Avoid These Traps When Valuing Medical Practices Which Have Contractual Relationships With Exempt Hospitals

Note: This article is based on issues discussed in Mr. Dietrich’s Medical Practice Valuation Guidebook (http://www.atlasbooks.com/marktpic/00344.htm) in the sections “Issues In Valuing Practices For Donation to an Exempt Hospital” and “Valuing Hospital-based Practices.”

Mistakes are commonly made by valuators due to their lack of awareness of the tax law as it applies specifically to exempt hospitals.

Errors can occur, to give one example, when the valuator fails to properly analyze the terms of the contractual relationship and its implications for goodwill, or when he fails to recognize the prohibition against exempt entities allowing any of their net assets to inure to the benefit of a private party. Some of the factors and key questions that the consultant must consider are presented and discussed, as well as sample case scenarios and valuation approaches. (Read article)

It’s That Season... Common Tax Issues Affecting Medical Practices

When advising physicians and their medical practices on tax matters, certain issues common to most of these clients or prospective clients should be watched for. Examples would include the personal service corporation rules, analysis and proper amortization of intangibles, accounting for below-market interest loans, and rules related to the purchase or lease of a practice-owned automobile…. (Read article)
Analyzing Medicare Risk Contracts: Four Years after the Balanced Budget Act 
(Part 2)

While risk contracting remains financially viable, it demands heightened attention to the details of utilization, cost, and actual claims payment.

In Part 1 (Dec. 01 issue), we reviewed the impact of the fixed 2% annual capitation increase on Medicare. In this part, we explore in greater depth the specific cost categories that need to be analyzed in determining whether reduced utilization and/or reduced costs per unit of service are possible. We also look at some claims processing problems and possible contract language to address them. (Read article)

Accounts Payable and Internal Controls

Regardless of the size of a medical practice, internal controls are vital. Surprisingly, they are also frequently overlooked. As serious as this is for the practice, it provides an excellent engagement opportunity for CPAs and healthcare consultants. This article presents a detailed checklist to audit the internal controls related to accounts payable in a medical practice….. (Read article)

Coming in March...

The Healthcare Economy: A Quarterly Report, over 40 pages of information and analysis designed for consultants and valuation experts who require comprehensive information and insight into this segment of the economy. The Quarterly Report provides text analysis as well as a variety of full color graphs to aid in communicating your recommendations and conclusions to your clients. You will also find footnote references providing active links to Internet sites, affording the opportunity for additional research or file documentation.

Issues or Questions?

“Well done” to those who have already shared some of their interesting situations or questions with us. We look forward to presenting more reader questions and feedback in future issues and encourage subscriber interaction. Email can be sent to Editors@medicalmanagementadvisor.com
Avoid These Traps When Valuing Medical Practices Which Have Contractual Relationships With Exempt Hospitals

Valuators are frequently called upon to value medical practices in connection with a transaction involving an exempt hospital, or where the physician practice has an existing contract with an exempt hospital. Although the former is generally thought of as a higher risk engagement for the consultant, failure to understand the tax law as it applies to contracts with exempt hospitals will be equally problematic for reaching the correct valuation in the latter circumstance. The errors typically occur when the valuator fails to take note of either the terms of the contractual relationship and its implications for goodwill, or the prohibition against exempt entities allowing any of their net assets to inure to the benefit of a private party.

Description of the affected practices
Hospital-based practices which have such contractual relationships include radiology, pathology, anesthesiology and in many cases, emergency room physicians. Also pay attention to neonatology practices (physicians who work in neonatal intensive care units) and, in teaching hospitals or academic medical centers, entire departments such as Surgery or Medicine may be structured in this fashion. Practices such as these are generally characterized by their being located within the hospital building and functioning as if they were an actual department of the Hospital, with the practices' physicians utilizing the hospital’s facilities. The billing for these services often consists of a professional component paid to the physician and a technical component paid to the hospital for use of the underlying equipment and facilities. The hospital has the right to determine the physicians who serve in these quasi department-like practices. This is in contrast to other members of the medical staff, such as internists or surgeons who have their own offices, patients and/or referral bases that they control. Such internists and surgeons will have hospital staff privileges, but these are generally awarded based upon approval of the medical staff in accordance with the hospital’s medical staff policies, rather than on the basis of a contract with the hospital.

It is typical for these practices to have a contract between the physician (or their entity) and the hospital for a specified period of time. The contract may “evergreen” (renew) automatically, or it may be renegotiated at the end of each term. As is the case with any contract, the terms should be read carefully as many valuation issues may be contained therein. In some cases, the contract may run between the hospital and the physician it has designated as chair of the particular department, and that Chair (or Chief) then retains other physicians to fulfill the terms of the contract he or she holds. This personal relationship or personal goodwill is a critical factor to identify and consider.

Tax issues to be considered
First and foremost, exemption from federal income tax requires that the hospital not allow any of its earnings or assets to inure to the benefit of a private party. Therefore, when a hospital enters into a contractual relationship with a physician practice (or any other entity for that matter), the arrangement and the terms must be evaluated for compliance with the inurement prohibition. The IRS carefully scrutinizes all “joint ventures” between exempt hospitals and physicians, and even a service contract is considered a joint venture.

Intermediate Sanctions
There is a two-tiered excise tax in the Internal Revenue Code that can be imposed on excess benefit transactions. This is defined as a transaction in which the payment of compensation, transfer of property or similar occurrences exceeds fair market value. The initial excise tax is 25% of the excess amount, which is paid by the individual (disqualified person) who receives the excess benefit. An additional 10% excise tax may be imposed on officers and directors of the exempt entity who knowingly approve of the transaction (unless not willful and due to reasonable cause). If the transaction is not corrected, a second tax of 200% of the excess amount can be imposed on the disqualified person.
A disqualified person is anyone who is in a position to exercise substantial influence over the exempt entity, with a five-year lookback rule. Included are directors, trustees (excluding honorary positions), top management, and ‘related parties’ such as family members or 35% or greater controlled corporations. The IRS temporary regulations include physicians such as Department Chiefs and those with compensation arrangements pegged to hospital revenues as disqualified persons.

Example

A radiology department is a good example of a hospital-based practice for purposes of this discussion. The radiologists provide services to patients by reading x-rays, MRIs, CTs, ultrasounds and other imaging examinations, as well as performing invasive procedures such as injecting contrast or performing needle biopsies. These professional services (“Part B”) are typically billed separately by the physicians to insurers and government programs such as Medicare. The hospital bills for the technical or equipment and facility related component (Part A). The radiologists are also typically charged with supervising hospital-employed technologists, overseeing the maintenance of equipment and ordering of supplies and similar functions.

One part of the hospital’s exempt mission is to provide high quality services to the patients of the hospital, and it is the accomplishment of this purpose that serves as the rationale for entering into the service contract with the radiologists. As discussed in the chapter “Valuing Hospital-based Practices”, valuators must carefully read these contracts for such provisions as unilateral termination, right of the hospital to designate the Chief of the Radiology Department, and right of the hospital to terminate the contract in the event that a new Chief is appointed.

Beyond the obvious implications for the value of goodwill, if any, contained in the service agreement, valuators need to consider the implications of the tax law on the terms in the contract. Such terms are designed to document the hospital’s control over what persons or entities serve in the hospital’s facilities, and to prevent the transfer of any portion of the value of those facilities to the service entities.

Factors

When considering the value of intangibles, valuators should bear in mind that many of the components of intangible value generally present in a business are not owned by the hospital-based practice. For example:

1. Location (The Service Contract permits the radiologists to use hospital facilities for their practice, but it does not give them a real property leasehold interest.)
2. Patient base (The patients “belong” to the hospital.)
3. Practice (Hospital) Name (Contracts generally permit the practice to include the hospital name as part of its corporate name only so long as the practice holds the service contract.)
4. Workforce-in-place (The nonphysician staff, such as technologists and clerical personnel, are hospital employees. The physician staff would only have value to a buyer to the extent that the net revenue stream from physician services is greater than the physician’s compensation.)

Further, the hospital cannot allow any of these assets to be owned by the practice since it runs afoul of the inurement provision. The hospital is permitted to allow the practice to take advantage of these assets only to the extent necessary for the hospital to accomplish its exempt mission of serving patients. The valuators may want to ask him or herself the following questions:

1. If the hospital were sold to a third party what portion of the sales proceeds related to intangibles would be payable to the physician practice? (The answer is almost certainly NONE.)
2. If the hospital were sold to a third party, what right does the practice have to continue to provide services to the new owner? (The answer would depend upon the language of the contract, but likely there would be NO such rights.)

Third party sales

The practice typically does not have the ability to transfer itself to a third party buyer. For example, assume that the shareholders of South End Hospital Radiology, PC desire to sell their practice to any willing buyer. Their contract with South End Hospital provides that the Chief of Radiology of South End Hospital must also be the President of South End Hospital Radiology, and the contract terminates when
that Chief is terminated by the Hospital. Who is going to buy such a practice?

Summary
The above analysis seems to lead to the inescapable conclusion that the intangible assets of a hospital-based practice such as radiology are limited to two: the personal goodwill and reputation of 1) first and foremost, the Chief of the Department, and then the remaining radiologists, and 2) the Contract itself.

Valuation approach
The Contract can be likened to a lease. If, for example, a building owner were attempting to sell a property subject to a non-terminable lease with three years remaining and the new owner wanted to occupy the property, the tenant would be in a position to negotiate a portion of the sales proceeds. The relevant portion would be equal to the difference between the current rental value of the property and the rent paid by the tenant. In effect, the tenant owns three years worth of the present value of the future rent stream, offset by the cost of purchasing that three-year’s rental stream, which is equal to the rent charged in the lease.

In point of fact, the tenant might negotiate a higher price to offset the cost of relocating, improving new space, and the superior negotiating position. This is precisely why many leases contain provisions giving the landlord the right to relocate the tenant to comparable space. If the lease contained renewal provisions exercisable solely by the tenant, this would require valuation as well, depending upon the impact of the sale on the leases’ continuation.

Applying the above analogy to the Contract Valuation:

1. Determine how long the remaining contract term is.
2. Determine renewal provisions.
3. Identify termination provisions.
4. Identify factors indicating that the Contract is connected to the personal goodwill of the Chief of the Department, i.e., ask, “whose Contract is it?”
5. Determine if the Chief has entered into a noncompete with the practice that might have the effect of assigning his/her personal goodwill to the practice. (Important!)

Internal buy-ins
A valuation engagement may also be undertaken for the purpose of determining the selling price to a new shareholder of the practice. A prospective new shareholder may, in fact, be willing to consider buying into the practice to earn a higher salary. The higher salary typically results from sharing in the “profits” of the practice in excess of the base salary paid to all physicians. Hospitals will perhaps not interfere with such buy-ins unless they inhibit the ability of the Department to recruit new physicians or create dissension that interferes with the quality of service. (In my own practice, I have seen a hospital block an attempted sale by the retiring Chief to a new Chief.)

The valuator, after review of the contract, may also wish to ask him or herself the questions: Is the real seller of the interest the practice entity or the Chief of the Department? Or, can the practice sell a hospital job to a doctor?

In these circumstances, the history of buy-ins and buyouts in the practice becomes particularly important. If there are none, this may be indicative of opposition by the hospital or reluctance by the practice to risk raising the issue. Of course, it may also be indicative of recruiting difficulty or tradition.

In addition to the particular issues of hospital-based practices, there are other common issues such as restrictions on disposition in the shareholders’ agreement and specified buy-out formulas. Often times, the “buy-out” is in the form of a deferred compensation agreement related to accounts receivable at the retirement date, rather than as equity. These deferred compensation agreements represent liabilities that need to be accrued on the books of a cash-basis entity as one element of determining net equity. A shareholder’s equity interest in such a circumstance may be limited to book value, while a separate asset in the form of a deferred compensation receivable exists. Buy-ins in these cases should (and often are) achieved through a differential salary during the buy-in period, often pegged to accounts receivable. Transactions determined through reference to accounts receivable, a readily identifiable asset of the service entity, are unlikely to raise issues of the type discussed elsewhere herein.
It's That Season...Common Tax Issues Affecting Medical Practices

The following are a number of tips and reminders on some of the tax issues you are likely to face this year when working with physician medical practices:

**Personal Service Corporation**

A personal service corporation must use a calendar year unless it can establish a business purpose for a different period or it makes a section 444 election, discussed later. For this purpose, a corporation is a personal service corporation if all the following conditions are met.

1) The corporation is a C corporation.
2) The corporation’s principal activity during the testing period is the performance of personal services.
3) Employee-owners of the corporation perform a substantial part of the services during the testing period.
4) Employee-owners own more than 10% of the corporation’s stock on the last day of the testing period.

The principal activity of a corporation is considered to be the performance of personal services if, during the testing period, the corporation’s compensation costs for personal service activities is more than 50% of its total compensation costs. Generally, the testing period for a tax year is the prior tax year.

For new corporations, the testing period for the first tax year of a new corporation starts with the first day of the tax year and ends on the earlier of the following dates.

1) The last day of its tax year.
2) The last day of the calendar year in which the tax year begins.

**Performance of personal services.** For this purpose, any activity that involves the performance of services in the fields of health, veterinary services, law, engineering, architecture, accounting, actuarial science, performing arts, or certain consulting services is considered the performance of personal services.

**Employee-owner.** An employee-owner of a corporation is a person who:

1) Is an employee of the corporation on any day of the testing period, and
2) Owns any outstanding stock of the corporation on any day of the testing period.

**Independent contractor.** A person who owns any outstanding stock of the corporation and who performs personal services for or on behalf of the corporation is treated as an employee of the corporation. This rule applies even if the legal form of the person’s relationship to the corporation is such that the person would be considered an independent contractor for other purposes.

**Amortization of Intangible Assets**

**Section 197 Intangibles**

A medical practice or healthcare entity must amortize over 15 years the capitalized costs of “section 197 intangibles” that were acquired after August 10, 1993.
A practice or entity must amortize these costs if they hold the section 197 intangibles in connection with its trade or business or in an activity engaged in for the production of income. The deduction each year is the part of the adjusted basis (for purposes of determining gain) of the intangible amortized ratably over a 15-year period, beginning with the month acquired. They are not allowed any other depreciation or amortization deduction for a section 197 intangible.

**Section 197 Intangibles Defined**

The following assets are section 197 intangibles.

1. Goodwill.
2. Going concern value.
3. Workforce in place, including its composition and the terms and conditions (contractual or otherwise) of its employment.
4. Business books and records, operating systems, or any other information base, including lists or other information concerning current or prospective customers.
5. A patent, copyright, formula, process, design, pattern, know-how, format, or similar item.
7. A supplier-based intangible.
8. Any item similar to items 3) through 7).
9. A license, permit, or other right granted by a governmental unit or agency (including renewals).
10. A covenant not to compete entered into in connection with the acquisition of an interest in a trade or business.
11. A franchise, trademark, or trade name (including renewals).

Amortization of any of the intangibles listed in items 1) through 8) that were created by the owner/shareholder is not deductible, unless it was created in connection with the acquisition of assets constituting a trade or business or a substantial part of a trade or business.

**Goodwill.** Goodwill is the value of a trade or business based on expected continued customer patronage due to its name, reputation, or any other factor.

**Going concern value.** Going concern value is the additional value of a trade or business that attaches to property because the property is an integral part of a going concern. It includes value based on the ability of a business to continue to function and generate income even though there is a change in ownership.

*Workforce in place, etc.* This includes the composition of a workforce (for example, its experience, education, or training). It also includes the terms and conditions of employment, whether contractual or otherwise, and any other value placed on employees or any of their attributes.

**Business books and records, etc.** This includes the cost of technical manuals, training manuals or programs, data files, and accounting or inventory control systems. It also includes the cost of customer lists, subscription lists, insurance expirations, patient or client files, and lists of newspaper, magazine, radio, or television advertisers.

**Patents, copyrights, etc.** This category includes package designs, computer software, and any interest in a film, sound recording, videotape, book, or other similar property, except as discussed later under *Assets That Are Not Section 197 Intangibles.*

**Customer-based intangibles.** A customer-based intangible is the composition of market, market share, and any other value resulting from the future provision of goods or services because of relationships with customers in the ordinary course of business. You must amortize that part (if any) of the purchase price of a trade or business that is for the following intangible (examples).

- Customer or patient base.
- Circulation base.
- Undeveloped market or market growth.
- Insurance in force.
- Any other relationship with customers that involves the future provision of goods or services.

Accounts receivable or other similar rights to income for goods or services provided to customers before the acquisition of that trade or business are not section 197 intangibles.

**Covenant not to compete.** A covenant not to compete (or similar arrangement) entered into in connection...
with the acquisition of an interest in a trade or business or substantial portion of a trade or business, is a section 197 intangible. An interest in a trade or business includes an interest in a partnership or stock in a corporation engaged in a trade or business.

If an amount is paid or incurred under a covenant not to compete (or similar arrangement) after the year in which the covenant (or similar arrangement) was entered into, the company must amortize that amount over the months remaining in the 15-year amortization period.

Amounts paid under a covenant not to compete (or similar arrangement) that represent additional consideration for the purchase of stock in a corporation cannot be amortized. They must be added to the basis of the acquired stock.

**Franchise, trademark, or trade name.** A franchise, trademark, or trade name is a section 197 intangible. A company can deduct amounts paid or incurred on the transfer, sale, or other disposition of a franchise, trademark, or trade name if all of the following apply to the amounts.

- They are contingent on the productivity, use, or disposition of the franchise, trademark, or trade name.
- They are part of a series of payments payable at least annually throughout the term of the transfer agreement.
- They are part of a series of payments which are substantially equal in amount or payable under a fixed formula.

A company must amortize any other amount, whether fixed or contingent that they paid or incurred because of the transfer of a franchise, trademark, or trade name.

**Below Market Interest Rate Loans**

A **below-market loan** is a loan on which the medical corporation charges no interest or on which interest is charged at a rate below the applicable federal rate. This is a common circumstance in many smaller medical practices. A below-market loan generally is treated as an arm’s-length transaction in which the physician, the borrower, is treated as having received:

1) A loan in exchange for a note that requires the payment of interest at the applicable federal rate, and
2) An additional payment.

The additional payment is treated as a gift, dividend, contribution to capital, payment of compensation, or other payment, depending on the substance of the transaction. In the case of a demand loan covered by the below-market loan rules, two transactions are assumed to have taken place:

1) A transfer of forgone interest from the corporation to the physician, and
2) A retransfer of the forgone interest from the physician to the corporation.

**Forgone interest.** For any period, forgone interest is:

1) The amount of interest that would be payable for that period if interest accrued at the applicable federal rate and was payable annually on December 31, minus
2) Any interest actually payable on the loan for the period.

The IRS publishes applicable federal rates each month in the Internal Revenue Bulletin. Their offices may also be contacted to get these rates or by checking on their web site at [http://www.irs.gov/](http://www.irs.gov/). How the physician treats the forgone interest depends on the type of loan they have. What follows is a discussion of the various loans and types of treatment of forgone interest.

**Gift and demand loans.** A **gift loan** is any below-market loan where the forgone interest is in the nature of a gift. A **demand loan** is one payable in full at any time upon the lender’s demand. If the physician receives a below-market gift loan or demand loan, they are treated as if having received an additional payment (as a gift, dividend, etc.) equal to the forgone interest on the loan. They then treat this amount as being transferred back to the corporation as interest. The physician may be entitled to deduct that amount as an interest expense, if it qualifies. The corporation must report this amount as
interest income. These transfers are considered to occur annually, generally on December 31.

**Term loans.** If the physician receives a below-market term loan (a loan that is not a demand loan), they are treated as having received a cash payment (as a gift, dividend, etc.) on the date the loan is made. This payment is equal to the loan amount minus the present value of all payments due under the loan. This excess amount is also treated as an original issue discount on the loan and the original issue discount rules apply.

**Loans subject to the rules.** The rules for below-market loans apply to:

1) Gift loans,
2) Compensation-related loans,
3) Corporation-shareholder loans,
4) Tax avoidance loans,
5) Loans to qualified continuing care facilities (made after October 11, 1985), and
6) Other below-market loans to the extent provided in the Regulations.

**Exceptions.** The rules for below-market loans do not apply to certain loans on days on which the total amount of outstanding loans between the borrower and lender is $10,000 or less. This exception applies only to:

1) Gift loans between individuals (if the gift loan is not directly used to buy or carry income-producing assets)
2) Compensation-related loans or corporation-shareholder loans (if the avoidance of federal tax is not a principal purpose of the loan).

A compensation-related loan is any below-market loan between an employer and an employee or between an independent contractor and a person for whom the contractor provides services.

**Accounting for Personal Use of a Medical Practice Owned Vehicle**

Physicians often let their corporations own or lease vehicles for them. In this instance, the corporation generally must include in the physician’s wages the amount by which the **fair market value** of the fringe benefit is more than the sum of the following amounts.

1) Any amount the employee paid for the benefit.
2) Any amount the law excludes from income.

However, the corporation and the physician may use special rules to value certain fringe benefits as described below.

If the law excludes a **fringe benefit cost** from gross income, do not include in the physician’s wages the difference between the fair market value and the excludable cost of that fringe benefit. If the law excludes a limited amount of the cost, however, include the fair market value of the fringe benefit that is due to any excess cost.

**Fair market value (FMV).** In general, the FMV of a fringe benefit is determined on the basis of all the facts and circumstances. The FMV of a fringe benefit is the amount the physician would have to pay a third party in an arm’s-length transaction to buy or lease the particular fringe benefit. Neither the amount the physician considers to be the value of the fringe benefit nor the cost the corporation incurs to provide the benefit determines its FMV.

**Employer-provided vehicles.** In general, the value of an employer-provided vehicle is the amount the physician would have to pay a third party to lease the same or a similar vehicle on the same or comparable terms in the same geographic area where the physician uses the vehicle. A comparable lease term would be the amount of time the vehicle is available for the physician’s use, such as a 1-year period. Do not determine the value by multiplying a cents-per-mile rate times the number of miles driven unless the physician can prove the vehicle could have been leased on a cents-per-mile basis.

**Special Valuation Rules**

The corporation may be able to use special valuation rules instead of the general valuation rule to value the use of any vehicle provided. The special valuation rules include the following rules.

—Automobile lease rule.
Vehicle cents-per-mile rule.
Commuting rule.
Unsafe conditions commuting rule.

**Conditions for use.** When reporting fringe benefits, the corporation can choose to use any of the special rules. However, neither the medical practice nor the physician may use a special rule to value any benefit, unless one of the following conditions is met.

1) The corporation treats the value of the benefit as wages for reporting purposes by the due date of the return (including extensions) for the tax year the benefit was provided.
2) The physician includes the value of the benefit in income by the due date of the return for the year they received the benefit.
3) The physician is not a control employee as defined later under Commuting Rule.
4) The corporation demonstrates a good faith effort to treat the benefit correctly for reporting purposes.

**Using the special rules.** All of the following rules apply when you use the special rules.

1) If the corporation uses one of the special rules to value a benefit they provide to the doctor, the doctor may in turn use that special rule. If the company does not use one of the special rules, the doctor can use a special rule only if the company does not treat the value of the benefit as wages for reporting purposes by the due date of the return (including extensions) and provided that one of the conditions just listed in items 2 through 4 is met. In any case, the physician can always use the general valuation rule discussed earlier.

2) If the corporation and the physician properly use a special rule, the physician must include in gross income the net value determined by the corporation, minus any amount he or she paid the corporation. The corporation and the physician can use the special rule to determine the amount the physician owes the company.

If the company provides vehicles to more than one physician, they do not have to use the same special rule for each physician. If the company provides a vehicle for use by more than one physician (for example, an employer-sponsored van pool), they can use any special rule. However, the company must use that rule for all physicians who share use of the vehicle.

3) The company can use the formulas in the special rules only with those rules. When they properly apply a special rule to a fringe benefit, the IRS will accept their value for that fringe benefit. However, if they do not properly apply a special rule, or if you use a special rule but are not entitled to do so, the IRS will use the general valuation rule to value the fringe benefit.

**Automobile Lease Rule**

If the company provides a physician or an employee with an automobile for an entire calendar year, they can use the automobile’s annual lease value to value the benefit. If they provide a physician with an automobile for less than an entire calendar year, the value of the benefit is either a prorated annual lease value or the daily lease value (discussed later). Include the lease value in the physician’s wages unless it is excluded from gross income by law. For this rule, automobile means any four-wheeled vehicle manufactured primarily for use on public streets, roads, and highways.

**Benefits excluded for business use.** If the doctor uses the automobile for business, he or she may qualify to exclude part of the lease value as a working condition fringe benefit. The company can reduce the amount of the lease value by the working condition fringe and include the net amount in the doctor’s
wages, or company can choose to include the entire lease value.

**Annual Lease Value & the Annual Lease Value Table**

The IRS provides what is called an “Annual Lease Value Table.” You should refer to IRS rules for the current table.

Generally, the company can figure the annual lease value of an automobile as follows:

1) Determine the FMV of the automobile on the first date the automobile is available to any physician for personal use.
2) Using the IRS Annual Lease Value Table, read down column 1 to find the dollar range within which the FMV of the automobile falls. Then read across to column 2 to find the annual lease value.

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**Analyzing Medicare Risk Contracts: Four Years after the Balanced Budget Act**

(Part 2)

Introduction

In part 1 of this article (Dec. 2001 Issue), we looked at the global changes in the Medicare Risk Contract reimbursement methodology and how hospital contracting has been affected. In this part 2, we look at other trends and potential areas for risk contractors to evaluate and seek changes.

**Outpatient costs**

The category of outpatient costs covers a wide range of costs, including specialty referrals, hospital outpatient surgery and other costs, emergency room services and imaging. The various categories need to be analyzed to determine trends in unit cost and utilization.

**Imaging**

Over the last five years there has been a vast increase in the usage of both MRI and CT, two of the most expensive imaging modalities. (MMA Note: This trend has been very clear among our clients, whether users or providers of imaging.) At the same time, the usage of inexpensive, traditional x-rays has been relatively stable. Risk contractors and their advisers should therefore carefully examine both the utilization and unit cost considerations for the higher cost imaging modalities.

As is the case for most categories of cost, those with high utilization lend themselves to subcapitation or discounted fee-for-service arrangements. Risk contractors should be able to extract significant price concessions for directing volume to a preferred provider of MRI and CT. The cost structure of these modalities is such that many of the costs are fixed, and the variable cost is relatively low compared to fee per case. Substantial profits are earned in these modalities as volume moves beyond breakeven.

Physician specialty referrals

The changes in the RBRVS adopted by the Medicare program through the BBA have substantially impacted the underlying costs of physician services. These changes have generally created significant increase in the Evaluation and Management codes, and substantial decreases in procedural reimbursement, particularly hospital-based surgery. The RBRVS schedule is updated each year in November and published in the Federal register (see http://www.hcfa.gov/whatsnew). It is generally implemented in the payment system the following April 1. Risk contractors should be certain that the HMO paying the claims is utilizing the current Medicare fee schedule (unless the contractor has adopted a different one.)

Contractors who have entered into subcapitated arrangements, such as for ophthalmology services, should be certain that fee-for-service claims are not being paid as well. This double payment can occur because capitated arrangements generally require a “claim” to be submitted in any event to monitor utilization and perhaps to allow bonus payments to be...
allocated among the providers based upon some contracted terms. Submission of these claims leads to the possibility that they will also be paid in error. This occurs because health plans fail to flag the CPT codes or provider codes properly, or because providers submit the claims incorrectly without an appropriate modifier to reflect that the service is capitated. A further complicating factor is the large losses suffered by HMOs over the last several years, resulting in layoffs and hiring of less qualified personnel. Add to this the fact that the HMO is spending someone else’s money in the case of the risk contractor, and you have a recipe for overpayment.

There may also be the occurrence of laxity in controlling referrals in a mature risk population. Increasing rates of utilization of specialists such as dermatologists would be an example of this. The Medical Director should be reviewing areas where referral control has slackened.

The possibility exists in this area as well for risk contractors to seek price concessions for directing volume to a preferred provider. Note that such agreements within the context of a capitated risk arrangement are not improper if drafted appropriately by qualified legal counsel.

Disease management
Contractors with access to detailed claims data should analyze it to determine the principal diagnoses that are driving costs. As is the case with most healthcare spending, a very few patients will account for the majority of costs. Patients suffering from acute illness, such as heart attack and pneumonia, are likely to constitute the largest subset of the cost of care. These costs are controllable only through effective contracting of outreferral providers and aggressive medical management, where practical. Chronic illnesses in the capitated population offer a greater opportunity for systematic savings than do acute illnesses. Among the chronic diagnoses that are costly and may offer an opportunity for potential savings are congestive heart failure (CHF), hypertension and chronic obstructive pulmonary disease (COPD).

Pharmacy

Prescription drug costs have displayed the highest unit cost increases in the last several years, often 15% per annum or greater. This is partially the result, certainly, of advances in the pharmacological treatment of various diseases. But advertising by the drug companies also now plays a significant role, particularly, in the current case, for arthritis, acid reflux, allergy and asthma treatments. Risk contractors need to adhere closely to drug formularies (and heaven help the contractor who does not have one). Agreements with the HMO also require that the contractor at risk for all or some portion of pharmacy costs be certain that 1) it is getting credit for rebates from Pharmacy Benefit Managers (PBMs) retained by the HMO, 2) it is getting credit for any patient co-pays, and 3) newly implemented increases in member premiums be used to fund pharmacy benefits. Failure to control pharmacy costs or provide for a means to pay for them (such as through supplemental premiums charged to enrollees) is a recipe for financial ruin. Graph 1, on the following page, plots the increase in total national expenditures (left axis) from 1990 (with the data for 2000 and thereafter projected) against those for prescription drugs (right axis). (http://www.hcfa.gov/stats/NHE-Proj/proj2000/default.htm contains this data).

Claims Processing Accuracy
Financial enforcement mechanisms should be written into risk contracts, particularly for those practices that have been victimized by inaccurate claims processing by the HMO. Points to be specified would include:

- Prompt resolution of claims errors
- Definition of “out of area” hospital and use of “most commonly traveled route” to determine the 30 mile factor used by HCFA/CMS
- Payment for hospital and other facility days not approved by pre-registration to be denied. (Note: in most delegated medical management situations, nurse case managers will notify the HMO of the number of days for which a patient has been approved in a facility.)
- Requirement that the HMO offset an improper payment against other payments due that provider, rather than “billing” the provider and awaiting repayment. For example, a fee-for-service claim paid in error to a subcapitated provider - while awaiting the repayment, the Risk contractor’s budget has paid the claim twice.
The vital role that internal controls play within any well-managed medical practice is widely recognized. Knowledgeable practice managers are well aware that poor controls in this single area can result in far more dire consequences than simply dampened earnings. The ability to offer a timely and low cost audit of an existing or potential client’s systems gives you an excellent service offering for new engagements. The following are questions that provide you with a quick means to identify and evaluate common internal accounting controls related to the client’s payables processing.

- Are all disbursements, except those from petty cash, made by pre-numbered checks?
- Are unused computer checks kept in a secure, locked location?

**MMA Note:** State “prompt payment” statutes and similar legislation requiring HMOs and other insurers to pay claims within specified time periods have complicated this problem.

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**Conclusion**

In part one of this article, we noted that the impact of the BBA’s fixed annual capitation rate increase of 2% necessitated that a practice and its advisors give intense scrutiny to costs, which otherwise would rise at a much faster rate. In this part, we have identified specific cost areas requiring careful review and control, most notably prescription drug costs. Risk contracting remains financially viable, but requires heightened attention to the details of utilization, cost and actual claims payment. A strong financial control function as well as a strong Medical Director function is critical for success in the future.

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**National Health Expenditures and Prescription Drugs**

![Graph showing national health expenditures and prescription drugs from 1990 to 2010.](image)

**Accounts Payable and Internal Controls**

The vital role that internal controls play within any well-managed medical practice is widely recognized. Knowledgeable practice managers are well aware that poor controls in this single area can result in far more dire consequences than simply dampened earnings. The ability to offer a timely and low cost audit of an existing or potential client’s systems gives you an excellent service offering for new engagements. The following are questions that provide you with a quick means to identify and evaluate common internal accounting controls related to the client’s payables processing.

- Are all disbursements, except those from petty cash, made by pre-numbered checks?
- Are unused computer checks kept in a secure, locked location?
• Are voided checks preserved and filed after appropriate mutilation?

• Is there a written prohibition against drawing checks payable to Cash?

• Is there a written prohibition against signing checks in advance? (i.e. Writing and then holding checks)

• Is a cash disbursement voucher prepared for each invoice or request for reimbursement that details the date of check, check number, payee, amount of check, description of expense account (and restricted fund) to be charged, authorization signature, and accompanying receipts? This control would mainly apply to larger medical practices.

• Are all expenditures approved in advance by authorized persons?

• Are signed checks mailed promptly?

• Does the check signer review the cash disbursement voucher for the proper approved authorization and supporting documentation of expenses?

• Are invoices marked Paid with the date and amount of the check?

• Are requests for reimbursement and other invoices checked for mathematical accuracy and reasonableness before approval?

• Is a cash disbursement journal prepared (or printed if computerized) and reviewed monthly that details the date of check, check number, payee, amount of check, and columnar description of expense account (and restricted fund) charged?

• Is check-signing authority vested only in those persons who are at appropriately high levels within in the medical practice?

• Is the number of authorized signatures limited to the minimum practical number?

• Do larger checks require two signatures?

• Are bank statements and canceled checks received and reconciled by a person independent of the authorization and check signing function?

• Are unpaid invoices maintained in an unpaid invoice file?

• Is a list of unpaid invoices regularly prepared and periodically reviewed?

• Are invoices from unfamiliar or unusual vendors reviewed and approved for payment by authorized personnel who are independent of the invoice processing function?

• How are double payments to vendors identified within the current payables system?

• If purchase orders are used, are all purchase transactions used with pre-numbered purchase orders?

• Are employees required to submit expense reports for all travel related expenses on a timely basis?
Ask The Editors

Q. Can a managed care contract really be negotiated or renegotiated?

A. Absolutely! The problem is that most medical practices don’t even try to negotiate a managed care contract. Most feel it would be a waste of time and resources since it appears managed care companies hold the upper hand most of the time. However, many medical practices will find that they do have hidden negotiation leverage that they don’t realize exists. Perhaps even more surprising for some is that this “hidden” leverage is especially true for smaller medical practices and can result in a measurably more successful contract negotiation. We are glad that this question was raised and, because of it, leverage and how to successfully negotiate a managed care contract will be discussed at length in the February issue.

Q. I am valuing a cardiology practice that includes both invasive and interventional cardiologists and wonder what significant factors I should consider? Also, can you give me an idea of what a discount rate for cash earnings would be?

A. Invasive cardiologists perform catheterization (a procedure where a catheter is threaded up through the artery on the right leg into the heart to visualize clogging or occlusion) while interventional cardiologists (also) perform angioplasty (a procedure where a catheter containing an inflatable “balloon” is threaded into the heart to expand the arteries and alleviate clogging). In general, since the Balanced Budget Act of 1997, the reimbursement for cardiac procedures has been declining relative to that for cognitive or nonprocedural services.

Here is a graph of the recent history of Medicare global reimbursement for right cardiac catheterization (CPT™ Code 93501©). The pattern is strange to the unfamiliar! Reimbursement on average went up in 2001 by 4.5%, but is going down by 5.4% in 2002. As you can see, reimbursement is now below the 1998 level! This represents a (.30%) compound rate of change over the four-year period.

![Medicare Global Reimbursement for 93501](image)

I recommend that you download the fee schedule for your state from [http://www.hcfa.gov/stats/99carr.htm](http://www.hcfa.gov/stats/99carr.htm) and investigate the history of reimbursement for the most significant revenue-generating procedures. There are often surprises.

Cardiology practices are more risky than a general internal medicine practice, the latter being what I regard as the baseline practice for establishing discount rates. Each practice must, of course, be evaluated to determine its own specific risk premium. Bearing that in mind, in my most recent valuation of a cardiology practice with a valuation date of June 30, 2001 I used a 36% discount rate on pre-tax cash earnings.