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Senior Managing Director
Healthcare Practice
Timothy Smith - Bio

- Senior Managing Director of Ankura Consulting Group
- Two decades of experience in the healthcare industry
- Nationally recognized thought leader in healthcare valuation
- Co-edited/co-authored the *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*
- 14 years with HCA:
  - Managed HCA’s fair market value compliance program for outside appraisals
  - Reviewed hundreds of business and compensation appraisals
  - Negotiated physician practice acquisition and divestiture transactions
  - Served as an ethics and compliance officer
- Accredited in Business Valuation (ABV) – AICPA
- CPA in two states

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Practice Losses: The New Ticking Time Bomb

Presentation Outline

• Real world compliance risk analysis
• The role of practice losses in recent cases
• Government’s view of practice losses
• Why do health system practices lose money?
• FMV and commercial reasonableness ("CR") issues
• How to prepare for real world compliance risk
Real World Compliance Risk

What’s Happening in Today’s Marketplace for FMV and CR Compliance
Practice Losses: The New Ticking Time Bomb

2015 MGMA Cost Survey: Net Income (Loss) per FTE Physician

<table>
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<tr>
<th>Type</th>
<th>Mean</th>
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<th>Median</th>
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Physician-Owned Practices Don’t Lose Money

2015 MGMA Cost Survey: Net Income (Loss) per FTE Physician

- Primary Care
- Nonsurgical Specialty
- Surgical Specialty
- Multispecialty

Mean, 25th, Median, 75th, 90th
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Real World Compliance Risk

• Recent Major Settlements with DOJ
  o Tuomey: $72.4 million (2015)
  o Halifax: $85 million (2014)
  o Citizens’ Medical Center: $21.75 million (2015)
  o Columbus Regional: $25 million + $10 million in contingency payments (2015)
  o North Broward Hospital District: $69.5 million (2015)
  o Adventist Health System: $115 million (2015)
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Real World Compliance Risk

• Recent Stark/AKS enforcement actions
  o Started by whistleblowers under False Claims Act (“FCA”)
  o Insiders to organization or deals with health systems
  o Backed by *qui tam* bar

• Health system litigation defense does not go to trial
  o Cases are defended through pretrial motions (dismiss / summary judgement)
  o Settlement if fail at pretrial motions
  o Some systems settle right away
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Real World Compliance Risk

• Post Tuomey world
  o Tuomey Health System lost two jury trials
  o FCA damages can be extreme
  o Fighting DOJ only raises the stakes for FCA damages
  o DOJ is aggressively pursuing enforcement

• DOJ’s role in whistleblower cases
  o To join or not to join?
  o If join, how much in FCA damages?
  o Prosecutor’s view of health system affects both decisions
Real World Compliance Risk

• Implications of a post Tuomey world
  o Cases are not resolved on the merits or expert arguments
  o Risk of being the next Tuomey starts in the office down the hall or with the physician you just spoke with
  o FCA damages can be staggering
  o Monetary damages are based on whether the DOJ views you as a player who fumbled or who willfully disregards the law
  o Individual liability: DOJ expects companies to “name names” of bad actors within the organization
Real World Compliance Risk

• Successful defense in a post *Tuomey* world
  o Must convince DOJ prosecutor not to join *qui tam* relator case
  o Need pretransactional documentation and processes to show not a “bad actor” or not “backfilling” to justify action after the fact
  o Need a persuasive or rigorous analysis that addresses how the government views FMV and CR physician compensation
  o Alternatively, dissuade the DOJ prosecutor from taking the case due to complexity or challenges in litigating the case
  o Alternatively, convince a judge to rule on a pretrial basis in your favor
  o *Otherwise, your organization will proceed to settlement talks*
The Issue of Practice Losses in Recent Cases

How Qui Tam Relators and the Government View Losses
Practice Losses in Recent Cases

• Practice losses in Tuomey and Halifax
  o Losses figure prominently in the CR analysis of the government’s expert
  o Was the contract set up to always lose money?
  o Losses may be justified in some cases

• North Broward case
  o Amended complaint mentions practice losses 88 times
  o Excessive compensation caused losses: $150 million loss over 8 years
  o Culture of loss-taking: expected and budgeted for losses
  o Tracked offsetting profits from referrals
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Practice Losses in Recent Cases

• Adventist Complaint

“The compensation offered to physicians (and to some "mid-level practitioners" like nurse practitioners and physician assistants) as an inducement for referrals includes overall compensation above fair market value, as evidenced by the Defendants' substantial and consistent losses on their physician practices. Defendants tolerate such losses only because Defendants are able to recover the losses, plus substantial additional sums, by ensuring the same physicians refer their patients to Defendants' hospitals for inpatient and ancillary services.” (Paragraph 3)

“Defendant Hospitals are thus compensating the doctors whose practices they have purchased at levels that not only exceed what Defendants can rationally pay while maintaining a physician practice that could be economically viable on its own merits, but that even more dramatically exceed what Defendants' employee physicians could reasonably expect to earn if those physicians had continued to own and operate the business themselves.” (Paragraph 148)

From Adventist Amended Compliant for Relators Payne, Church, and Pryor (emphasis added)
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Practice Losses in Recent Cases

• Citizen’s Medical Denial of Motion to Dismiss:

“Relators have made several allegations that, if true, provide a strong inference of the existence of a kickback scheme. Particularly, the Court notes Relators’ allegations that the cardiologists’ income more than doubled after they joined Citizens, even while their own practices were costing Citizens between $400,000 and $1,000,000 per year in net losses. 

Even if the cardiologists were making less than the national median salary for their profession, the allegations that they began making substantially more money once they were employed by Citizens is sufficient to allow an inference that they were receiving improper remuneration. This inference is particularly strong given that it would make little apparent economic sense for Citizens to employ the cardiologists at a loss unless it were doing so for some ulterior motive—a motive Relators identify as a desire to induce referrals.”
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The Government’s View of Practice Losses

• Attorney representing health system in *qui tam* case

“This is out of the blue. *The gist of what the government is saying is that employment arrangements with physicians are presumptively not commercially reasonable unless the entity makes a profit.*”

Linda Baumann, with Arent Fox, as quoted in the article, “In New Angle on Stark Cases, Government Hits Hospitals for Lack of Physician Profit,” *Report on Medicare Compliance*, July 9, 2013
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The Government’s View of Practice Losses

• Former DOJ Attorney

“In the government’s eyes, profit is required for commercial reasonableness. The government is making the argument that if it’s not profitable, the hospital is paying for referrals.”

Why Health System Practices Lose Money

Examining the Causes of Losses
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Why Health System Practices Lose Money

• Employer and physician performance issues
• Consequences of hospital-physician integration
  o Potential for higher cost structures for certain resources
  o Operational changes: payer mix, locations, services
  o Providing services in low volume areas
  o Hiring primarily to provide hospital ED call coverage
  o **Conversion of technical component or ancillary services to HOPD**
    ➢ Compensation levels for many specialties are based on physicians receiving the net profits from in-office ancillaries
Why Health System Practices Lose Money

• Move to survey-based compensation
  o Many health systems base physician compensation *exclusively* on the “survey says” approach without regard to key economic factors
  
  ➢ Recent industry panel discussion on what to pay physicians for quality: “We’re waiting on a survey to come out”
  
  o “Survey says” nearly all doctors should make the median
  o “Survey says” wRVU production alone sets physician compensation
  o “Survey says” regional data reflects my local marketplace
  o But, “survey says” ignores fundamental factors in practice economics
  o Ignoring practice economics can result in losses
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Why Health System Practices Lose Money

• The reality of the surveys
  o *Not based on statistical sampling: they do not reflect the US marketplace*
  o Not use for inferential statistics: sample represents the entire population
  o *MGMA disclaims any use of its data for inferential statistics; its survey is descriptive statistics, i.e., analysis of a particular dataset*
  o Duplication of responding organizations in SCA and AMGA
  o Over-represented by large multispecialty groups: premium comp
  o Do not report data by local market
  o Do not report all the factors affecting physician compensation
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Surveys vs. AMA Data for US Physician Marketplace

Practice Ownership

- Physician
  - AMA 2013
  - AMA 2015
  - MGMA 2015
  - AMGA 2015
  - SCA 2015

- Hospital/Health System

- Other
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Surveys vs. AMA Data for US Physician Marketplace

Practice Type

- Single Specialty
  - AMA 2013
  - AMA 2015
  - MGMA 2015
  - AMGA 2015
  - SCA 2015

- Multispecialty / Other

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Surveys vs. AMA Data for US Physician Marketplace

Practice Size Based On Physicians In Group

- Less than 50
- 50 +

- AMA 2013
- AMA 2015
- MGMA 2015
- AMGA 2015
## Impact of Local Payer Rates Study

<table>
<thead>
<tr>
<th>Market / Rate Level</th>
<th>Market Commercial to Medicare Ratio</th>
<th>Revenue per WRVU</th>
<th>Compensation per WRVU</th>
<th>Compensation to Revenue %</th>
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# Practice Losses: The New Ticking Time Bomb

## Impact of Local Payer Rates Study

<table>
<thead>
<tr>
<th>Market / Rate Level</th>
<th>Model Compensation per wRVU</th>
<th>MGMA Median Compensation per wRVU</th>
<th>Variance per wRVU</th>
<th>Total Practice Impact</th>
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Alternatives to Survey-Based Compensation

• Earnings-based compensation
  o Revenues less costs = net practice earnings = reasonable compensation
  o Prevailing paradigm for physicians in US
  o *Normalize revenues and costs*
    o Comprehensive analysis of elements of physician productivity and economic efficiency

• RBRVS-based compensation
  o RBRVS indicates the proportion of reimbursement to allocate to physician comp + benefits and to practice overhead
  o Government methodology for estimating physician compensation
FMV and CR Compliance Risks for Health System Losses on Physician Practices

What Loss Causes are Problematic for Stark/AKS Compliance
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FMV and CR Compliance Risk Issues

• Employment and physician performance issues
  o Initial / startup losses easier to justify
  o Can long-term performance issues be justified?

• Consequences of hospital-physician integration
  o Losses from specific health system choices easier to justify
  o Community need appears to be a valid rationale, per Tuomey trial
  o Can be valid business reasons for losing money on practices
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**FMV and CR Compliance Risk Issues**

- Conversion of in-office ancillaries to HOPD
  - Stark allows physicians to be compensated from net profits on in-office ancillaries only if certain conditions are met under the group practice definition.
  - If the ancillaries do not meet these conditions, can you pay the physicians using rates implicitly based on these net profits?
  - Pure valuation theory would say yes: physician has alternatives and only hospitals can convert ancillaries to HOPD for higher reimbursement.
  - *But, this question is also a regulatory compliance matter*.
  - Use of surveys has better “optics” but not erase the fundamental issue.
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FMV and CR Compliance Risk Issues

• Uninformed / exclusive use of survey data
  o Government’s primary valuation expert argues *median* compensation rates (per wRVU or collections %) are categorically FMV, moving up to the 75th percentile in limited situations
  o *But, expert also states CR is a separate analysis: practice losses must be justified apart from referrals and for regulatory compliant business purposes*
  o DOJ prosecutors view practice losses as compliance red flags, if not *prima facie* evidence, of an arrangement not being CR
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FMV and CR Compliance Risk Issues

• Uninformed / exclusive use of survey data
  o *Qui tam* relators focus on ongoing losses as justifiable only due to referrals
  o Judge in the Citizens’ case was unpersuaded by the survey median analysis, *when practice lost money and docs given a pay raise*
  o Appraisal body of knowledge does not support the exclusive use of the market approach
  o Stark regulations partly to blame for “survey says” approach (IMHO)
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FMV and CR Compliance Risk Issues

• Ineffective defenses from case history
  o General appeals to community need
  o Appeals to “mission-driven” organizational status or purpose
  o General appeals to physician shortages
  o General claims about recruiting difficulties
  o General claims about ensuring hospital ED call coverage
  o General or unsubstantiated claims about physicians leaving the market
  o General claims about poor payer mix
  o Physician makes national median
Addressing FMV and CR Compliance Risk for Practice Losses

Ideas to Reduce Compliance Risk
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Addressing Compliance Risk for Practice Losses

• Compliance programs and culture matter
  o Excessive pressure on compliance officers can result in 
    *qui tam* relator cases costing tens of millions of dollars
  o Avoid *qui tam relator* risk at the organizational level

• Analyze potential for losses on front-end of a deal
  o Incorporate loss forecasting and justification as part of FMV and CR review and approval processes
  o Regulators view upfront analyses more favorably than after-the-fact justifications
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Addressing Compliance Risk for Practice Losses

- Develop fact-specific, detailed business rationales
  - Document specific facts and circumstances
  - Logically relate the impact of specific facts and circumstances on practice losses: why do they contribute to losing money?
  - Don’t make contradictory or self-refuting cases:
    - High community need, with low physician volumes: community need implies unmet demand; physician should be able to ramp up easily
    - National physician shortages mean always paying 90th percentile to get a physician: if national shortage, survey data already reflects high demand/low supply comp levels
  - Get real facts and circumstances, not “heard on the street”
Addressing Compliance Risk for Practice Losses

• Quantitative analysis matters: do the numbers
  o Identify the causes of practice losses through financial analysis
  o Quantify the impact of payer mix and low volumes
  o Quantify the impact of hospital-specific operational and cost decisions
  o Analyze the impact of in-office ancillary conversions to HOPD
  o RBRVS model provides a useful benchmark
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Addressing Compliance Risk for Practice Losses

• Run physician practices like a real business
  o Obtain best payer rates possible for physician contracts
  o Manage costs, including corporate functions
  o Fix revenue cycle issues
  o Make hospitals pay the true value of hospital ED call coverage to health system practices
  o Use actual placement or new-hire survey data for what experienced physicians are making at new jobs
  o Use earnings-based and RBRVS compensation models, along with survey data
Questions?

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