

**THE MSO'S PROGNOSIS AFTER THE ACA:
A VIABLE INTEGRATION TOOL?**

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February 11 and 12, 2013, Phoenix, Arizona

I. Management Service Organizations (MSOs): Background and Basics

A. A Brief History¹

The 1990's saw a surge in Management Services Organizations (MSOs). At that time, as now, there was a focus on integration, consolidation and cooperation. The healthcare industry considered payment changes associated with managed care and an anticipated shift from traditional fee for service (FFS) reimbursement to capitation models. At the time, integration was intended to address increased scrutiny, an increased need to manage resources, and advancing technology (especially information technology). There was a particular focus the impact of consolidation / integration on physicians. Employment relationships were notable for the associated loss of control by the physician, with the tradeoff being increased security in a changing and challenging environment. MSOs were seen as an alternative to employment that would not only address the need for more security, but would also allow the physician to retain more control over his/her own destiny.

With the early 2000's came a breakup of the integrated delivery systems which were popular in the preceding decade.² Commentators suggest that the disintegration

¹ For historical perspective, see (1) AHLA Managed Care Law Institute, Chicago 1994, "Management Services Organizations (MSOs): Structural, Legal and Operational Issues" Paul R. DeMuro. Westlaw citation: AHLA-Papers P06089440; AHLA Managed Care Law Institute, Chicago 1995; (2) "Business Issues in Integrated Delivery System and Management Services Organization Development." Dennis C. Aster, Westlaw citation AHLA-Papers P12049506 (3) "Physician Equity Model Management Service Organizations." Dennis S. Diaz, Westlaw citation: AHLA Papers P12049537.

stemmed from a lack of information technology needed to manage risk contracts (such as electronic health records and data on claims); overpaying physicians for their practices; acquisitions without achieving economies of scale, a failure to coordinate care for the population most in need, the chronically ill; and the fact that the impetus for change came from providers rather than from payors.³

With the passage of the Patient Protection And Affordable Care Act and the rise of the Accountable Care Organization (ACO), integration strategies are in the spotlight once again.

B. What is an MSO?

A Management Service Organization (MSO) is a business that provides non-clinical services to providers. MSOs are most commonly known for providing administrative services to physician practices, but services provided by particular MSOs can vary widely (see the list below). Some MSOs provide a menu of services where providers select which administrative functions the MSO will provide. Others specialize exclusively in a certain type of service, such as Electronic Health Records (EHR).

An MSO may simply provide management and administrative services to a practice, or it may acquire a practice's assets (thereby providing capital to the practice) and subsequently enter into agreements to provide the practice with space and/or equipment. MSOs may be owned by non-healthcare provider investors, by a hospital, by

² AHLA Hospitals and Health Systems Law Institute, Las Vegas 2007, "Employing Physicians Without Buying Their Practices: How Hospitals Are Avoiding The Mistakes Of The Past" Peter A. Pavarini. Westlaw citation: AHLA-Papers P02060713; AHLA Hospitals and Health Systems Law Institute, Orlando 2008, "The Physician Enterprise Model: Beyond The Hospital – Physician Joint Ventures To The Realm Of True Integration" Peter A. Pavarini. Westlaw citation: AHLA-Papers P02140814.

³ Lawton R. Burns and Mark V. Pauly, *Accountable Care Organizations May Have Difficulty Avoiding The Failures Of Integrated Delivery Networks Of The 1990s*. 11 HEALTH AFFAIRS 2407, 2408-2009 (2012).

a group of physicians, a joint venture between a hospital and physicians, or a health plan. They may interact with, be combined with or evolve into an Independent Practice Associations (IPA) or ACO. Some MSOs provide specialized services to other MSOs.

Generally, the purpose of an MSO is to assist physician practices with the administrative challenges associated with running their business. MSOs take advantage of economies of scale to provide the practice with a heightened level of expertise and to help the practice obtain better results at lower cost. MSOs can be attractive to physician practices because, while the practice receives significant administrative assistance from the MSO, unlike an employment scenario, the physicians can maintain a significant level of autonomy.

C. Examples of MSO Services:

Administrative, Operational, Financial: providing administration and practice management; developing, implementing, and monitoring practice policies and procedures; managing inventory; preparing budgets and financial statements; managing overhead and revenue; accounting and auditing; payroll and benefits; inventory management; transcription services; phone systems/services; scheduling; developing and managing practice protocols and clinical policies; administration of physician income distribution model; assisting with accreditation; negotiating, monitoring, and managing contracts; business development and marketing, sales, public relations, and provider relations; obtaining insurance/reinsurance, risk management, Utilization Management / Quality Assurance.

Personnel: screening and hiring employees (clinical and nonclinical); providing office staff, billing and coding personnel, IT personnel, CEO, CFO, CIO, technologists;

providing human resources policies and/or performing human resources function; leadership training; staff training.

Education: in-service training, compliance training, disease-specific education for staff and patients.

Coding, Billing and Collection: monitoring and implementing policies and programs for proper billing and coding; providing coding personnel; monitoring and training on regulatory compliance, claims submission, claims timeliness guidelines; monitoring claims status; managing accounts receivable; establishing and maintaining lockbox; collections or collection agency coordination; monitoring and educating on reimbursement changes; monitoring and assistance with eligibility determinations and prior authorization, third party liability, coordination of benefits, and overpayments; providing billing support; reporting; claims audits; appealing denials; pursuing claims recoveries; maintaining payment logs; providing customized billing reports.

Office Space: assessment and management of physical plant, locating and leasing office space to practice (i.e., contracting directly for space for the provider).

Equipment: assessment and management of equipment needs; leasing equipment to practice.

Information Technology: assessing and strategic planning regarding IT implementation; server maintenance; network management; providing, monitoring, and training on EHR systems and practice management software; providing, implementing, integrating, and updating hardware, software; providing IT personnel and support; providing billing systems; providing helpdesk; data conversion; document management and scanning.

Compliance: preparing, implementing, and monitoring policies for compliance with requirements such as fraud and abuse, HIPAA Privacy and Security, disaster planning, CLIA, OSHA, FMLA, and state statutes and regulations.

Credentialing: maintaining provider files; managing enrollment and credentialing with health plans and payors; reporting to payors; assisting with credentialing standards.

Group Purchasing: obtaining group purchasing discounts; contracting for supplies and pharmaceuticals.

Managed Care: assisting with managed care negotiations and contracting; assisting with compliance with requirements, policies and procedures, referral authorizations, health plan audits, and regulatory changes; assistance with IPA policies and procedures; monitoring managed care contracts.

Strategic Planning: analysis, implementation, development of integrated delivery systems; assistance with forming IPA; consulting services; project management; decision support; startup, acquisition or sale of physician practices; coordinating/developing shared risk arrangements.

This manuscript focuses on the use of MSOs by health systems, hospitals and larger group practices as vehicle for aligning with physicians or smaller, independent physician practices.

II. Key Legal and Regulatory Concepts

A. The Stark Law

The federal self-referral law at Social Security Act §1877; 42 USC §1395nn is commonly known as the "Stark Law" after Congressman Pete Stark, a California congressman who introduced and has strongly supported the statute. The Federal

physician self-referral proscription prohibits physicians from ordering “Designated Health Services” (DHS)⁴ for Medicare (and to some extent, Medicaid) patients from entities with which the physician (or an immediate family member) has a “financial relationship.” The Center For Medicare And Medicaid Services (CMS) has issued regulations and guidance interpreting the Stark law; the regulations appear at 42 CFR §411.350 *et seq.*⁵

The term "financial relationship" includes both compensation arrangements and investment and ownership interests.⁶ The term "referral" under the Stark Law is defined broadly, "the request or establishment of a plan of care by a physician which includes the provision of the designated health service." Stark includes a general prohibition on self-referrals and a number of exceptions.⁷ Specifically, the statute and regulations provide that a number of types of financial relationships do not even fall with the purview of the

⁴ The term "designated health services" ("DHS") includes the following: clinical laboratory services; physical therapy, occupational therapy, and speech language pathology services; radiology and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices; home health services and supplies; outpatient prescription drugs; and inpatient and outpatient hospital services. Social Security Act § 1877 (42 U.S.C. 1395nn).

⁵ On August 14, 1995, CMS published final regulations implementing the Stark Law's prohibition against the ordering of clinical laboratory services from an entity with which a physician has a financial relationship (the "Stark I Regulations"). The Stark I Regulations became effective on September 13, 1995. On January 9, 1998, CMS published proposed regulations implementing the statutory prohibitions under Stark II (the "Stark II Proposed Regulations"). See 63 Fed. Reg. 1659 (Jan. 9, 1998). On January 4, 2001, almost three years to the day after the Proposed Stark II regulations were issued, CMS published in the Federal Register "Phase I" of the Final Stark II regulations (the "Phase I Regulations"). 66 Fed. Reg. 856. Although the majority of the Phase I regulations became effective January 2002, the effective date of one sentence of the regulation (concerning percentage based arrangements) was continuously delayed. On March 26, 2004, CMS published in the Federal Register "Phase II" of the Final Stark II regulations (the "Phase II Regulations") as an interim final rule with comment period. 69 Fed. Reg. 16054. The comment period ended on June 24, 2004 and the Phase II Regulations become effective July 26, 2004. In addition, on August 8, 2006, CMS issued final regulations creating an exception for non-monetary remuneration that is used solely to receive and transmit electronic prescription drug information as well as exceptions for electronic health records software and directly related training services. 71 Fed. Reg. 45140. On July 11, 2007, CMS included a number of proposed revisions to the Stark Law in the Medicare Physician Fee Schedule. Then, on September 5, 2007, the OIG released the Stark II Phase III Final Regulations that became effective December 4, 2007.

⁶ 42 U.S.C. § 1395nn(a)(2), 42 CFR 411.354.

⁷ 42 U.S.C. § 1395nn(b); 42 CFR 411.357.

statute. In addition, there are a host of exceptions that apply to ownership and compensation arrangements.

MSO arrangements between providers with referral relationships, such as a physician or physician practice and a hospital, will generally constitute a "financial relationship." Accordingly, it is critical that the arrangements between these providers satisfy the requirements of the applicable Stark exceptions.

1. Personal Services Arrangements.⁸

Any provision of services **from physician to the MSO** should comply with the personal services arrangement exception. However, another exception (the fair market value compensation exception) applies to services from the entity to the physician (see Section II.A.2 below). This exception for personal service arrangements protects compensation arrangements between a physician and an entity if the physician is an independent contractor and not an employee of the entity. The exception requires: (1) a written agreement that specifies the services covered by the arrangement; (2) that the arrangement cover all of the services to be provided **by the physician to the entity**; (3) that the term of the agreement must be for one year or more; (4) that the aggregate services contracted for must not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement; (5) that the compensation to be paid over the term of the agreement be set in advance, not exceed fair market value, and not be determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties; and (6) that the services to be performed

⁸ 42 U.S.C. § 1395nn(e)(3); 42 CFR 411.357(D) et seq.

under the arrangement not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

Since the personal services arrangements exception only applies to covered services provided by the physician to the entity, we must look elsewhere for an exception that protects services provided by the MSO to the physician or physician practice.

2. Fair Market Value Exception⁹

The fair market value exception was promulgated under the authority of the secretary to specify exceptions and regulations that are permissible because they do not pose a risk program or patient abuse.¹⁰ It excepts compensation from an arrangement between an entity and a physician for the provision of items or services (other than the rental of office space) by the entity to the physician or group of physicians under the following conditions: (1) The arrangement is in writing, signed by the parties, and covers only identifiable items or services, all of which are specified in the agreement, (2) The writing specifies the timeframe for the arrangement, which can be for any period of time and contain a termination clause, provided that the parties enter into only one arrangement for the same items or services during the course of a year. An arrangement made for less than 1 year may be renewed any number of times if the terms of the arrangement and the compensation for the same items or services do not change, (3) The writing specifies the compensation that will be provided under the arrangement. The compensation must be set in advance, consistent with fair market value, and not determined in a manner that takes into account the volume or value of referrals or other business generated by the referring physician. Compensation for the rental of equipment may not be determined using a

⁹ 42 CFR §411.357(l).

¹⁰ 72 F.R. 51059 (September 5, 2007), "...the exception, which was promulgated using our authority under section 1877(B)(4) of the Act."

formula based on (i) A percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services performed or business generated through the use of the equipment; or (ii) Per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred by the lessor to the lessee. (4) The arrangement is commercially reasonable (taking into account the nature and scope of the transaction) and furthers the legitimate business purposes of the parties. (5) The arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission. (6) The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates a Federal or State law.¹¹

The Stark III guidance,¹² explicitly acknowledged that the amendment to "the text of the exception for fair market value compensation in §411.357(l) [was] to permit application of that exception to arrangements involving fair market value compensation to physicians from DHS entities, as well as to arrangements involving fair market value compensation to DHS entities from physicians."

3. Payments By A Physician For Items And Services¹³

This exception is only available where none other applies.¹⁴ It allows for to payments made by a physician (or an immediate family member) to an entity as compensation for any other items or services that are furnished with a price that is consistent with fair market value and that are not specifically addressed in another

¹¹ 42 CFR §411.357(l).

¹² 72 F.R. 51057 (September 5, 2007).

¹³ 42 U.S.C. § 1395nn(e)(8); 42 CFR 411.357(i).

¹⁴ 42 CFR 411.357(i); 72 F.R. 51056 – 51057 (September 5, 2007), "the exception does not apply to items or services for which there is another potentially applicable exceptions in §411.355 through §411.357".

provision. In the context of this exception, “services” means any kind of services, not exclusively those defined as “services” for purposes of the Medicare program.

4. Rental of Office Space and Equipment¹⁵

While not as common as MSOs that exclusively provide administrative services, some MSOs lease property, office space, and/or equipment to physicians. This service relieves the physician of the administrative and time-consuming burden of locating and maintaining space. However, it is vital that the arrangement meet the requirements for this Stark exception.

This exemption protects arrangements for the use of premises in which: (1) the lease is set out in writing, signed by the parties, specifies the premises (which must be used exclusively by the lessee when used by the lessee), and is for a term of at least one year;¹⁶ (2) the space rented or leased does not exceed that which is "reasonable and necessary" for legitimate business purposes;¹⁷ (3) the lessee may make payments for the use of common areas if the payments do not exceed the lessee's pro rata share of expenses for such common space based on the ratio of space used exclusively by the lessee to the total amount of space (other than common areas) occupied by all persons using the common areas;¹⁸ (4) the rental charges over the term of the lease must be set in advance, be consistent with fair market value, and not determined in a manner that takes into account the volume or value of any referrals or other business generated between the

¹⁵ 42 U.S.C. § 1395nn(e)(1); 42 CFR 411.357(a), (b)

¹⁶ 42 U.S.C. § 1395nn(e)(1)(A)(iii); 42 CFR 411.357(A)(iii).

¹⁷ 42 U.S.C. § 1395nn(e)(1)(A)(ii); 42 CFR 411.357(A)(ii).

¹⁸ *Id.*

parties; and the lease must be commercially reasonable even if no referrals were made between the parties.¹⁹

The exception for equipment rental is similar to the space rental exceptions: (1) the lease must be set out in writing, signed by the parties, and must specify the equipment covered by the lease;²⁰ (2) the equipment must be used exclusively by the lessee when used by the lessee;²¹ (3) the lease term must be at least one year, and the equipment rented or leased must not exceed that which is "reasonable and necessary" for legitimate business purposes;²² (4) the rental charges over the term of the lease must be set in advance, consistent with fair market value, and not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties; and the lease must be commercially reasonable even if no referrals were made between the parties.²³

3. Isolated Transactions²⁴

In the case of an MSO that intends to acquire the practice assets of a physician practice, the isolated transactions exception is implicated. The MSO's acquisition of the practice's assets can provide an infusion of capital for the practice. However, where a hospital is involved, the transaction should meet the requirements of the isolated transaction exception to be an acceptable arrangement between a physician and an entity with which (s)he has a referral relationship.

¹⁹ 42 U.S.C. § 1395nn(e)(1)(A)(iv); 42 CFR 411.357(A)(iv).

²⁰ 42 U.S.C. § 1395nn(e)(1); 42 CFR 411.357(b)

²¹ 42 U.S.C. § 1395nn(e)(1)(A)(ii); 42 CFR 411.357(b)(ii).

²² 42 U.S.C. § 1395nn(e)(1)(A)(ii); 42 CFR 411.357(b)(ii).

²³ 42 U.S.C. § 1395nn(e)(1)(A)(iv); 42 CFR 411.357(b)(iv).

²⁴ 42 U.S.C. § 1395nn(e)(6); 42 CFR 411.357(F).

The isolated financial transactions exception protects transactions, such as a one time sale of property or practice, where the amount of the payment is consistent with fair market value and does not take into account, directly or indirectly, the volume or value of any referrals between the parties. In addition, the remuneration provided must be commercially reasonable even if no referrals are made.

There cannot be any additional transactions between the parties for six months, except for transactions that satisfy another Stark exception. However, this will not cause issues with the anticipated lease and services / management arrangements, as other transactions (including a lease of office space, personnel, and personal services) are allowed so long as they are specifically permitted under another Stark exception.

Post-closing adjustments are permitted to the extent they are not related to the volume or value of referrals. Based on clarifications in the Stark II Phase III, an isolated transaction can also include installment payments. The payments must be immediately negotiable or guaranteed by a third party, secured by a negotiable promissory note, or subject to a similar mechanism to ensure payment even in the event of a default by the purchaser or obligated party. CMS has noted that the mechanism to ensure payment even in the event of a default by the obligated party is a critical element. This may be less of an issue for MSOs because physicians are unlikely to be in a position where they want to waive payments.

4. Indirect Compensation²⁵

This exception becomes an issue when the MSO is a hospital subsidiary entity; it addresses indirect compensation arrangements and mandates that they satisfy the

²⁵ 42 CFR 411.357(P).

following requirements: (1) the compensation received by the physician from the person or entity with which the referring physician has the direct financial relationship is "fair market value" for services and items actually provided "not taking into account" the volume or value of referrals for the entity furnishing designated health services; (2) the compensation arrangement between the physician and the entity with which the physician has the direct financial relationship is set out in writing, is signed by the parties, and specifies the services covered (except for bona fide employment arrangements, which need not be in writing but must be for identifiable services and commercially reasonable even if no referrals are made to the employer); and (3) the arrangement does not violate the federal health care program Anti-Kickback Statute or any laws or regulations governing billing or claims submission

B. The Anti-kickback Statute

The Federal anti-kickback statute²⁶ provides criminal penalties and civil monetary penalties for individuals and entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce business for which payment may be made under a federal healthcare program. The type of remuneration covered by the anti-kickback statute includes but is not limited to kickbacks, bribes, and rebates. The statute applies to any such remuneration whether made directly or indirectly, overtly or covertly, in cash or in kind. Prohibited conduct includes not only remuneration intended to induce referrals, but also remuneration intended to induce the purchasing, leasing, ordering, or arranging for any goods, facility, service or item paid for by a federal healthcare program.

²⁶ Social Security Act §1128B(b), 42 USC §1320a-7B(b).

In recognition of the fact that the prohibition contained in the anti-kickback statute has the potential to impact legitimate arrangements, a number of exceptions have been enacted and are known as “safe harbors.”²⁷ According to public statements made by representatives of the OIG and the Department of Justice, as well as the preamble to the safe harbors,²⁸ if an arrangement meets one of the applicable safe harbors, it is fully protected from both criminal and civil liabilities under the Anti-kickback Statute. However, failure to meet all of the requirements of an applicable safe harbor does not make the conduct per se illegal. Rather, the preamble to the final safe harbor regulations indicates that the conduct outside the current safe harbor should be judged on a case-by-case basis.²⁹

1. Space, Equipment, and Personal Services and Management Contracts.

Just as it is important for the MSO relationship to comply with the Stark law with regard to the provision of leased premises or equipment and the provision of services (as discussed in section II. A. above), the relationship should also be structured in light of the anti-kickback safe harbors.

The OIG has created three separate safe harbors for certain contracts related to space rental,³⁰ equipment rental,³¹ and personal services and management contracts.³² These safe harbors share common requirements; all three safe harbors require: a written agreement; a term of at least one year; that the aggregate payment amount as well as the premises, equipment, or services covered be specified in advance; and that if the

²⁷ 42 C.F.R. § 1001.952.

²⁸ 64 Fed. Reg. 63518 et seq.

²⁹ *Id.*

³⁰ 42 C.F.R. § 1001.952(b).

³¹ 42 C.F.R. § 1001.952(c).

³² 42 C.F.R. § 1001.952(d).

agreement does not contemplate full-time services, the agreement must also specify the schedule of intervals, their precise length, and the exact charge for such intervals. To "preclude schemes involving the use of multiple overlapping contracts to circumvent the one year requirement," the OIG has added a requirement to all three safe harbors that the agreement cover all space, equipment or services for the term of the agreement. Payments must be based on fair market value and cannot vary based on the volume or value of any Medicare or state health care program-covered referrals or business generated between the parties.

4. Investment Interest

Where a hospital and a physician practice are contemplating a joint venture MSO, the investment interest safe harbor³³ is implicated. The Investment Interest Safe Harbor regulations contain sets of criteria for investment interests: (1) in investment interests in large, publicly held companies; (2) in investment interests held in smaller healthcare companies; and an investment in healthcare entities that are located in Medically Underserved Areas ("MUAs").

*Small Investment Interests.*³⁴ With respect to the small entity safe harbor, each of the following eight standards must be satisfied: (1) No more than forty percent (40%) of the value of the investment interests of each class of investments may be held in the previous fiscal year or previous twelve (12) month period by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for, the entity. (2) No more than forty percent (40%) of the gross revenue of the entity in the previous fiscal year or previous twelve (12) month period

³³ 42 C.F.R. § 1001.952(a).

³⁴ 42 C.F.R. § 1001.952(a)(2).

may come from referrals or business otherwise generated from investors. (3) The terms on which an investment interest is offered to a passive investor, who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity, must be no different than the terms offered to other passive investors. (4) The terms on which an investment interest is offered to an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must not be related to the previous or expected volume of referrals, items, or services furnished, or amount of business otherwise generated, from that investor to the entity. (5) There may not be any requirement that a passive investor make referrals to, be in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity as a condition for remaining as an investor. (6) The entity or any investor may not market or furnish the entity's items or services (or those of another entity as part of cross-referral agreement) to passive investors differently than to non-investors. (7) Neither the entity nor any investor (nor other individual or entity acting on behalf of the entity or any investor in the entity) may loan funds to or guarantee a loan for an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity if the investor uses any part of such loan to obtain the investment interest. (8) The amount of payment to an investor in return for the investment interest must be directly proportional to the amount of the capital investment of that investor.

*Investment in Entities in MUAs.*³⁵ This safe harbor can apply to MUAs, located in either rural or urban areas. Many of the requirements for this safe harbor are similar to

³⁵ 42 C.F.R. § 1001.952(a)(3).

the small investment safe harbor. This safe harbor eliminates the 60/40 Revenue Rule and modifies the 60/40 Investor Rule to a 50/50 Investor Rule (no more than 50% of the value of the investment interest of each class of investments may be held by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity); OIG has included a requirement that at least 75% of the business in the previous fiscal year or previous twelve (12) month period be derived from services furnished to persons in an MUA or who are members of a medically underserved population ("MUP").

C. Potential Legal Pitfalls

1. Corporate Practice of Medicine

Prohibitions on the Corporate Practice of Medicine vary according to state law. The provision generally arises in light of a state's proscription against the unauthorized practice of medicine and specifically against a non-licensed individuals' owning, maintaining, or operating a place of business in which an individual is employed or otherwise engaged to practice medicine. If an MSO is too involved in the operations of a medical practice, a state's corporate practice of medicine prohibitions may be implicated.

For instance, in a matter involving orthodontic practices in Texas, certain MSO agreements were invalidated based on the violation of state law. *In The Matter Of OCA, Inc.*³⁶ related to an MSO that provided orthodontists with purchased or leased office space and equipment. The MSO conducted the financial and marketing activity of the practices, maintained facilities, equipment, and personnel required for the practices, and stipulated how much each orthodontist was required work. The orthodontists were

³⁶ 552 F.3d 413 (5th Cir, 2008),

compensated on an hourly basis for seeing patients and were essentially only left with control over diagnosing and treating patients. The MSO was paid for its overhead, and charged an hourly management fee. Profits were split between the ownership interests of the MSO and the orthodontists. The orthodontists were not authorized to withdraw funds from their operating account, so the OCA periodically transferred money from these accounts to pay the orthodontists their compensation. The course of a bankruptcy proceeding involving the MSO, the orthodontists sought to invalidate their agreements with the MSO. The Fifth Circuit upheld the bankruptcy court's ruling which invalidated the agreements under Texas law because they created an interlocking set of obligations that gave the MSO considerable control over the orthodontists practice.

2. Antitrust

It is a primary purpose of an MSO to address common industry problems. However there are certain topics that may raise issues under the Sherman Antitrust Act (which prohibits price-fixing and monopolization), the Clayton Act (which prohibits mergers that are likely to stifle competition), the Federal Trade Commission Act (providing the Federal Trade Commission with the authority to investigate and stop unfair competition and deceptive practices), the Robinson-Patman Act, and various state laws which set forth areas of conduct considered illegal restraints of trade.

Included in the prohibited activities under the antitrust laws of the United States are agreements to fix charges, prices, markups, or the conditions or terms of the sale of any product or service; participation in meetings or conversations with competitors during which either fixing or maintaining prices or limiting competition is discussed; discussing or disseminating any information in which current or future prices charged or

to be charged for products or services are set; agreeing to limit, curtail, restrict, or otherwise control the amount or availability of any health care product or service; agreeing to refuse to quote or sell products or provide health care services to any purchaser or subscriber; agreeing to allocate markets or customers, subscribers, or patients; agreeing to jointly sell or refrain from selling or discriminating in favor of or against any payer, HMO, or health insurance issuer or subscriber or patient. Competitors are generally prohibited from discussing prices, markets or division of markets or any effort to limit free and open competition.

Antitrust laws and state laws relating to collaboration between competitors may be implicated in the context of an MSO's provision of services to competing providers, particularly services relating to assistance with contracts, including managed care contracts and relating to obtaining preferential pricing in the context of group purchasing. There is a potential for antitrust issues when the MSO is managing contracts and having collaborations between horizontal competitors and great care should be taken through this process. Antitrust counsel should be consulted regarding which safe harbors can apply, if any. The FTC and DOJ have promulgated a number of specific safe harbors, and should an arrangement be scrutinized, proper structuring can result in a review under a rule of reason analysis rather than a per se illegality standard for price-fixing, illegal information of information or market allocation.

The traditional assumption is that there are two opposing methods of analyzing conduct under Section 1 of the Sherman Act: the rule of reason and the per se rule. This assumption derives from the belief that practices affecting the market can be neatly classified as either pro-competitive or anticompetitive. Thus, pro-competitive conduct

should receive the benefit of the doubt under a rule of reason that considers all of its possible competitive justifications and beneficial effects. Anticompetitive practices, on the other hand, should be condemned under the per se rule without giving a defendant the opportunity to prove that a restraint may have a redeeming beneficial purpose. Thus, under the Per Se Rule, the practice is automatically illegal because of its anti-competitive nature. Under the Rule of Reason, a full investigation, focusing on unreasonableness, of whether a practice has anti-competitive purposes or anti-competitive consequences

Physician networks and other joint ventures among health care providers are of particular importance in antitrust enforcement, as the size and practices of joint enterprises have a critical impact on the competitive performance of health care markets. Antitrust doctrine in this area requires a careful balancing of anticompetitive harms resulting from enhanced provider power and pro-competitive benefits arising from new entry or enhanced efficiency. Government agencies have attempted to clarify the applicability of broad antitrust doctrine to many kinds of health care ventures by issuing more than ninety advisory opinions on health industry conduct, a series of guidelines on provider joint ventures, and joint venture guidelines of general applicability.³⁷ Although these policy statements have made some level of impact in clarifying the agency's enforcement positioning, they are not legally binding and have not yet been buttressed by binding court precedent.

3. Tax Exempt Organization Issues

³⁷ Department of Justice and Federal Trade Commission, "Statements of Antitrust Enforcement Policy in Health Care," <www.usdoj.gov/atr/public/guidelines/1791.htm> (December 12, 2001).

Tax-exempt hospitals face special issues when entering into MSO arrangements or ventures. The a particular structure or contract should be carefully considered in light of its potential impact on the hospital's status.

An organization (corporation, community chest, fund, or foundation) may qualify for exemption from federal income tax under section 501(a) of the Internal Revenue Code (the "Code") as an organization described in section 501(c)(3) of the Code if it is organized and operated exclusively for charitable, religious, educational, scientific, or literary purposes. Most nonprofit healthcare organizations are eligible for recognition of exempt status as organizations described in section 501(c)(3). Nearly all non-profit hospitals qualify as organizations that are organized and operated exclusively for charitable purposes through the promotion of health. The promotion of health has been recognized as a charitable purpose. Qualified organizations are granted an exemption from federal income taxation by law. A non-profit entity should evaluate any potential effect that the MSO relationship (particularly an equity joint venture between a non-profit hospital and a for profit entity), may have on its tax exempt status. It is important to structure relationships with IRS tax-exempt rules in mind to avoid putting the hospital's status at risk.

III. Valuation of MSOs and MSO Arrangements

A. Conceptual underpinnings of valuation theory

Business valuation is a forward-looking science. It attempts to quantify in the form of a sum of money, at a given date, the right to receive future economic benefits beyond that date. On the other hand, the valuation of compensation provisions under a

service arrangement is the process of converting to an amount of cash or a cash equivalent the service provided by one or more persons or entities to another during a given length of time.

B. Financial considerations

Entering into management arrangements often involves significant decision-making for all parties, requiring sound financial analysis to gain an understanding of the financial feasibility, capital and financing requirements, return on investment, and tax implications. Parties to the arrangement or business venture should be keenly aware of how the proposed structure of the contractual arrangement or the MSO itself affects current profitability and capital requirements, which can only be confidently assessed through a complete financial analysis. Financial analysis include the consideration of overhead, working capital infusion and debt requirements, tax implications and other financial aspects of the proposed arrangement. While insufficient to assess the fair market value of a proposed business venture or arrangement, a sound financial analysis is important to understand how the deal will affect the parties and will be of significant importance in valuation methodology under the income-based approach.

C. Broad financial valuation approaches applicable to business and service arrangement appraisal

The body of knowledge in professional appraisal practice, regardless of discipline (i.e., business valuation, real estate appraisal, asset appraisal, etc.), generally looks to the application of three broad approaches to valuation, as follows: the asset- (or cost-) based approach, the income-based approach, and the market-based approach. Each such

approach serves as a means to evaluate the economics of the asset, business interest, or financial arrangement being valued, with each approach viewing the subject from a unique perspective. Within each broad approach, one or more methods exist that the valuation analyst can deploy to generate indications of value. These broad approaches to valuation theory should generally be *considered* by the valuator; however, the degree to which the valuation analyst applies each approach and the methods that generate results within that approach will depend on factors that include the relevance of the approach to the subject assignment and the degree to which competent information exists to permit its use.

D. Key valuation terminology³⁸ applicable to MSO appraisal

- Cash flow. Cash that is generated over a period of time by an asset, group of assets, or business enterprise.
- Cost of capital. The expected rate of return that the market requires in order to attract funds to a particular investment.
- Discount rate. A rate of return used to convert a future monetary sum into present value.
- Economic benefits. Inflows such as revenues, net income, net cash flows, etc.
- Going concern. An ongoing operating business enterprise.
- Intangible assets. Nonphysical assets, such as franchises, trademarks, patents, copyrights, goodwill, equities, mineral rights, securities, and contracts that grant rights and privileges and have value for the owner.
- Marketability. The ability to quickly convert property to cash at minimal cost.

³⁸ *International Glossary of Business Valuation Terms*. as adopted in 2001 by the American Institute of Certified Public Accountants, American Society of Appraisers, Canadian Institute of Chartered Business Valuators, National Association of Certified Valuators and Analysts, and The Institute of Business Appraisers.

- Valuation date. The specific point in time as of which the valuator's opinion of value applies.

E. Valuation concepts applicable to businesses and service arrangements

Valuation is very much impacted by subjectivity and is therefore subject to the opinion of the valuator. There has existed for decades a body of knowledge related to general business valuation, which has undoubtedly benefited the theory of valuation of health care business enterprises. On the other hand; however, valuation of compensation for health care contractual arrangements is a relatively new field, and only in recently years have industry leaders begun to develop a knowledge base from which those who value compensation arrangements can measure value with some degree of uniformity. To a large degree, while business enterprises and contractual arrangements represent different economic dynamics, the broader approach to applying valuation theory has a great deal of similarity, as will be more fully explored in these materials.

a. Standards of value

“Value” is ascribed significance in transactions and contractual arrangements because of the consideration associated with the deal, and how it is defined depends on the person who uses the term and how it is used. Essentially, the standard of value gives definition to the term by explaining the type of worth being sought, and several standards of value exist to correspond to the various types of value that can be achieved.

i. Widely recognized standards of value

Among the universally accepted standards of value are intrinsic value, investment value, fair value and fair market value.

1. Intrinsic value

The value that an investor considers, on the basis of an evaluation or available facts, to be the “true” or “real” value that will become the market value when other investors reach the same conclusion.³⁹

2. Investment value

The value to a particular investor based on individual investment requirements and expectations.⁴⁰

3. Fair value

Fair value is defined as “the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.”⁴¹ Certain states’ laws provide for dissenting shareholder rights, permitting the purchase of a petitioning shareholder’s shares at the value before considering the impact of the dissenting action that has taken place.

4. Fair market value

The present-day industry standard definition of fair market value originated with the publication of Internal Revenue Service Revenue Ruling 59-60, stating that the definition of “fair market value” is, in effect, “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 of relevant facts. Court decisions frequently state in

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ IFRS Standard 13, *Fair Value Measurement*, International Accounting Standards Board (2011: London).

addition that the hypothetical buyer and seller are assumed to be able, as well as willing, to trade and to be well informed about the property and concerning the market for such property.”⁴² The IRS provides further definition as to reasonableness of compensation paid by tax-exempt organizations, and valuation analysts look to the following definition from Internal Revenue Code section 4958 and related regulations: “The value of services is the amount that would ordinarily be paid for like services by like enterprises (whether taxable or tax-exempt) in like circumstances (i.e., reasonable compensation).”⁴³

The International Glossary of Business Valuation Terms defines fair market value as “[the] price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arm’s 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.”⁴⁴

ii. Regulatory standard of fair market value

The health care industry is not without material regulations that govern relationships between parties that have the ability to make referral decisions based on the financial relationships that exist among health care providers. Not the least among these is the Stark Law, more fully described above. The Stark Law contains its own definition of fair market value, replete with prohibitions against compensation based on the volume or value of referrals.

⁴² Rev. Rul. 59-60, 1959-1.

⁴³ Treas. Reg. 53.4958-4(5)(b)(1)(ii).

⁴⁴ American Institute of Certified Public Accountants, *et al.*, *Supra*.

The Stark Law definition of fair market value is implicated in many health care transactions and contractual arrangements because of the referral relationship that exists between the parties to the transaction or contract. According to the Stark Law, “[fair] market value means the 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. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals. With respect to rentals and leases described in §411.357(a), (b), and (l) (as to equipment leases only), ‘fair market value’ means the value of rental property for general commercial purposes (not taking into account its intended use). In the case of a lease of space, this value may not be adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor when the lessor is a potential source of patient referrals to the lessee. For purposes of this definition, a rental payment does not take into

account intended use if it takes into account costs incurred by the lessor in developing or upgrading the property or maintaining the property or its improvements.”⁴⁵

Under the Federal anti-kickback statute safe harbor for space rental, “[the] term fair market value means the value of the rental property for general commercial purposes, but shall not be adjusted to reflect the additional value that one party (either the prospective lessee or lessor) would attribute to the property as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare, Medicaid and all other Federal health care programs.”⁴⁶

Under the Federal anti-kickback statute safe harbor for equipment rental, “[the] term fair market value means that the value of the equipment when obtained from a manufacturer or professional distributor, but shall not be adjusted to reflect the additional value one party (either the prospective lessee or lessor) would attribute to the equipment as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.”⁴⁷

b. Premise of value (going concern or liquidation – orderly or forced)

The premise of value represents an assumption about the likely set of assumptions about the highest and best use of the subject being valued. Determining the appropriate premise of value is a critical step in the valuation. Among the alternative premises of value are going concern and liquidation, with liquidation further categorized as an

⁴⁵ 42 C.F.R. §411.351.

⁴⁶ 42 C.F.R. §1001.952(b)(6).

⁴⁷ *Id.* §1001.952(c)(6).

assemblage of assets, an orderly liquidation, or a forced liquidation. Valuation as a going concern assumes continued use or an assemblage of assets capable of producing an income stream.

F. Commercial reasonableness

Several exceptions to the general prohibition under the Stark Law require that arrangements be “commercially reasonable.” These include, but are not limited to, the office space rental exception,⁴⁸ the equipment rental exception,⁴⁹ the isolated transactions exception,⁵⁰ and the certain group practice arrangements with a hospital exception.⁵¹ The personal services arrangement exception, which will be of importance in many management service arrangements, requires that services be “reasonable and necessary for the legitimate business purposes of the arrangement.”⁵²

Certain safe harbors to the Federal anti-kickback statute, such as the following, also include “commercially reasonable” language: the space rental safe harbor,⁵³ the equipment rental safe harbor,⁵⁴ the personal services and management contracts safe harbor,⁵⁵ and the sale of practice safe harbor.⁵⁶

CMS, then HCFA, in the 1998 Stark proposed rule, interpreted “‘commercially reasonable’ to mean that an arrangement appears to be a sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of

⁴⁸ 42 U.S.C §1395nn(e)(1)(A)(v).

⁴⁹ *Id.* §1395nn(e)(1)(B)(v).

⁵⁰ *Id.* §1395nn(e)(6)(A).

⁵¹ *Id.* §1395nn(e)(7)(A)(vi).

⁵² *Id.* §1395nn(e)(3)(A)(iii).

⁵³ 42 C.F.R. §1001.952(b)(6).

⁵⁴ *Id.* §1001.952(c)(6).

⁵⁵ *Id.* §1001.952(d)(7).

⁵⁶ *Id.* §1001.952(e)(2)(iv).

any potential referrals.”⁵⁷ Subsequently, in the preamble to the Stark interim final rule, Phase II, CMS noted 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.”⁵⁸

G. Valuation of MSO fee arrangements

In often greater frequency than valuations of MSO business enterprises, appraisal experts are called upon to establish the fair market value of MSO fee arrangements between parties that have the ability to refer federal health care program beneficiaries. These referral relationships have the ability to implicate the Stark Law and the Federal anti-kickback statute and, therefore, are required to be at a fair market value level to satisfy Stark exceptions and AKS safe harbor provisions.

a. Application of broad valuation approaches in MSO fee arrangement appraisal

There are no formal standards in the valuation of compensation or fee-based arrangements between health care providers. The health care valuation community has recognized the need for a comprehensive body of knowledge, and many experts have written on the subject of valuing contractual arrangements, such as management fees. The valuation of contractual arrangements such as a management service arrangement applicable to a hospital, physician practice, or ambulatory surgery center is akin to the valuation of a business enterprise in the use of broad valuation approaches of cost,

⁵⁷ 63 Fed. Reg. (Jan. 9, 1998), p. 1700.

⁵⁸ 69 Fed. Reg. (Mar. 26, 2004), p. 16093.

income and market, although the types of methods applied under each approach will vary greatly from those used in the value of a business interest and may vary widely from one compensation arrangement to the next.

i. Cost-based approach

In establishing the value of service arrangements, the cost-based approach often takes on the form of a reproduction cost method or a replacement cost method. The International Glossary of Business Valuation Terms defines replacement cost as the current cost of a similar new property having the nearest equivalent utility to the property being valued.⁵⁹ Translated to service arrangements, this equates to the cost of a similar service with the nearest equivalent utility. Likewise, reproduction cost is the current cost of an identical new property.⁶⁰ Again, translated to service arrangements, this equates to the current cost of an identical service.

In a simplistic example, consider the MSO arrangement in which the management company furnishes only billing services, using a specific type of physician billing software. Reproduction cost would look to the cost of the identical service, while replacement cost would look to the cost of a similar service with the nearest equivalent utility, such as engagement of a competing billing service.

Central to the equation in many such replacement cost analyses is the time and resources necessary to create the service. Take for example accounting services furnished under an MSO agreement. In establishing fair market value under the cost-based approach, the analyst may look to the replacement cost method by considering time estimates of accounting staff at their fully-loaded hourly rate equivalents to arrive at the

⁵⁹ American Institute of Certified Public Accountants, *et al.*, *Supra*.

⁶⁰ *Id.*

value of the similar service of nearest equivalent utility. In addition, the analyst compares the profit margin on this service to the margins of other management and staffing companies in other industries through the use of subscription services such as Risk Management Association and Integra. This valuation exercise includes an analysis of the respective levels of risk assumed by the parties to the agreement.

This becomes an increasingly complex exercise as more and more services are added. Methods under the cost-based approach often look at the values of separate individual service lines to arrive at the cumulative value of the aggregate MSO service. Because the MSO service is often a menu of management services, the service is often accumulated from individual services in the cost-based approach and built up to arrive at the conclusion of aggregate fair market value. Each such service may be analyzed differently to arrive at the overall value conclusion. These services vary in complexity, and some are heavily dependent upon the size of the organization being managed and must therefore be adjusted for size in terms of revenues or other measure of resource commitment. It is also increasingly common to find incentive payments for attainment of clinical quality, patient satisfaction, efficiency, outcomes, and financial metrics. This necessitates an analysis of the value of the incentives, again with consideration of the levels of risk assumed by the parties to the arrangement.

To ensure a sound analysis, it is crucial that the parties and the valuation analyst clearly communicate as to the specific services to be part of the MSO service offering. To effectively analyze the MSO agreement using methods under the cost-based approach, the valuation analyst will request information about the personnel necessary to perform the tasks that make up the service, as well as the time associated with the service, the

compensation and benefit rates associated with each assigned individual, and non-payroll costs applicable to the service.

While compensation provisions provide for payment of management fees as fixed fees, percent-of-revenue fees, and incentive bonus compensation, in certain cases, the MSO may pass some costs along to its customer. For example, the MSO may own real estate or contract directly for space and occupancy costs on behalf of a medical practice, and the MSO may pass those costs directly to the practice in accordance with the terms of the management services agreement. In space and equipment rental or sublease arrangements, the valuation analyst will again consider the risk to the lessor associated to be quantified in the form of a margin on the lease or sublease. In other cases, the MSO may procure medical supplies and pharmaceuticals and pass the costs along to the medical practice, in which case the value of the MSO's service extends beyond the pass-through costs to include the cost of inventory procurement and management.

ii. Income-based approach

In the consideration of the income-based approach to the valuation of MSO arrangements, the nature of MSO arrangements dictates a unique means for employing income-approach methodology, primarily because the management services seldom result in the generation of professional service revenues in health care facilities. This differs from arrangements in which the service furnished by a vendor is subsequently billed to patients or third-party payers.

Fortunately, the income-approach methodology can be deployed as both buyer-side and seller-side analyses.

From the perspective of the purchaser of management services, methodology under the income-based approach allows the valuation analyst to evaluate the profitability of the purchaser after having purchased the services. Through benchmarking techniques, the analyst can evaluate the level of the purchaser's profitability to evaluate whether the management fee structure of the MSO arrangement has a decrement on buyer profitability. As an example, published data exists and is widely available on the operations and profitability of ambulatory surgery centers (ASCs). Application of benchmarking of ASC profitability against published survey data can help the analyst determine the value of the service relative to the overhead structure of the ASC. Similar data also exists for physician practices and can be of value to the analyst in measuring the value of services received from the MSO in a physician practice management setting after the management services are put into place.

From the perspective of the seller of the management services, methodology also exists that permits the analysis of return on investment for the MSO entity as to the fees it earns relative to its investment in assets, technology, personnel, etc. Using market data on profit margins earned by management companies within and outside the health care market, the valuation analyst can ascertain whether the MSO is sufficiently profitable on the services it furnishes to its customers and the risk it assumes in doing so.

Likewise, comparative profitability analyses attempt to match the margins (often contribution margin or pre-tax profit) of both buyer and seller of the management service, with a goal of ensuring that neither entity enjoys a disproportionately high margin as a result of the MSO arrangement. This involves a review by the analyst of the profit

margins of both buyer and seller of the service to ensure that margins are proximate relative to risk assumed by each in the arrangement and, if not, can be explained.

iii. Market-based approach

Methods under the market-based approach are the most commonly used among the more prevalent MSO arrangements, such as turnkey services or those without a great deal of variation of the number or complexity of services or the structure of the contractual arrangements. For example, for physician practice billing service arrangements, the use of market data to value the service being furnished is not uncommon. Similarly, when the menu of management services does not vary to a large extent or in the case of ASC management arrangements – in which many service providers furnish similar offerings – the market-based approach can be found to be useful. However, in more complex arrangements with more significant market baskets of services and unusual fee structures, finding truly comparable arrangements becomes increasingly difficult.

It is appropriate to find market-based methodology used to value individual services that are part of an overall larger service offering valued under the cost-based approach. For example, an MSO arrangement that includes 10 *a-la-carte* services, one of which is billing and collection of physician professional fees, is analyzed by the valuator under the market-based approach for that single service, although the overall MSO arrangement may not be adequately represented by comparables in the marketplace at the aggregate level.

Among the methods available under the market-based approach for the valuation of MSO fee arrangements are the published survey data method and the guideline

contracts method. These methods allow the valuation analyst to use data related to comparable arrangements to measure the value of the subject arrangement.

The published survey data method employs the use of widely available free, subscription, or purchased data to evaluate service arrangements that may be comparable to the subject arrangement being valued. Membership and trade associations, consulting firms, and other organizations publish data regarding management fee arrangements that can be purchased or obtained free-of-charge by request or via the Internet. Two types of arrangement in which data is available include physician practice management costs and ASC management fee costs. The Medical Group Management Association reports management fees paid to MSOs as one of the costs disclosed in its Cost Survey.⁶¹ Similar products can be found that report data on costs expended by physician practices for billing and management services. For ASCs, surveys by firms that consult with these providers report on management fees paid by surgery centers. The use of this data, adjusted for level of revenues, type of provider revenues (i.e., professional component, technical component, facility fees, etc.), number of full-time equivalent physicians, scope of services to be provided, and other normalizing measures permit the analyst to convert market data into an indication of fair market value fees for the services under the MSO arrangement. Many valuation firms develop and use algorithms to score service arrangements and to compare to market data, adjusting the indications of value derived from the market data to account for nuances in the subject arrangement. Such algorithms may assign points to the duties and responsibilities of the manager, with point values also assigned to those duties reserved for the practice or entity being managed. Furthermore,

⁶¹ *Cost Survey, 2012 Report on 2011 Data*, Medical Group Management Association (2012: Englewood, Colorado).

weights are assigned to duties and responsibilities to account for the relative significance, with the overall weighted average impacting the adjustment to the market values obtained from survey data.

In the guideline contracts method, the valuation analyst locates management agreements that contain as many similarities to the subject agreement as can be reasonably identified, from which the analyst makes adjustments similar to those noted in the published survey data to account for size and scope of manager duties and responsibilities. Being mindful of the fact that these contracts are likely between health care providers that are referral sources, the analyst should consider this method as a reasonableness test or use this method only in concert with other methodology.

b. Synthesis and reconciliation

In making conclusions from the indications of value derived from the various methods employed, no method can be considered an absolute. To produce a sound conclusion, the valuation analyst must consider results of methods deemed most reliable for rendering a conclusion of fair market value and exclude those results deemed less reliable. Notwithstanding, all methods can serve as reasonableness tests on the results of other methods. Conclusions determined by various methods will not be in exact agreement; therefore, the analyst must use objectivity and informed judgment to determine the aggregate significance of the methodologies upon which reliance is placed. This synthesis process yields a value conclusion that considers the results of the analyst's professional judgment and relative reliance, which may be presented in a point value or a range of values.

c. Reporting fundamentals

While there are no formal valuation standards related to reporting on valuations of compensation arrangements, business valuation reporting standards give some degree of insight into the types of reporting content that inform readers as to the identity of the parties, the nature of the arrangement, covered dates, intended users, standard of value, sources of information, valuation approaches, and conclusions reached in the valuation engagement. The following represents a useful listing of report contents that best present the full details associated with the valuation of an MSO fee arrangement:

- Cover or transmittal letter
- Table of contents
- Introduction including but not limited to the following: identity of the client; purpose and intended use of the valuation; intended users and restrictions on use; report date; dates for which report is valid (or “shelf life”); standard of value; scope restrictions or limitations; subsequent events; and reliance on the work of a specialist
- Analysis of the subject arrangement and parties to the arrangement
- Economic and market analyses
- Valuation approaches and methods considered
- Valuation approaches and methods used
- Synthesis and reconciliation
- Value conclusion
- Representations of the valuation analyst
- Qualification of the valuation analyst
- Sources of information used in the valuation

- Assumptions and limiting conditions
- Appendices and exhibits

H. Valuation of MSO business enterprises

On occasion, the need arises to establish the value of the MSO business enterprise. This may be necessitated by transactions involving the entry or exit of an investor in the business or a complete sale or purchase of the business. However, in most cases, the need for a valuation of the MSO business is attributed to the creation of a joint venture MSO and the equity interests created by two or more health care providers coming together to operate the MSO. In some cases, a hospital and group of physicians jointly invest in the MSO, and the valuation is performed out of necessity to determine the equity and working capital contributions by one or more of the parties, as well as to determine the value of the MSO business enterprise after its formation.

a. Application of broad approaches in MSO business enterprise valuation

The value of a business, investment, or asset is dependent upon its ability to generate a stream of future economic benefits to the investor. Hypothetical buyers and sellers in an open market have alternatives to consummating a transaction involving the given business, investment, or asset. Furthermore, the value of a business, investment, or asset can be determined by the cost of acquiring an equally desirable substitute. In application of these principles, business valuation methodology is broadly categorized into three approaches, as follows:

i. Asset-based approach

The asset-based approach is a general way of determine an indication of value based on the entity's underlying assets and liabilities. This approach is based on the theory that an asset's worth is directly related to the amount that would be required to reproduce or replace it. The asset-based approach generally results in an upper limit of value for assets that can be easily replaced or reproduced, since no prudent investor would pay more for an asset than the cost to create a comparable one. Similarly, no prudent investor would pay to create an asset that would not generate an income return under the regulatory structure commensurate with the outlay that is allowed. In application, the business' assets and liabilities are adjusted to fair market value, replacement value, or liquidation value.

The asset-based approach is generally more appropriate when valuing a controlling ownership interest, because the controlling owner controls the commercial use (e.g., operation, license, lease, or sale) of business assets, while a minority owner generally would not. Even when the asset-based approach is not the best measure of an entity's value, it gives an indication of the value of the tangible assets.

ii. Income-based approach

The income-based approach deploys methods that generally consider the business interest being valued as an investment, the purpose of which is to produce an economic benefit for the investor. This application involves determining an appropriate risk-based relationship between income and value and converting the estimated income into an estimate of value. This conversion of income to value relies on the concept that an equally desirable substitute for a company being valued would be another investment

producing an equal amount of future economic benefits assuming similar risk. Common measurements of economic benefits include earnings and cash flows.

Two commonly applied methods under the income-based approach in health care valuation are the capitalized earnings method and the discounted cash flow method. If an entity is established with stable earnings history that can be expected to continue, the capitalized earnings method is generally appropriate. If the entity is newly formed or its history is not considered indicative of its future earnings, the discounted cash flow method is most appropriate. With most health care providers, future health care reimbursement is uncertain, resulting in a default to the discounted cash flow method.

The income-based approach for a business enterprise valuation is dependent upon the concept of present value, as the dollar amount that an investor would be willing to pay today for the stream of expected economic benefits is the value of that investment. The mathematical formula for present value is:

$$PV = \frac{E_1}{(1+k)} + \frac{E_2}{(1+k)^2} + \dots + \frac{E_n}{(1+k)^n}$$

PV = Present value

E = Expected economic income in each of the periods 1 through n, n being the final cash flow in the life of the investment

n = Number of periods

k = Discount rate or cost of capital

This formula⁶² is the foundation for discounting future economic benefits. For example, the discounted future cash flow method requires projecting the future free cash

⁶² Shannon P. Pratt, *Valuing a Business: The Analysis and Appraisal of Closely Held Companies* at 117(5th ed. 2008) (New York: McGraw-Hill, 2008).

flows of the business and discounting it to present value at the opportunity cost of capital or “discount rate.” According to Roger Ibbotson, “The opportunity cost of capital is equal to the return that could have been earned on alternative investments at a specific level of risk.”⁶³

iii. Market-based approach

The underlying theory of the market-based approach is that a company, an asset, or arrangements can be valued by reference to reasonably comparably companies, assets or arrangements where values for the comparables or “guidelines” exist. In the case of an interest in a business, a comparable may be a publicly traded equity interest, such as a common stock, or a similar privately held business. Ensuring comparability is important to the effective use of methods under the market-based approach; comparability can take many forms, including but not limited to size as measured in revenues, profitability, or assets.

b. Methodology central to MSO business enterprise valuation

The variation in business structures of MSOs dictates that counsel have a general understanding of applicable fair market value definitions, widely accepted business valuation theories, and methodologies appropriate to the subject MSO venture. For example, in the case of an equity joint venture MSO, the fair market value definition nearly always includes the Stark definition of fair market value and, when a tax-exempt organization is party to the venture, the Internal Revenue Service definition.

The nature in which the joint venture is consummated impacts the circumstances under which valuations are performed. For example, it may be appropriate to establish

⁶³ Pratt, Cost of Capital: Estimation and Applications at 4 (New Jersey: John Wiley & Sons, Inc., 1998).

the fair market value of assets contributed by one or more parties to a joint venture MSO and working capital contributed by others. Consider the example of a joint venture between a hospital and a group of physicians for the operation of an equity-model MSO. The physician group may contribute technology assets to the venture; however, the hospital may desire to hold a majority interest in the new company. Therefore, the hospital may be required to contribute enough capital to the joint venture to result in the appropriate level of ownership. Under this fact pattern, the physicians' asset contribution should be appraised to determine the value of equity contributed to the new company by the physicians and to evaluate the capital requirement for the hospital-partner.

Within the broad classifications of asset, income, and market approaches, there are many methods for determining a business' or its assets' value, the applicability of which are driven by the facts and circumstances of the subject interest or asset. Some examples of methods applicable to the valuation of equity interests in include the following:

- i. Asset-based Approach: Adjusted Net Asset Method

Under the adjusted net asset method, a company's assets and liabilities are adjusted to fair market value, often individually or by categories. Various methods can be employed to adjust the assets and liabilities to fair market value, including inputs based on individual valuation methodology. For example, furniture and equipment of an MSO may be adjusted to fair market value determined through the use of market-based inputs, while inventories may be valued using cost data.

The value indicated under this method is often a controlling, marketable value, because a controlling owner has the right to liquidate the assets without obtaining approval from minority owners.

Although this method can be used in practically any valuation, it is generally not indicated in establishing a value for operating enterprises, but may be used in establishing a “floor value” if used in conjunction with other valuation approaches and methods.

ii. Income-Based Approach: Discounted Cash Flow Method

The discounted cash flow method considers the interest being valued as an investment mechanism, the purpose of which is to produce free cash flows for the investor. Application of this method involves establishing expected cash flows for the business, determining the appropriate relationship between cash flows and value, and converting the stream of cash flows into an estimate of value.

To utilize the discounted cash flow method, the valuation analyst must determine appropriate cost of capital or discount rate.

Determination of Capitalization and Discount Rates:

The International Glossary of Business Valuation Terms⁶⁴ defines the terms as follows:

Discount rate: A rate of return used to convert a future monetary sum into present value.

Capitalization rate: Any divisor (usually expressed as a percentage) used to convert anticipated economic benefits of a single period into value.

The discount rate represents the rate of return that an investor requires of an investment to compensate for its inherent risk. The higher the risk, the higher the expected return. The capitalization rate is related to, and derived from, the discount rate,

⁶⁴ American Institute of Certified Public Accountants, *et al.*, *Supra*.

by subtracting the expected average long-term growth rate from the discount rate. Hence the relationship between the discount and capitalization rate is as follows:

$$\text{Discount Rate} - \text{Growth} = \text{Capitalization Rate}$$

Estimating long-term growth requires consideration of multiple factors, including the company's historical growth and prospects for the overall industry.

Because the cost of capital is one of the most significant variables in the valuation process, much has been written about its determination, and several methods exist to calculate the discount rate or capitalization rate for a particular investment. Some of these include the following:

- Build-up method
- Weighted average cost of capital (WACC) formula
- Capital asset pricing model (CAPM)

Developing discount and capitalization rates is a complex process and depends largely on the inherent risk in the entity being valued. The degree of inherent risk is a function of several factors, including the general economic conditions, the industry outlook, and company-specific strengths and weaknesses. An example of company-specific strengths and weaknesses in one MSO equity joint venture includes the following:

Strengths:

- Management expertise
- Financial condition
- Favorable operating history

- Long-term contracts with customers
- Employee longevity
- Technology assets and their condition

Weaknesses:

- Uncertainty in the health care industry
- Declining economic conditions
- Future expectations for declining reimbursement
- Geographical dispersion
- Competition

Net Cash Flow to Equity

It is necessary to project the expected economic benefit the investment will provide. Net cash flow is often preferred in health care valuations because it represents the return to the investor that can be removed from the investment and used in any manner without impairing the operating potential of the health care enterprise. Net cash flow to equity is calculated as follows:

	Net after-tax operating income
Plus:	Non-cash expenses, including depreciation and amortization
Plus:	Debt proceeds
Minus:	Debt retirements
Minus:	Incremental working capital needs
Minus:	Capital expenditures
Equals:	Net cash flow to equity

Financial Statement Projections

Financial statement projections are necessary to establish projected economic benefits for the company being valued, until a period is reached in which economic stability could be reasonably projected. Quite often, projections are based on management's assumptions and representations about the expected course of business and the impact of economic forces on the business, but scrutiny is advised to understand the inputs, assumptions and representations and whether they are reasonable in light of known and expected conditions.

iii. Market-Based Approach: Guideline Company Transaction and Guideline Public Company Methods

In the guideline company transaction method, the analyst searches publications, databases, or fee-based resources. These include BIZCOMPS, Done Deals, FactSet Mergerstat, and Pratt's Stats, among others. This often involves companies from the same Standard Industrial Classification ("SIC") or NAICS code; however, in some circumstances, information from a company in a different industry is also useful.

Revenue Ruling 59-60 specifically states that in valuing the stock of closely held corporations or the stock of corporations where market quotations are either lacking or too scarce to be recognized that "the market price of stocks of corporations engaged in the same or a similar line of business having their stocks actively traded in a free and open market, either on an exchange or over-the-counter" is a fundamental factor that requires careful analysis.⁶⁵

⁶⁵ Rev. Rul. 59-60, *Supra*.

The guideline public company method represents an objective source of data, with share prices of publicly traded companies set by many arms-length transactions involving buyers and sellers. These transactions indicate how the market values the comparable public company. The downside to the guideline public company method is that it may be difficult to find truly comparable companies in a qualitative and quantitative sense, particularly as it relates to management services organizations.

Bona fide market-based methodologies should not be confused with rule-of-thumb formulas, which apply mathematical relationships between price and certain variables (i.e., EBITDA, revenues, number of beds, etc.) based on experience, observation, hearsay, or a combination of these. However, rules of thumb may serve well as reasonableness tests for the indications of value obtained through the use of properly applied valuation methods.

c. Overview of discounts and premiums

In application of methodology to arrive at the value of a business or business interest, the valuation analyst is presented with a value that falls into one of the following four “levels” of applicable value:

- Controlling, marketable interest: the value of a controlling interest, enjoying the benefit of market liquidity.
- Controlling, non-marketable interest: the value of a controlling interest, lacking the benefit of market liquidity.
- Non-controlling, marketable interest: the value of a minority interest, lacking control, but enjoying the benefit of market liquidity.

- Non-controlling, non-marketable interest: the value of a minority interest, lacking both control and market liquidity.

Two fundamental tools used by appraisers to move from one level of value to another are discounts and premiums. This is useful when the indicated value represents a marketable level of value, but the interest held calls for a non-marketable level. Discounts reduce indicated values to account for lack of control or marketability, while premiums increase value.

i. Discount for Lack of Marketability

In determining the value of an interest in a closely held entity, such as an MSO or equity joint venture MSO, it is essential to consider the marketability of the interest or lack thereof. Marketability refers to the ease and expediency in which an investment can be sold, or its liquidity.

Investors place great value on the ease of converting the investment into cash at minimal cost. In the case of a publicly-traded company, stock can be sold with relative ease through the markets; however, a ready market does not exist for a closely held investment in an enterprise such as an MSO, making it less liquid in relation to other investments. Unlike the owner of publicly traded securities, the owner of an ownership interest in an MSO cannot pick up the telephone, call a broker, and generally convert the shares into cash within three business days. All else being equal, an investor expects more incentive to invest in a closely held entity than in a publicly-held entity. Such an incentive usually takes the form of a discounted price on the investment, thus the discount for lack of marketability comes into play. In cases in which the indicated value is a marketable level of value, lack of marketability detracts from value.

The degree to which a discount for lack of marketability exists depends on both the underlying facts and circumstances and the available empirical evidence. The greater the difficulty and the longer the time frame involved in converting the equity interest into cash, the greater the discount, as these discounts are applied for the purpose of reflecting the market's perceived diminution in value.

Elements that determine the degree of lack of marketability include the following:

- Whether the entity is publicly held or closely held
- Whether and to what extent there are restrictions on the sale or transfer of equity interests
- Whether evidence of a market for the equity interest exists

Determination and Application of Discount

There have been many studies indicating a discount for lack of marketability for ownership interests in which a ready market does not exist. These studies are divided into two classes: restricted stock studies and initial public offering (“IPO”) studies, both of which are outside the scope of this paper. The restricted stock and IPO studies provide good evidence and quantification of the discount that should be applied to the subject interest; however, both are not without their challenges and need for professional judgment in their application.

The following is an extended list of key qualitative factors that have an effect on marketability:

- Dividend policies
- Evidence of a market of potential purchasers

- Existence of available and reliable of data
- Industry as a whole
- Prospects for a public offering
- Prospects for growth
- Restrictive transfer provisions
- Revenue and earnings size and stability of the subject company
- Shareholder relationships
- Size and type of business interest being valued
- Time and expense associated with a completed transaction

ii. Discount for Lack of Control (Minority Interest Discount)

A minority interest is an ownership interest comprising anything less than 50 percent of the voting interest in a business enterprise. A central valuation consideration when valuing a minority interest or partial interest in an entity is the degree of control inherent in the partial interest, as the value of a controlling interest less than 100 percent or minority interest in a business is seldom equal to the owner's proportionate share of the value of the business taken as a whole, and a controlling interest in a business is worth more than an interest that lacks control. Consider a business owned by a 49 percent owner and a 51 percent owner. To the extent that the 49 percent owner lacks control over the business, the minority owner's interest is worth less than 49 percent of the total value of the business, and a discount for lack of control or minority interest discount is applicable. On the other hand, the 51 percent owner, assuming this interest has control over the business, may be more valuable than simply 51 percent of the value of the entity,

in which case a control premium is applicable. Again, the determination of the level of premium for control or discount for lack of control is outside the scope of this manuscript; however, it is an important point in many valuations of closely held and publicly traded business interests.

d. Synthesis and reconciliation

In making conclusions from the information derived from the various methods employed, no method is absolute. To produce a sound value conclusion, the analyst must apply the greatest consideration to the value indications generated by the methods deemed most reliable. Notwithstanding, all methods can serve as reasonableness tests on the results of the other methods. Conclusions determined by various methods will not be in exact agreement; therefore, the analyst must use objectivity and informed judgment to determine the aggregate significance of the methodologies upon which reliance is placed. This synthesis process yields a value conclusion that considers the results of the analyst's professional judgment and relative reliance, which may be presented in a point value or a range of values.

e. Reporting fundamentals

Unlike the valuation of compensation arrangements, business valuations are subject to specific reporting standards promulgated by sanctioning bodies and membership organizations, including the following:

- American Institute of Certified Public Accountants
- American Society of Appraisers
- Institute of Business Appraisers

- National Association of Certified Valuators and Analysts

In addition, the Appraisal Foundation maintains the Uniform Standards of Professional Appraisal Practice, which applies to disciplines including and extending beyond those of business valuation.

Because of the substantial compliance risk associated with transactions between parties with the ability to refer federal health care program beneficiaries for health care services including designated health care services, detailed written reports are advisable in the case of valuation of health care business enterprises to support the analyses, opinions, and conclusions reached by the valuation analyst.

I. Reviewers' tips and traps

It is critical ensure that sufficient time exists between the issuance of the initial draft report and the closing or renewal date to permit sufficient review of the valuation report by the parties and counsel, as well as to allow changes, in advance of any negotiation and document preparation that must take place prior to the date of execution of definitive agreements. A few important questions to ask in the process include the following:

- Does the appraiser clearly understand the management services to be furnished and contractual obligations of the parties or the nature of the transaction?
- Does the appraiser clearly understand the parties to the arrangement or transaction, along with the compliance ramifications of the relationships that exist among the parties?

- Does the appraiser understand the nature of the compensation arrangement that exists under the MSO arrangement, and is the valuation analyst aware of the compliance implications of compensation that varies with the volume or value of referrals of designated health services?
- Did the valuation analyst interview representatives of the MSO and the managed organization, and does the report summarize those interviews and the resultant findings?
- Has the analyst explained the consideration of the three broad valuation approaches and why certain approaches were or were not considered?
- Has valuation analyst employed valuation methods that are logically explained in the report, and if certain methods are commonly found in these types of appraisals and not found in the subject valuation, has the analyst explained why such method was not considered in the subject analysis?
- Does the analyst’s synthesis of the various methods receive adequate explanation, with well-documented, logical conclusions, based on reasoned judgment?

IV. Post-ACA Implications for MSOs

Physicians are now asking themselves: “How do I transition from fee-for-service to value-based care? Which health system should I join? How do I optimize my patients’ outcomes, satisfaction, and safety while minimizing the cost of care by leveraging informatics?”⁶⁶ MSOs have a potential answer to each of these questions. An MSO can assist with monitoring, explaining and ultimately addressing reimbursement transitions

⁶⁶ Charles L. Lockwood, MD MHCM. “A Crystal-Ball View Of Healthcare In 2016.” *Contemporary OB/Gyn* p. 6, (December 2012).

through the strategic and financial services it provides to physicians and their practices (see examples in Section I.C. above). It can serve as a stepping stone to a larger health system, acting as an interim step and giving physicians a glimpse of the administrative processes and a preliminary understanding of how a particular health system will operate. An MSO can also provide the IT platform to address the extraordinary amount of information that will be demanded by public and private payors (and eventually patients), towards the ultimate goal of improving quality and minimizing cost.

A. MSOs Continue As An Integration Tool For Hospitals And Physicians

An MSO provides practices with services needed to operate efficiently and profitably within the large bureaucracy of a health system. MSOs also function well to deliver these services to hospital-controlled practices in an integrated system.

Hospitals continue to use MSOs as a strategy to support independent practices by furnishing billing, EHR, and other administrative services. Some of the many tools offered by full-service MSOs can include turnkey practice operations or a la carte services from many of the services listed beginning on page two of this document. MSO's can help physicians who have declining medical income caused in part by increasing administrative costs by providing stability in that regard. MSOs support the strategy of allowing hospitals to align more closely with non-employed physicians, allowing them to remain independent. Particularly, many physicians have come to view ancillaries as an important revenue stream. Unlike employment, where physicians generally cannot continue to control this revenue stream, this is a possibility with the MSO structure.

MSOs are physician-centric, serving not only employed and academic medical center physicians, but affiliated medical staff and independent contractor physicians as well, attracting and keeping these independent physicians aligned with the hospital as part of the system's overall collaborative strategy.

Nevertheless, physicians and hospitals are culturally different, and many hospitals still lack the experience to manage physician practices as effectively as desired. Hospitals are large, bureaucratic organizations, and are often managed as such; physician practices are small professional practices run as small businesses. Physician-led MSOs are particularly astute in serving small- to medium-sized practices, as are hospital-physician joint venture MSOs with meaningful physician leadership. MSOs are also effective at eliminating waste, duplicative roles, and inefficiencies.

Effectively managing the MSO doesn't mean using under-utilized hospital personnel. Hiring people experienced in running physician practices, including successfully growing integrated networks, is key. It is also important to keep in mind the differences between primary care practices and specialist practices, remembering that one size does not always fit all.

Integrated delivery systems are not completely out-of-sync when it comes to managing physician practices. As IDS networks become more innovative, so too will their MSOs. Those MSOs created by the IDS organizations will be better able to deliver a uniform management package and benefits structure for integrated groups, making the transition more seamless. If the MSO is experienced in acquisitions, the model plan for acquisitions will step through the process easier. This will likely result in no adoption of

the old EHR or PM systems. This means that the product selection should be carefully thought out and done so with the end game of practice transitions in mind.

The advent and federal government support of EHR systems provides a tool for physicians and hospitals to align around patient needs. When combined with traditional MSO service offerings and shared governance, a coordinated model of care is supported administratively.

The MSO can also become an effective service offering for health systems to participating physicians in clinically integrated networks (CINs). By getting physicians on the same technology platform and streamlining services among physicians and physician practices in the CIN, clinical integration becomes that much easier.

MSOs can also help hospitals obtain insight into community and medical staff needs in order to better understand and align with physician goals. MSO's can be a tool for developing and retaining medical staff, for instance when used for newer recruited physicians as they begin independent practice but find themselves ill-equipped to deal with the substantial administrative, financial, and legal aspects of their new practice.

B. MSOs in supporting roles for IPAs, PHOs, and ACOs

ACOs that operate on a large scale have are thought to have opportunities for success in part because of economies of scale in areas of information technology and administrative functions. However, some small ACOs have been able to succeed despite a lack of the economies of scale enjoyed by the largest of ACOs, because they are able to gain their economies of scale through the use of MSOs. MSOs also function to provide data on cost and quality. Even high-performing hospital-physician arrangements have

characteristics that can be considered as part of a joint hospital-physician ACO effort, including MSO arrangements. These allow leverage of EHR systems, an essential foundation at the heart of the ACO issue. In addition to cost control and efficiencies in administrative functions, some of the ways MSOs can contribute to IPA and ACO success are through a robust electronic health record system with secure web portal access for patient and provider communication, as well as data aggregation across the provider network.

To the extent that the ACO will wrap around several large independent practices, information systems will be a root issue. Sharing of clinical data will permit continuing process improvement and establishment of clinical best practices and other quality initiatives.

Physician Health Partners (www.phpmcs.com) is a Denver-based integrated care network, formed in 1996 as an MSO. PHP collaborates with over 300 primary care providers and approximately 600 specialists in the Denver metro area and is a Pioneer ACO.

C. MSOs In Supporting Role For Health Plan Partnerships With Physician Groups

Integration between health plans and physicians is a relatively new phenomenon.

The parties must agree to work collaboratively. This includes administrative aspects of the health plan / physician group relationship, including IT and collaboration on administrative and other business duties.

This health plan / physician group relationship revolves around establishment by a health plan of an MSO to provide management services to the medical group. One such

structure involves health plan ownership and operation of the MSO, with physician participation in governance of the MSO. These are generally turnkey operations, and consist of billing, collection, and employment of clinic non-physician employees. The MSO purchases the assets of the medical practice, but the physicians continue to own the group practice entity and employ the physicians. The MSO provides the turnkey services to the practice for a fee, generally in the form of a percentage of revenues.

D. Joint Venture MSOs As A Hospital-Physician Partnership Strategy

The hospital and physicians may form a relationship that involves joint equity ownership of an MSO that provides management services to physician practices or other health care facilities, such as ASCs. IT, revenue cycle management, accounting, patient services, human resources, and credentialing, along with space, personnel, and equipment in some models, are included in the MSO service offering.

The joint venture MSO in which a physician (or physician practice) and a hospital jointly own an MSO entity, may not be the basis for complete integration because ultimately, the venture is limited to a single group of physicians. It does not integrate the hospital and the community of physicians as a whole. Nevertheless, an MSO may be the way to open the door to a collaborative relationship with a physician or physician practice that has resisted integration previously, particularly in the form of employment and due to concerns about loss of control or particular revenue streams. A physician practice may find a more attractive alternative in a joint venture whereby the physician obtains an equity interest through contribution of practice property and the hospital contributes capital. While this model does not reach the sophisticated level of integration provided

by Accountable Care Organizations, it may serve as an interim step when reaching for more lofty collaborative goals.

V. Hypothetical Study

1. Fictional Cast of Characters

- Urban Memorial Hospital, a 400-bed acute care hospital in Mega City
- H. I. Power, CEO of Urban Memorial Hospital (“UMH”)
- Dr. Gitwell, a local family practice physician; a founding member and member of the board of directors of Mega Physicians Network (“MPN”), a local IPA
- Willie N. Able, Vice President at UMH and Director of Urban Physician Management, a management services organization operated by UMH
- Kashin Advisors, a private equity and health care valuation firm
- D. Esquire, outside counsel for UMH.

2. Fact Pattern

UMH has been a part of the Mega City community since 1950 and is considered one of the top three hospitals in the area. Dr. Gitwell has been in the Mega City community since 1975 and has been active in UMH leadership for the past 20 years. Mr. Power and Dr. Gitwell have had a good relationship over the years since Mr. Power joined UMH; however, Dr. Gitwell has resisted employment offers by UMH. Dr. Gitwell cites several reasons for preferring autonomy:

- 1) Dr. Gitwell prefers to retain clinical decision making in his practice and worries that, in selling to the hospital, he would forfeit that independence

- 2) Dr. Gitwell is well leveraged through nurse practitioners and earns a good living as a family practice physician; previous negotiations with UMH have broken down because the hospital couldn't match his earnings and the profits he enjoys from mid-level providers
- 3) Dr. Gitwell also benefits from some ancillary services, the profits from which he feels would be relinquished to UMH if his practice were to be sold

Dr. Gitwell is a bit old-fashioned and was slow to invest in an electronic medical record system. Once the decision was made, it took still longer to actually move forward with the acquisition, and now that the down payment has been made on the system, the installation has yet to be scheduled, and the practice continues to operate with paper charts.

MPN, however, is more progressive under Dr. Gitwell's leadership. The IPA was very active in accepting capitated contracts in the 1990's and managed risk successfully for 10 years. The members of MPN stayed loyal to the IPA during the first few years of the new millennium, when IPAs lost their luster in many areas, and leadership managed to keep the IPA viable in the fee-for-service market. With the advent of the Accountable Care Organization as part of the Affordable Care Act, MPN and other IPAs in the region have formed a joint steering committee to consider the benefits of the ACO model, and Dr. Gitwell has led a coalition to investigate an ACO model for managing diabetes and related co-morbidities in adolescents and adults.

Under Power's leadership, UMH has undertaken an aggressive primary care network building program in the past seven years. While not profitable, UMH has been able to build a large primary care base as a result of this effort, and Dr. Gitwell has been instrumental in supporting UMH's efforts to recruit and employ primary care physicians. After several failed attempts to retain Dr. Gitwell as an employee of UMH, Power is convinced that affiliation with

Dr. Gitwell and a goodly number of other like-minded physicians in the UMH service area will further solidify the primary care network while allowing those physicians to remain autonomous. This, Power believes, will be the backbone for the planned Clinically Integrated Network (“CIN”) that has been on the drawing board for more than three years at UMH.

To jump-start this effort, Power enlists Able, the up-and-coming VP at UMH with responsibility for Urban Physician Management, or UPM, which has been a fledgling MSO used to provide billing and practice management services to UMH-employed physicians that were part of a recent acquisition of a smaller non-profit hospital, Smallburg Memorial. Smallburg, prior to the financial downturn that led to the UMH acquisition, was acquiring physician practices at such a rapid pace that it never converted them to the same physician practice management system; therefore, UPM was formed to standardize billing and collections in the Smallburg practices prior to moving them into the mainstream PM and EHR systems operated by UMH for the remainder of its employed physician practices. Able quickly made a name for himself through the Smallburg project, and Power feels Able and UPM may be just the right combination to provide Dr. Gitwell and others like him part of a win-win strategy. Power feels that a number of benefits can be gained, including the following:

- The physicians, who have actively resisted UMH’s employment offers, continue to practice autonomously; UMH does not risk negative financial implications of additional primary care practice acquisitions and employment losses
- Physicians like Dr. Gitwell have the opportunity to reap the benefits of the HITECH Act stimulus funds
- UMH and physicians can benefit from the Stark exception for community-wide health information system

- The physicians can begin to practice in a way that captures data that will be useful for managing population health through UPMs resources
- UMH further solidifies its PCP network strategy and builds a coalition of physicians that may soon be part of its CIN or ACO efforts
- UMH is able to expand and test its MSO service offering through UPM on a larger scale, from which it hopes to springboard to serve both specialists and coordinated care organizations

Power meets with Able to discuss his plans for UPM. In this initial meeting, Power lays out his strategy for UPM with Able, and both agree that it is a bold undertaking, but one that can be accomplished. The steps are to fast-track the completion of the Smallburg transition to the UMH main PM and EHR systems to free up the UPM personnel and technology to move forward with the aggressive MSO offering to the community independent physicians. Next, Dr. Gitwell is to be invited to meet with Power and Able to get his input and buy-in, with the ultimate objective being his active role in the marketing of the MSO to his colleagues – his own practice as the first test subject. Third in the action plan is the community-wide rollout of the MSO after several key physicians have already committed to UPM management service agreements. Finally, Power lays out his plans for taking the MSO beyond physician practices to serve managed care and coordinated care organizations. At the conclusion of the meeting, Power agrees to set a meeting with Mr. Esquire to address the legal issues; the meeting with Dr. Gitwell will follow shortly thereafter.

The Meeting with Mr. Esquire (Legal Analysis)

In the meeting with Mr. Esquire, counsel points out to Power and Able some of the particular benefits of the MSO structure for this relationship. First, there is limited risk for both parties if things don't work out. Since the MSO agreement is only for services, there is a lower level of commitment than it Dr. Gitwell was employed and his practice acquired. It is easier for both parties to get out if it's not working. On the other hand, it is a nice way for Dr. Gitwell and the hospital to begin to collaborate and get on the same page. If the relationship does work, it might prove to be a stepping stone for more collaboration and closer integration between Dr. Gitwell and the hospital.

Additionally, since Dr. Gitwell wants to keep control of and revenue from his ancillaries and mid-level providers, he can do so. In an employment structure, ancillaries would present a challenge, but the MSO structure, Dr. Gitwell can continue to rely on the group practice exception with regard to the revenue from his ancillary services.

Mr. Esquire suggests that in their discussions with Dr. Gitwell, if there is an interest, Mr. Power and Mr. Able could present several additional options. He suggests that that, if Dr. Gitwell is looking for capital, there is a possibility for Dr. Gitwell to sell his property or equipment to the MSO and the MSO could lease the property or equipment back to Dr. Gitwell. Of course, this would have to comply with regulatory requirements, including meeting fair market value and commercial reasonableness, but it is an option that could be pursued if there is interest. Likewise, Mr. Esquire points out that the MSO could provide administrative personnel for Dr. Gitwell's office, if there is an interest. Further, Mr. Esquire suggests that Dr. Gitwell could also invest in the MSO as a joint venture with the hospital, either now or in the future.

Mr. Esquire anticipates the need for a number of documents, which may include the following:

- A preliminary letter of intent/term sheet to memorialize the agreement with Dr. Gitwell
- MSO Services Agreement:
 - Need a list of exact items services to be provided: accounting? Financial? Billing/coding? Supplies? Staff?
 - IT Services: this will be part of the agreement, but will need to know more specifics such as:
 - will it include both EHR and PM systems?
 - timeframe (will it be implemented immediately or over time?),
 - plans for upgrades, technical support,
 - IT ownership, data ownership and transfers
- Asset Purchase Agreement And Lease Agreement (To the extent there is a desire to transfer any equipment or property with Dr. Gitwell leasing it back
- Employment Agreements (if Dr. Gitwell wishes for UPM to take over his office staff)
- UPM should consider doing due diligence before undertaking the project

With regard to the IT issues, Mr. Esquire points to the Stark exception for EHR items and services (42 CFR §411.357(w)), noting that it requires that the donor of the IT not have actual knowledge that the physician has already obtained items or services equivalent to those provided. He recommends investigating of the possibility of Dr. Gitwell rescinding his existing contract in light of the fact that the new system has not yet been implemented, but notes remaining concerns about how this will be treated under §411.357(w)(8). Mr. Esquire also notes that the MSO can provide a good foundation for rolling out the communitywide HIT, but advises of the limitations on what can be provided to community physicians under 42 CFR §411.357(u).

Regarding the prospective, long term strategy of collaboration between the MSO and IPA, Mr. Esquire believes this is a good long-term plan to develop relationships with the doctors who are IPA members, and that Dr. Gitwell might provide advice to the MSO on how to do this and helps with the strategic direction. Compensation to Dr. Gitwell for his assistance could be appropriate under the Stark personal services exception and Antikickback personal services and management safe harbor. However, he cautions that there is also a potential for antitrust concerns involved with a management of contracts between and collaborations among horizontal competitors. He advises that they proceed very carefully through the process of collaborating with the IPA. In fact, he recommends that Mr. Power and Mr. Able speak with antitrust counsel regarding which safe harbors can apply, if any. He notes that the FTC and DOJ have promulgated a number of specific safe harbors, and these should be complied with to avoid allegations of per se illegality for price-fixing or illegal sharing of information or market allocation.

Additionally, Mr. Esquire also likes the concept of using the MSO as a vehicle to get community physicians on the same EHR system, and notes that this goal is compatible with the hospital's long-term CIN strategy. However, Mr. Esquire reminds Power and Able that PCPs and specialists often have different needs, and if the MSO takes a one-size-fits-all approach to all types of doctors, it may prove problematic.

Mr. Esquire suggests that they consider whether the MSO can serve as the technological foundation for gathering needed quality/cost data that will be crucial to the child and adolescent diabetes ACO that the IPA is contemplating.

Finally, Mr. Esquire says it is crucial to get assistance from Kashin. He recommends a preliminary financial analysis to make sure that the deal makes financial sense. And beyond that,

he advises, that virtually every legal test for the arrangements they are considering rely to some extent on fair market value and commercial reasonableness. Accordingly, he recommends retention of Kashin, particularly for consideration of the MSO fee.

The Meeting with Dr. Gitwell

The meeting with Dr. Gitwell goes almost as well as Power and Able had hoped. Dr. Gitwell was initially skeptical about anything to do with an electronic health record system that would render his current investment worthless, but came around when Able explained the robust benefits of the UPM system and its ability to expand to a patient portal. Dr. Gitwell is understandably concerned about the cost of enrolling in the MSO arrangement with UPM, and since this is Able's first foray into what is an almost turnkey solution, everyone agreed that Mr. Esquire's advice regarding the use of Kashin was absolutely essential. As the meeting concludes, Dr. Gitwell agrees to use his relationships in the physician community to help with some early "wins" for UPM, and promised to allow his practice to be used as a demonstration model for physicians who wanted to see UPM in action. Power and Esquire promise to make the logistics seamless and quick, and Able agrees to contact Kashin right after the meeting.

Shortly after his call to Kashin, the valuation firm begins preparing a letter of engagement through Esquire's firm, to be performed under attorney/client privilege. Within a couple of days, Able receives a request for data and a meeting invitation to discuss the terms of the management service agreement. As some of the terms have been in place from the Smallburg arrangements, Able is able to have Esquire modify the terms to cover the additional services that UPM will furnish to Dr. Gitwell's practice. Able supplies this information and other requested

data from UMH and Dr. Gitwell’s practice to Kashin, who begins the work of performing the valuation analysis.

3. Financial Analysis

Kashin’s valuation analysis begins with the cost-based approach, using the financial statements of Dr. Gitwell’s practice for the past three years. Kashin noted the following from his analysis of Dr. Gitwell’s practice as averages for the past three years:

Description	Amount (\$000s)
Revenues	790
Operating expenses; mid-level provider compensation and benefits	520
Physician compensation	240
Physician benefits	30

Kashin prepares analyses of the income and expenses of the practice, but also evaluates the personnel and other costs associated with UPM’s billing and administrative services. Kashin employs a replacement cost analysis to estimate the value of the management service to be performed by UPM for Dr. Gitwell’s practice. In the replacement cost analysis, Kashin prepares a pro forma analysis to evaluate the cost of a substitute service of nearly equivalent utility – not identical to UPM. Kashin evaluates the time of personnel that would be assigned to Dr. Gitwell’s practice, including the allocated hours to Dr. Gitwell’s practice of a practice manager, revenue cycle personnel, credentialing staff, financial accounting staff, human resources staff, UR/QM staff, and trainers, just to name a few. Using market data on these

positions and fully loaded benefits and other personnel costs, Kashin arrives at the total personnel costs associated with the substitute service and includes an appropriate market level margin using published data from staffing firms. Similarly, Kashin evaluates other PM and EHR systems in the market, applies depreciation rates for technology equipment and amortization rates for software to arrive at an annual costs for the operation of a substitute IT system and applies an appropriate risk-adjusted return on investment for UPM. Adding in other administrative cost based on the services that comprise the management services to be furnished by UPM and applying a market-based factor representing the profit that a service provider would earn on the service, Kashin arrives at an indicated value under the cost-based approach of \$83,000, which represents 10.5 percent of revenues when applied to Dr. Gitwell's practice.

Kashin continues the valuation by performing an analysis under the income-based approach. Kashin considers both buyer-side and seller-side economics, but concludes that buyer-side (Dr. Gitwell) is most feasible of the two, as a seller-side economic analysis is not feasible to measure as a return on investment, as much of the UPM investment in technology and personnel were made relative to the Smallburg venture. Proceeding with the buyer-side analysis, Kashin performs an analysis of the overhead of Dr. Gitwell's practice before and after contracting with a hypothetical MSO, using data on family practice overhead rates taken from the Medical Group Management Association's *Cost Survey*. Kashin concludes that the costs relieved by a practice such as Dr. Gitwell's in the assumption of the MSO's service would equal \$141,000, or 17.8 percent of revenues.

Finally, Kashin concludes the valuation analysis with the application of the market-based approach. Kashin considers the published survey data method, but finds that two widely used

surveys that report overhead rates and amounts per physician for physician practices do not report MSO fees for family practices or report billing services only. Kashin concludes that this is not sufficient to render a reliable indication of value; however, he is able to consider 26 guideline contracts for management services, locating contracts in the past three years that are equivalent in scope or can be normalized to reflect any differences in services that exist between the guideline and the subject agreement terms.

By analyzing these contracts, Kashin was able to determine that the median primary care contract represented 10.0 percent of net patient service revenues, while the median family practice MSO contract represented 11.0 percent, yielding a range of \$79,000 to \$86,900.

In the end, Kashin concluded that the methods under the cost-based and market-based approaches were of the highest relevance to the overall analysis, and based on the quality of the data and the applicability to the subject valuation, each should be considered in the final analysis. However, because the cost-based methodology yielded a single point value falling precisely at the midpoint of the range of the market data, Kashin determined to rely solely on the market data, and concluded on a range of \$76,000 to \$86,900 as the rate for the management fee for the services to be provided by UPM.

4. Outcome

As the results of the valuation are made known, Esquire is able to begin a Term Sheet from the initial meeting Dr. Gitwell and the UPM leaders. With the Term Sheet completed, Power and Able meet with Dr. Gitwell and present the proposed terms of the MSO arrangement, including a fixed fee of \$7,000 per month. With Dr. Gitwell's consent and minor modifications to the non-monetary provisions of the Term Sheet, Able contacts Esquire and asks for an

executable Letter of Intent, which is delivered the next morning and executed that day. Esquire's firm then works to complete the definitive documents to memorialize the management service arrangements, relying on the provisions of the Stark fair market value compensation exception and the Federal anti-kickback statute personal services and management contracts safe harbor.

Once the Smallburg transition is completed, UPM begins the transition of Dr. Gitwell's practice and MSO management of Dr. Gitwell's practice commences. Dr. Gitwell, anxious to demonstrate the success of UPM to colleagues in the community invites other providers to see the MSO operation in place in his practice, which sets the stage for UPM expansion to multiple practices in the area. Dr. Gitwell's leadership and relationships have proven successful for UPM.

Power, Able, Esquire then set a meeting with Esquire's partner, a knowledgeable antitrust attorney, to counsel with UPM on joining forces with MPN, the local IPA. Alternatives are presented, including options for UPM to provide outsourced administrative services to MPN.

Concurrently, Able works with UMH IT developers in creating systems to capture data related to management of adolescent and adult diabetics, including Hemoglobin A1c control, blood pressure monitoring, tobacco cessation for adults, and patient satisfaction scores. This information is captured to begin measuring physician adherence to clinical protocols as a precursor to ACO development, and UPM is slated to be on the ground floor in providing data for the ACO model.

Finally, Power and his team responsible for the CIN meet with Able about using UPM as a service offering for CIN-enrolled physicians, providing a common platform for CIN physicians for practice management and electronic health records. With UPM moving forward, UMH can begin in earnest its work on CIN development.