation of $500,000 at the 80th percentile for each physician?

What if you have a valuation from Scooby Doo Valuations for $8 million and $750,000? Note: $7.9 million of the purchase price is allocated to goodwill. It is a three page valuation and you question the credentials of the valuation professionals. What do you do now?

Does your analysis change if HeartsRUS was never on staff at Anytown Hospital but exclusively used the other hospital located three miles from Anytown Hospital?

Anytown Hospital’s Director of Physician Development promised that there would not be a noncompete for either transaction. Note Anytown’s courts find reasonable restrictive covenants enforceable.

What regulations should keep you up at night?