# HCCA'S 21ST ANNUAL COMPLIANCE INSTITUTE

LESSONS LEARNED: HOW RECENT ENFORCEMENT CASES PROVIDE INSIGHT INTO EFFECTIVE COMPLIANCE PROGRAMS FOR FAIR MARKET VALUE AND COMMERCIAL REASONABLENESS

HORNE CPAs & BUSINESS ADVISORS

ANKURA CONSULTING

0

## PRESENTERS

TIMOTHY SMITH
CPA/ABV
*Ankura Consulting*

ANKURA CONSULTING

GREG ANDERSON
CPA/ABV, CVA
*HORNE LLP*

HORNE CPAs & BUSINESS ADVISORS

## SESSION LEARNING OBJECTIVES

- Learn What Fair Market Value (FMV) and Commercial Reasonableness (CR) Issues Are Driving Recent Enforcement Activity for Hospital-physician Arrangements and Transactions.
- Use Lessons Learned from Recent Cases to Analyze Organizational Processes, Practices, and Outcomes and Identify High-risk FMV/CR Compliance Risk Areas.
- Develop Improved Organizational Structures and Processes to Manage and Reduce Real World FMV/CR Compliance Risk.

ANKURA CONSULTING

2

HORNE CPAs & BUSINESS ADVISORS

## DISCLAIMER

- This program is a general discussion of regulatory and business issues; it should not be relied upon as legal, valuation, business, financial, compliance, or other professional advice.
- The panelists will provide their own views and not those of their current or past employers or clients.
- Not all slides will be covered in detail. Some are for reference only.
- The slides are the result of the collaboration of the panelists and reflect their individual and collective thoughts and observations.
- This presentation may include a discussion of hypothetical scenarios. Any hypothetical scenarios are intended to elicit thoughtful and lively discussion, but do not represent actual events.
- This program may include a discussion of certain ongoing or settled *qui tam* or other lawsuits. The discussion is based on publicly available documents and allegations in the lawsuits. We wish to remind participants that allegations are allegations only. We also wish to remind participants that the list of cases and related issues we discuss may not be comprehensive.

ANKURA CONSULTING

3

HORNE CPAs & BUSINESS ADVISORS

# FMV AND CR ISSUES THAT DRIVE RECENT ENFORCEMENT ACTIVITY FOR HOSPITAL-PHYSICIAN ARRANGEMENTS AND TRANSACTIONS

HORNE CPAs & BUSINESS ADVISORS

ANKURA CONSULTING

4

## THE HIGH RISK OF PHYSICIAN ARRANGEMENTS

- "Arrangements with physicians are the highest compliance risk area in 2017,"[1] according to Richard Kusserow, former Inspector General. The most significant source for identifying Stark violative contracts remains whistleblowers. "The number one enforcement priority for both the OIG and DOJ will continue to be any arrangement that implicates the Anti-Kickback Statute and Stark Law."

[1]Kusserow, Richard, "Kickback Cases Remain Top DOJ and OIG Priority in 2017", Strategic Management Services, LLC. Jan. 2017, accessed Feb. 11, 2017.

ANKURA CONSULTING

5

HORNE CPAs & BUSINESS ADVISORS

## RECENT MAJOR SETTLEMENTS WITH DOJ INVOLVING PHYSICIAN ARRANGEMENTS

- Tuomey - $72.4 million *
- Halifax - $85 million
- Citizens' Medical - $21.8 million
- Columbus Regional - $35 million
- North Broward - $69.5 million
- Adventist - $118.7 million
- Lexington County - $17 million

Business Valuation:

- DaVita - $389 million (total)

* Negotiated settlement from $237 million jury verdict

ANKURA CONSULTING

6

HORNE CPAs & BUSINESS ADVISORS

## U.S. *ex. rel.* DRAKEFORD v. TUOMEY HEALTHCARE SYSTEM, INC

- Things You Didn't Know about *Tuomey*, But Should Have Known
  - DOJ's closing argument (both trials) began with painting the physician arrangements as a vehicle for Tuomey to retain lucrative HOPD surgery revenues instead of allowing lower cost ASC rates into the market.
  - "Instead, ladies and gentlemen, this was a scheme by a hospital to lock in all the outpatient referrals in town once competition cropped up. And the way the hospital did that, ladies and gentlemen, was *to pay doctors more than they could ever possibly make working on their own.*" (Tuomey 1 Trial – Closing Argument)

ANKURA CONSULTING

7

HORNE CPAs & BUSINESS ADVISORS

## U.S. *ex. rel.* DRAKEFORD v. TUOMEY HEALTHCARE SYSTEM, INC

- DOJ fact-checked Tuomey's claims about community need
  - Depositions showed physicians were not a risk to leave the community
  - Deposition showed no real issues over call coverage
  - Tuomey medical staff had grown substantially prior to physician deals
- **75th percentile is NOT FMV based on this case!**
  - DOJ's expert said median compensation ratios (per wRVU and % of collections) is the FMV level
  - In unique circumstances, 75th percentile rates can be FMV



## U.S. *ex. rel.* DRAKEFORD v. TUOMEY HEALTHCARE SYSTEM, INC

- Tuomey's practice losses were an indication of payment for referrals
  - Used in DOJ's closing arguments (both trials)
    - "And, finally, just use your common sense. The only reason that it makes sense to [pay] these doctors a million and a half dollars a year is to save the eight to $12 million a year in referrals. And even Paul Johnson, the Tuomey's CFO, acknowledged on cross-examination or, excuse me, on direct examination that really, yeah, the hospital was getting back for all that money was referrals." (Tuomey 2 Trial – Closing Argument)
  - DOJ's valuation expert testified the losses were an indication the arrangements were not commercially reasonable
    - Losses are justified in some cases, but not Tuomey's

## *U.S. ex. rel. BAKLID-KUNZ v. HALIFAX HOSPITAL MEDICAL CENTER*

- Halifax Hospital Medical Center
  - County/taxing district hospital in Volusia County, Florida, with 678 beds
- *Qui tam* relator - hospital compliance officer
- Case issues
  - Compensating oncologists based on HOPD profits
  - Compensating neurosurgeons above FMV
- DOJ won summary judgment on oncologists compensation.
- Halifax settled after losing summary judgment.



## *U.S. ex. rel. BAKLID-KUNZ v. HALIFAX HOSPITAL MEDICAL CENTER*

- Neurosurgeons (3 FTEs)
  - Compensation formula
    - Base salary
    - Bonus: 100% of collections above base salary
    - Specific collection rates set for certain types of patients or payers
  - Halifax lost motion for summary judgment on neurosurgeons.
  - DOJ and Halifax hired valuation experts and their reports were included in pleadings for case.

## *U.S. ex. rel. BAKLID-KUNZ v. HALIFAX HOSPITAL MEDICAL CENTER*

- DOJ's Expert: Reported wRVUs Unreliable
  - Reported wRVUs were materially above the 90th percentile: 2x 90th in many cases.
  - Material inconsistency from year-to-year
  - Collections per wRVU below the median, but hospital had favorable payer mix.
  - Internal compliance reviews showed major billing and coding problems, including RNs performing patient visits.



## *U.S. ex. rel. BAKLID-KUNZ v. HALIFAX HOSPITAL MEDICAL CENTER*

- DOJ's Expert: Reported wRVUs Unreliable (cont'd)
  - Time analysis
    - E&M comparison: at or well above FP median wRVUs
    - Consultant found docs hours equivalent to 6,900 to 8,700
  - *Rejected use of comp/wRVU for FMV analysis*

## *U.S. ex. rel. BAKLID-KUNZ v. HALIFAX HOSPITAL MEDICAL CENTER*

- DOJ's Expert FMV Analysis: Comp Not FMV
  - 75th percentile rates used as FMV due to data issues; "benefit of doubt to hospital"
  - Comp to pro collections ratio used
  - Neurosurgeons comp ratios above 75th percentile
  - Compensation and professional collections benchmarking not correlate
  - One neurosurgeon given 67% pay increase upon employment



## *U.S. ex. rel. BAKLID-KUNZ v. HALIFAX HOSPITAL MEDICAL CENTER*

- DOJ's Expert CR Analysis: Contracts Not CR
  - Favorable treatment in comparison to other employed physicians: car allowance, set collection rates, others
  - Compensation model allowed docs to receive 100% of collections.
  - Practice would ***always*** incur a loss
  - ***Material financial losses on practice, but internal report netted referrals against losses***

## *U.S. ex. rel. BAKLID-KUNZ v. HALIFAX HOSPITAL MEDICAL CENTER*

- Government intervened in case
- Case settles with DOJ for **$85,000,000**
- Qui tam relator to receive $20,800,000 from settlement



## U.S. *ex. rel.* PARIKH v. CITIZENS MEDICAL CENTER

- Citizens Medical Center (CMC)
  - County hospital in Victoria, TX, with 296 beds
- FCA / *qui tam* claim filed by 3 local cardiologists who were at odds with CMC; prior lawsuit between parties
- Allegations of multiple issues including kickback, billing, others
- Significant allegations about referral patterns and requirements for cardiac surgeries and cardiology privileges
  - Cardiologists to refer to CMC's exclusive cardiac surgeon and perform services at CMC

## U.S. *ex. rel.* PARIKH v. CITIZENS MEDICAL CENTER

- Alleged collective compensation levels of 3 employed cardiologists went from $630,000 (pre-employment) to $1,400,000 (post-employment).
  - Higher than private practice mentioned 10 times in complaint
  - No FMV studies prepared; just board approval
- Practice losses: 2008 = $400,000 / 2009 = $1 million
- Referrals alleged to be reason for incurring practice losses
  - Not commercially reasonable to lose money continually



## U.S. *ex. rel.* PARIKH v. CITIZENS MEDICAL CENTER

- CMC responses in pleadings
  - Employed cardiologists made around the national median
  - Legitimate reasons for comp to go up under employment
    - *More charity care in private practice*
  - One doctor had competing offers.
  - Employment offered for physician retention purposes
  - Employed cardiologists made less than the *qui tam* relator cardiologists

## U.S. *ex. rel.* PARIKH v. CITIZENS MEDICAL CENTER

- Judge's Ruling on 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."



## U.S. *ex. rel.* PARIKH v. CITIZENS MEDICAL CENTER

- Government intervened in case.
- Case settles with DOJ for **$21,750,000.**
- Qui tam relators to receive $5,981,250 collectively from settlement

## U.S. *ex. rel*. BARKER v. COLUMBUS REGIONAL

- Columbus Regional Healthcare System
  - Nonprofit hospital in Georgia and Alabama
  - Case involved HOPD cancer center for one of its hospitals
- *Qui tam* relator: former administrator of cancer center (2011-13)
- Focus on compensation and billing for Andrew W. Pippas, M.D.
  - Employed medical oncologist since 2003
  - Center's medical director
  - Paid based on wRVUs plus stipends for directorships



## U.S. *ex. rel*. BARKER v. COLUMBUS REGIONAL

- Total compensation for Dr. Pippas (in $ millions):

| 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|---|
| $1.742 | $1.698 | $1.635 | 1.564 | $1.508 | $1.500 | $1.500 |

- Compensation per wRVU rate:
  - $113.67 through 2008 / $90 thereafter
- Directorship compensation per year
  - Cancer center = $200,000
  - Clinical research = $100,000

## U.S. *ex. rel*. BARKER v. COLUMBUS REGIONAL

- FMV opinions
  - Late 2008: high but OK
  - Early 2009: too high (different firm); cut rate to $90/wRVU
  - Early 2013: too high due to being credited for wRVUs of another physician and an NP
- *Qui tam* relator findings circa 2011
  - Billed for work of another physician
  - Paid for wRVUs of other physician and APPs



## U.S. *ex. rel*. BARKER v. COLUMBUS REGIONAL

- *Qui tam* relator findings circa 2011
  - Billing and payment for other providers' wRVUs not stopped until April 2013, despite 2007 outside audit and internal audits beginning in 2008
  - Upcoding for E&M codes reported in late 2008; also not corrected until April 2013
- Other issues with Dr. Pippas
  - Working less than 5 days per week
  - Not working expected hours on directorships

## U.S. *ex. rel*. BARKER v. COLUMBUS REGIONAL

- Other issues with physician relationships at hospital
  - Overlapping medical directorships / too many directorships
  - Internal audit found other compliance issues
- Key themes in complaint
  - Excessive comp because at or above 90th percentile (5x)
  - No commercial reasonableness analyses for deals
  - Paid in excess of collections by significant amounts
  - 2013 FMV opinion should have been applied retroactively due to practice of crediting wRVUs from other providers.



## U.S. *ex. rel*. BARKER v. COLUMBUS REGIONAL

- CRHS purchase of Tidwell Cancer Treatment Center (TCTC)
  - Relator allegations
    - Price paid in excess of FMV
    - Not commercially reasonable in the absence of referrals because purchase was defensive and not in response to community need
  - Purchased July 15, 2010, for $10.7 million from radiation oncologist
  - Draft valuation used for transaction
    - Prepared for competing health system used to support FMV
    - FMV = $9.1 million based on DCF only
  - Relator hired own valuation experts

## U.S. *ex. rel*. BARKER v. COLUMBUS REGIONAL

- Relator expert's CR analysis of purchase of TCTC
  - CRHS's purchase strategy was purely defensive, and not for community need.
  - Equipment at TCTC was outdated.
  - Dr. Tidwell's competence and ability to practice medicine to the standard of accepted care was identified as an ongoing issue with other CRHS oncologists.
  - CRHS did not appear to support the TCTC's operational and strategic efforts.
  - $10.67 million purchase price was in excess of FMV.
  - CRHS pulled together its letter of intent and marched to the July 15, 2010 close without typical due diligence.
  - CRHS did not obtain a final FMV Opinion.
  - CHRS's market for new radiation therapy patients was mostly stagnant.



## U.S. *ex. rel*. BARKER v. COLUMBUS REGIONAL

- Government intervened in case
- Settlement with DOJ
  - Columbus - **$25,000,000** plus up to **$10,000,000** in contingency payments
  - Dr. Pippas - **$425,000**

## U.S. *ex. rel*. REILLY v. NORTH BROWARD HOSPITAL DISTRICT

- North Broward Hospital District
  - Nonprofit health system with 30 facilities in South Florida
- *Qui tam* relator: Michael Reilly, M.D.
  - Local orthopedic surgeon
  - Offered employment by North Broward, but declined
  - *Appears* to have obtained inside financial documents to assist in case
  - Press interviews: not happy with what Broward was doing



## U.S. *ex. rel*. REILLY v. NORTH BROWARD HOSPITAL DISTRICT

- Compliant: Broward losses millions on its employed physicians
  - $150 million between 2004 and 2011
  - Loses are due to overcompensating its physicians.
  - Compensates physicians in excess of collections.
  - *Keeps internal reports showing IP and OP contribution margin for each physician.*
  - Broward offsets practice losses by IP/OP contribution margin.
  - Losses only financially sustainable and CR is consider referrals.

## U.S. *ex. rel*. REILLY v. NORTH BROWARD HOSPITAL DISTRICT

- Highly detailed complaint full of alleged data on Broward's physician practices
  - Orthopedic surgeons
    - $24 million total loss since 2004
    - CEO tells *qui tam* relator making money due to referrals
    - Pressure to refer ancillaries
  - 2011 review for major physician groups
  - 2009 losses by hospital
  - References various contribution margin reports



## U.S. *ex. rel*. REILLY v. NORTH BROWARD HOSPITAL DISTRICT

- Highly detailed complaint (cont'd)
  - Physicians paid over 90th percentile; some with low production
  - Low charity care: not cause of low collections
  - Planned and budgeted for losses
- **Key theme: practice losses**
  - Mentioned 77 times in the body of complaint (74 pages)
  - Practice losses show compensation not FMV

## U.S. *ex. rel*. REILLY v. NORTH BROWARD HOSPITAL DISTRICT

- Government intervened in case
- Broward settles with DOJ for **$69,000,000**
- *Qui tam* relator to receive $12,045,655 from settlement



## U.S. *ex rel.* PAYNE, et al. v. ADVENTIST HEALTH SYSTEM

- Adventist Health System
  - Nonprofit health system
  - Case involved physician relationships at facilities in Florida, Illinois, North Carolina, Tennessee, and Texas
    - These states joined with U.S.
- *Qui tam* relators: all worked at Park Ridge Health hospital
  - Michael Payne: Risk Manager
  - Melissa Church: Executive Director of Physician Services
  - Gloria Pryor: Compliance Officer for Physician Offices

## U.S. *ex rel.* PAYNE, et al. v. ADVENTIST HEALTH SYSTEM

- Key allegations
  - Physicians paid excessive compensation to induce referrals, resulting in practice losses
  - Losses offset by profits generated for the hospital
  - Management admitted comp for referrals
  - Bonus formulas included HOPD revenues
  - Billing and upcoding issues
  - Kickback schemes for lab, pharmacy and other areas
  - Highly detailed complaint full of data and specifics



## U.S. *ex rel.* PAYNE, et al. v. ADVENTIST HEALTH SYSTEM

- Practice losses a key demonstration of excess compensation
  - Mentioned about 51 times in the complaint
  - Sustained practice losses for 10 years
  - Comp "not rationally related" to practice earnings
  - Comp not "economically viable on its own merits"
  - Exceeded comp possible in private practice
  - Allegations of specific instances when management stated losses were acceptable because of hospital referrals

## U.S. *ex rel.* PAYNE, et al. v. ADVENTIST HEALTH SYSTEM

| 2012 Projected Gain/Loss Per Employed Physician | | | |
|---|---|---|---|
| Hospital | Primary Care | Medical | Surgical |
| Park Ridge | ($93,379) | ($37,332) | ($101,403) |
| Manchester | $205,305 | - | ($183,474) |
| Takoma Regional | ($82,873) | ($175,247) | ($77,096) |
| Adventist Health Partners | ($12,934) | ($138,204) | ($115,607) |
| Huguley | ($61,445) | - | ($153,582) |
| Central Texas | ($182,077) | $538,408 | ($254,810) |
| Metroplex | ($77,424) | ($40,726) | ($208,857) |
| Emory-Adventist | ($108,414) | - | ($703,324) |
| Gordon | ($429,082) | - | ($321,964) |
| Shawnee Mission | ($19,381) | ($185,593) | ($132,598) |
| FH - Zephyrhills | ($50,028) | ($251,975) | ($442,965) |
| FH - Carollwood | - | - | ($42,000) |
| FH - Tampa | ($493,386) | ($160,558) | ($83,788) |
| FH - DeLand | ($101,380) | ($253,657) | ($75,354) |
| FH - Fish Memorial | ($101,492) | ($188,823) | ($226,639) |
| FH - Flagler | ($14,961) | ($42,360) | ($70,420) |
| FH - Memorial | ($18,101) | $11,906 | ($48,175) |
| FH - Heartland | ($104,513) | ($191,320) | ($190,058) |
| FH - North Pinellas (aka Helen Ellis) | $24,496 | - | ($211,272) |
| FH - Waterman | ($14,016) | - | ($235,936) |
| FH/FHMG | ($118,173) | ($177,469) | ($188,858) |

ANKURA CONSULTING

HORNE CPAs & BUSINESS ADVISORS

#AICPAhealt

## U.S. *ex rel.* PAYNE, et al. v. ADVENTIST HEALTH SYSTEM

- Physician cost center accounting
  - Revenues included professional and HOPD facility fees
  - Costs: physician comp, support staff, facility costs, and hospital overhead
- Tracking of hospital contribution margin by physician
  - Reported hospital-side profits by physician
  - Management used to justify practice losses and comp levels
  - Report limited to senior management
  - *Relators accidentally given report*

ANKURA CONSULTING

39

HORNE CPAs & BUSINESS ADVISORS

#AICPAhealt

## U.S. *ex rel.* PAYNE, et al. v. ADVENTIST HEALTH SYSTEM

- Contract compensation caps related to losses were not enforced
- Physicians paid various perks
- Bonuses paid from revenues that included HOPD amounts
  - "Part A" payments
  - Management regularly spoke to physicians about being paid from HOPD revenues
  - Practice losses, despite inclusion of HOPD facility fees
  - High bonus amounts for little work
  - Total compensation exceeded collections



## U.S. *ex rel.* PAYNE, et al. v. ADVENTIST HEALTH SYSTEM

- Management became concerned about compensation levels.
  - Internal review
    - 50 physicians over MGMA 90th percentile
    - Many had production below median
  - Concerns over bonus plan: "Part A" payments
  - Hospitals told to stop "Part A" payments but did not
  - No self-reporting due to fear of high penalties
  - *Changed comp plan to RVU model, but total compensation remained the same*

## U.S. *ex rel*. DORSEY v. ADVENTIST HEALTH SYSTEM

- Adventist Health System (AHS)
  - For physician relationships at facilities in Florida, Illinois, North Carolina, and Texas
    - These states joined with U.S.
- *Qui tam* relator
  - Sherry Dorsey: COO of Physician Enterprise AHS
    - Reported to senior executives
    - Began work 7/12/12
    - AHS notified Dorsey was a witness on 5/23/13



## U.S. *ex rel*. DORSEY v. ADVENTIST HEALTH SYSTEM

- Complaint provides chronicle of Dorsey's meetings with senior AHS executives and operators.
- Complaint allegations
  - Compensation based on DHS referrals / HOPD revenues
  - 85 physicians paid over MGMA 90th percentile, many over $1 million per, and some between $2-3 million
  - Expressed incredulity to senior management about compensation and production levels
  - Recommended coding audit

## U.S. *ex rel.* DORSEY v. ADVENTIST HEALTH SYSTEM

- Complaint allegations (cont'd)
  - Compensation model to convert to wRVUs but total compensation to remain same
  - Senior management ignored her concerns
    - Required to return over 90th percentile report
    - Warned not to raise major concerns
  - Provides information on specific physicians



## U.S. *ex rel.* PAYNE, et al. v. ADVENTIST HEALTH SYSTEM
## U.S. *ex rel.* DORSEY v. ADVENTIST HEALTH SYSTEM

- Government intervened in both cases
- AHS settles with DOJ for **$115,000,000**

## U.S. *ex rel.* HAMMETT v. LEXINGTON COUNTY HEALTH SERVICES DISTRICT

- Lexington Medical Center (LMC)
  - 428-bed county hospital in West Columbia, South Carolina
  - Over 600 physicians and 70 medical practices
- *Qui tam* relator: David Hammett, MD
  - Neurologist who LMC employed and later terminated
  - Part of a 7-doc internal medicine group LMC acquired (not a owner in the group)
  - Group had significant imaging ancillaries, including an MRI



## U.S. *ex rel.* HAMMETT v. LEXINGTON COUNTY HEALTH SERVICES DISTRICT

- Employment termination lawsuit provided information used in whistleblower case.
- Key allegations
  - Buying access to patients via acquiring physician practices
  - Paying commercially unreasonable compensation
  - Mandating referrals by employed physicians and punishing those who do not refer
  - Paying for referrals through high compensation levels

## U.S. *ex rel*. HAMMETT v. LEXINGTON COUNTY HEALTH SERVICES DISTRICT

- Employment offers to group: all physicians except one would receive higher compensation
- Hammett's compensation plan
  - Base salary of $318,758, up from $250,000 pre-employment
  - Bonus: tiered comp/wRVU rates: $50, $74, $98
  - Earned on average about $600,000 per year
- Alleged other physicians had median productivity but compensated in excess of MGMA 90th percentile



## U.S. *ex rel*. HAMMETT v. LEXINGTON COUNTY HEALTH SERVICES DISTRICT

- Alleged physicians told high comp in exchange for referrals
- Purchase price for practice: $1.5 million, and made post-deal payments to owners not in purchase agreement
- Practice loses money post-acquisition.
  - Hammett told losing money due to higher compensation and reduced ancillary profits
- LMC tracks imaging referrals, which declined post acquisition.
- Alleged physicians instructed to increase ancillaries.

## U.S. *ex rel.* HAMMETT v. LEXINGTON COUNTY HEALTH SERVICES DISTRICT

- Hammett continues to refer outside ancillaries, as he did pre-employment; alleged he was pressured about referrals
- LMC terminates Hammett.
- Government intervened in case.
- LMC settles with DOJ for **$17 million.**
- Hammett receives **$4.5 million.**



## U.S. *ex. rel.* ELISABETH MARKLEY v. SPARTANBURG REGIONAL HEALTH SERVICES DISTRICT, INC.

- Spartanburg Regional Healthcare System (SRHS)
  - South Carolina governmental health system (self-funded)
  - Multiple hospitals and facilities
  - Services counties in South and North Carolina
  - 300 physicians in Medical Group of the Carolinas (MGC)
- *Qui tam* relator: Elisabeth Markley
  - Former physician compensation coordinator
  - Worked on physician contracting

## U.S. *ex. rel.* ELISABETH MARKLEY v. SPARTANBURG REGIONAL HEALTH SERVICES DISTRICT, INC.

- Alleged she raised issues about compensation but was told to "shut up" about them
- Alleged she was promised promotions, but not given
- Terminated due to restructuring

- Case filed in September 2015 and unsealed in October 2016
- DOJ is investigating, but has not intervened in the case.



## U.S. *ex. rel.* ELISABETH MARKLEY v. SPARTANBURG REGIONAL HEALTH SERVICES DISTRICT, INC.

- Key allegations
  - Practices losses due to compensation in excess of FMV and not CR; practices always projected to lose money
  - Make up for losses with referrals
  - Meetings about hiring new physicians would include discussions of how much referral revenue they would bring
  - Avoiding outside FMVs by excluding compensation
  - Paying for services not actually provided
  - Acquiring practices to get referrals

## U.S. *ex. rel.* ELISABETH MARKLEY v. SPARTANBURG REGIONAL HEALTH SERVICES DISTRICT, INC.

- Practice losses
  - 97 MGC groups operated at a loss; 11 made a profit
  - Total loses in FY15 = **($40,569,674)**
  - Losses never projected to turnaround
- High compensation for certain physicians; above 75th percentile
- Example of oncologist deal
  - Discussed downstream revenue of $30-$40 million per year
  - Paid $600,000 in total comp
  - Projected to lose $589,000 per year



## U.S. *ex. rel.* ELISABETH MARKLEY v. SPARTANBURG REGIONAL HEALTH SERVICES DISTRICT, INC.

- Circumventing of outside FMV process
  - Policy to obtain outside FMV if comp over 75th percentile
  - Markley told to exclude comp items to keep under 75th
  - Pay employed physicians on 1099 basis for certain services
- Payment for services not provided
  - Management of practice groups
  - Quality outcomes
  - Administrative services
  - Supervision of NPs

## U.S. *ex rel.* DAVID BARBETTA v. DAVITA, INC. AND TOTAL RENAL CARE, INC.

- DaVita, Inc.
  - Publicly traded dialysis center provider
- *Qui tam* relator: David Barbetta – senior financial analyst in M&A
- Dialysis center transaction allegations
  - Sales of shares of existing dialysis centers below FMV
  - Purchases of physician-owned dialysis centers above FMV
  - *De novo* joint ventures that made little to no economic sense apart from referrals



## U.S. *ex rel.* DAVID BARBETTA v. DAVITA, INC. AND TOTAL RENAL CARE, INC.

- Allegations regarding DaVita's buy/sell strategies
  - Manipulation of financial models used by analysts and provided to outside appraiser to value dialysis centers
    - *Ad hoc* adjustments to financial models
    - Application of non-standard formulas and algorithms
  - "Gaming" revenue and cost assumptions given to the valuation firm
  - Only obtained a valuation when purchasing 100 percent of a partner's interest in a jointly-owned center

## U.S. *ex rel.* DAVID BARBETTA v. DAVITA, INC. AND TOTAL RENAL CARE, INC.

- Government intervened in case.
- DaVita settles with DOJ for **$389 million.**



## KEY FMV/CR ISSUES IN ENFORCEMENT CASES

- **Losses, losses, losses, losses, and more losses**
  - Losses presented as definitive indication that compensation is above FMV
  - Losses are only justifiable and rational by taking into account referrals.
- Physicians paid over the MGMA 90th percentile are suspect and probably being paid for referrals.
- Making more money under hospital employment than in private practice is suspect.
- Tracking referrals and offsetting practice losses with profits on referrals
- Compensation in excess of collections

## KEY FMV/CR ISSUES IN ENFORCEMENT CASES

- Discussions and analyses of physician referrals as part of deals
- Paying physicians for the production of another provider
- Billing and coding issues
- Valuation issues
  - No valuation
  - Using old valuations or draft valuations
  - Manipulation of the valuation process or data



## KEY FMV/CR ISSUES IN ENFORCEMENT CASES

- High levels of wRVUs that are questionable
- Payments for services not provided
- Rationale and explanations that don't square with the facts
- Defenses that have little impact
  - Nonprofit status
  - Community need – sole provider or safety net hospital
  - Median compensation
  - "Hospitals all lose money on their physician practices" (made by Tuomey in closing arguments)

## KEY FMV/CR ISSUES IN ENFORCEMENT CASES

- What's Not a Key Issue
  - Matching compensation and production (percentile matching) is occasionally used to indicate excessive compensation.
    - Example: 65th percentile wRVUs warrants 65th percentile total compensation
  - Practice losses are by far the more broadly used economic indictor of compensation in excess of FMV.
  - Industry's exclusive focus on surveys and percentile matching is out of sync with current enforcement trends.

ANKURA CONSULTING



HORNE CPAs & BUSINESS ADVISORS

## USING LESSONS LEARNED FROM RECENT CASES TO ANALYZE ORGANIZATIONAL PROCESSES, PRACTICES, AND OUTCOMES AND IDENTIFY HIGH-RISK FMV/CR COMPLIANCE RISK AREAS

HORNE CPAs & BUSINESS ADVISORS

ANKURA CONSULTING

## THE CURRENT ENFORCEMENT ENVIRONMENT

- In a Post-*Tuomey* World, Providers Are Settling Cases Rather Than Litigating Them Through Trial.
  - FMV and CR issues will not be fully litigated based on the merits or technical arguments.
  - Unlikely pretrial motions can prevail based on expert opinions outside of trial process.
  - Settlement context changes the playing field: must meet regulators based on their worldview
    - Did you do wrong?
    - Are you a good actor or bad actor?



## THE CURRENT ENFORCEMENT ENVIRONMENT

- Investigations are Emerging Due to Q*ui Tam* Relator Cases (Whistleblowers)
  - Based on deal "insiders" with access to insider information
  - Often not based on front-end FMV/CR issues, but about administration of contracts and contract outcomes
- Government responses to *qui tam* relator filings
  - Join the suit?
  - If join, how large of a fine to pursue under FCA?

## AVOIDING BADGES OF FRAUD

- How Do Prosecutors Think about a Case?
  - Lying
  - Cheating
  - Stealing
- These are the real themes put to the jury, rather than technical arguments
- Avoid practices that are considered "badges of fraud"



## AVOIDING BADGES OF FRAUD

- Reports and analyses offsetting practice losses against hospital referral profits
- Hospital operators talking about how practice losses are offset by hospital profits from referrals
- Physician compensation based on outpatient or other hospital service line profits
- Practice losses combined with high compensation and other "bad facts" indicating an offset between losses and referral profits
- Compensation models that essentially force losses (i.e., the compensation formula affords no chance for the practice to breakeven or make money)
- Lack of legitimate business reasons for losses (e.g., charity care, startup of a business, or needed coverage for necessary hospital service line such as trauma)
- Practice losses on arrangements where significant hospital profits are made as a result of the arrangements or can be tied indirectly to the arrangements

## THE CURRENT ENFORCEMENT ENVIRONMENT

- Settlements Based on DOJ's Perception of the Compliance-Orientation of the Organization
  - Existence and effectiveness of compliance programs and systems
    - Organizations should effectively establish a compliance orientation
    - Previously tainted organizations face the need to rehabilitate
  - Organizational systems to promote compliance



## THE CURRENT ENFORCEMENT ENVIRONMENT

- Settlements Based on DOJ's Perception (cont'd)
  - Outcomes of transactions and arrangements
    - Compensation levels
    - Practice losses
    - Contract terms and conditions
  - Review of real facts and circumstances rather than purported or perceived facts and circumstances

## FAILED PROCESSES CONTRIBUTING TO COMPLIANCE RISK

- Failed Deal Development Processes
  - Executives aggressively promoting deals while manipulating financial data and models
  - Insufficient controls to prevent bad actors from violating the one-purpose test
- Absence of Adequate Segregation of Duties
  - Executives with access to internal analysts and data provided to external valuation firms



## FAILED PROCESSES CONTRIBUTING TO COMPLIANCE RISK

- Flawed Process for Establishing and Documenting FMV
  - Lack of documented, defensible conclusions of FMV
    - Deals move forward without FMV support
    - Deals are based on incomplete external analysis performed for another party or another purpose
    - Conclusion or documentation is technically unsupportable
  - Lack of independent review or quality control processes
    - Unchecked manipulation of internal data and financial models
  - Haste to close the deal is the greatest driving force

## FAILED PROCESSES CONTRIBUTING TO COMPLIANCE RISK

- Inadequate Process for Use of Outside Valuation Consultants
  - Blatant manipulation of data furnished to outside valuator
  - Suppression of undesired valuations, opinion shopping
  - Selective use of valuator for limited transactions (i.e., buy-only)
  - Inadequate valuator qualification and monitoring process, resulting in plug-and-play valuations
  - Reliance on incomplete analysis obtained for another party or purpose



## FAILED PROCESSES CONTRIBUTING TO COMPLIANCE RISK

- Deficient Process for Establishing and Documenting CR
  - Defensive or anti-competitive decisions for unnecessary services are allowed to take precedence over legitimate business reasons
    - Buying a business of little strategic or community benefit other than referrals
    - Buying redundant, used, or outdated equipment
    - Employing providers with questionable standards of care
    - Entering a stagnant market or service line
  - Lack of compliance training and monitoring

## FAILED PROCESSES CONTRIBUTING TO COMPLIANCE RISK

- Process and Organizational Issues
  - Lack of adequate FMV and CR review process
  - Lack of segregation of duties or "separation of powers"
    - Hospital operators driving physician deals
    - No independent compliance functions with institutional power
    - Comparing physician practice losses to hospital contribution margin reports
    - Involvement of hospital management in the administration of physician contracts



## FAILED PROCESSES CONTRIBUTING TO COMPLIANCE RISK

- Process and Organizational Issues
  - Lack of organizational compliance structures
    - Problems identified but not resolved
    - Instructions to change compensation not followed
    - Compensation not based on contract terms
    - Attribution of wRVUs from other providers
    - Ignoring concerns of employees who raise legitimate compliance issues
  - Compliance training
  - Legal oversight?

## DEVELOPING IMPROVED ORGANIZATIONAL STRUCTURES AND PROCESSES TO MANAGE AND REDUCE REAL WORLD FMV/CR COMPLIANCE RISK

HORNE CPAs & BUSINESS ADVISORS

ANKURA CONSULTING

76

## ENTERPRISE RISK MANAGEMENT (ERM) FOR FMV/CR

- New Compliance Paradigm
  - Mitigate risks for FMV/CR compliance based on enforcement environment
    - Focus not only on technical, regulation-oriented compliance
    - Prevent *qui tam* relators from emerging
    - Reduce settlement amounts in case of compliance "fumble"
  - Foster compliance orientation through organizational structures and systems

ANKURA CONSULTING

77

HORNE CPAs & BUSINESS ADVISORS

## FOUR CRITICAL RISK AREAS

- Process Risk
  - Industry compliance paradigm: get FMV and legal review on front-end of deal
    - "Check the box" orientation
    - Often, focus on issues not at issue in enforcement actions
  - Pre-transactional systems and processes have weaknesses in ensuring front-end and *long-term* FMV/CR compliance.
  - Executives incorrectly believe the transaction or arrangement falls outside the purview of the Stark law.



## FOUR CRITICAL RISK AREAS

- Implementation/Administration Risk
  - Deals are not operationalized consistent with expert opinions or internal approvals.
  - Contracts are not administered as approved or according to the written terms.
  - Contacts not administered according to the valuation opinions or internal approvals.

## FOUR CRITICAL RISK AREAS

- Circumstantial Risk
  - Facts and circumstances have changed from when the deal was originally approved.
- Outcomes Risk
  - Arrangements result in high risk outcomes or "red flags" based on current enforcement trends.



## FMV/CR PROCESS BEST PRACTICES

- Health System Narrative to Reduce Potential Compliance/Enforcement Risk
  - The health system must provide a broader analysis based on a pre-transactional study in which an individual physician transaction is viewed in the context of an overall long term fiscal strategy and not a singular compensation arrangement.
  - Create a plenary omnibus financial, clinical, and legal strategy for the health system addressing as a part of that strategy its short and long term physician acquisition goals to satisfy prospective market conditions, including value based programs, bundled payments, joint venture, and ACO models.
  - Creation of an omnibus pre-transactional document broadly articulating the integration strategy with forecast of potential hospital losses over a transition term serves to replace the government's view physician loss equals payment for referrals.

## FMV/CR PROCESS BEST PRACTICES

- Health System Narrative to Reduce Potential Compliance/Enforcement Risk
  - Issues to address in the strategy document
    - How does the health system intend to effectuate clinical alignment to address the clinical and financial challenges with its business lines?
    - Do the proposed clinical services contribute to the development or operation of a clinical service line?
    - Are the financial and clinical purposes of the proposed arrangement specifically addressed based on FMV and CR, as well as related to the overall financial and clinical integration goals of the health system?



## FMV/CR PROCESS BEST PRACTICES

- CR Involves a Financial and Contractual Analysis
  - Compensation relative to collections
  - Bonus structure based on revenue minus expenses, rather than first dollar earned
  - Assessment of certain contractual terms
  - Immateriality of the belief that many hospital–based physician practices lose money

## FMV/CR PROCESS BEST PRACTICES

- Remedy Deficient Organizational Compliance Mindset
  - In several *qui tam* actions, employees were ignored or retaliated against when raising legitimate compliance issues.
  - Implement controls to prevent bad actors from violating the one-purpose test.
  - Engage in FMV/CR compliance training and monitoring.
- Establish Organizational Risk Parameters and Tolerance Thresholds Around the Four Corridors of FMV/CR Risk.



## FMV/CR PROCESS BEST PRACTICES

- Process Risk
  - Deal development process
  - Approval process
  - Contracting process
  - Payment process
  - Process for establishing FMV
  - Process for establishing CR
  - Process for using outside valuation consultants
  - Internal process compliance testing

## FMV/CR PROCESS BEST PRACTICES

- Implementation/Administration Risk
  - Process for implementing contracts
  - Process for contract administration
- Circumstantial Risk
  - Process for implementing facts and circumstances review
  - Process for periodic review of facts and circumstances



## FMV/CR PROCESS BEST PRACTICES

- Outcomes Risk
  - Review of internal and external valuations
  - Review of deal file documentation
  - Review of contract administration
  - Review of facts and circumstances
  - Financial outcomes analysis
    - Physician clinical compensation benchmarks
    - Analysis of practice losses
  - Process compliance auditing

## FMV/CR PROCESS BEST PRACTICES

- Address Real-world Enforcement Risk in the Context of an Organization's Goals, Values, and Available Resources
- Be Prepared for a Compliance Emergency: Optimum Defense for a *Qui Tam* Relator Filing
- "Stress Test" Processes and Outcomes to Find Weaknesses and Address Them



## KEY TAKEAWAYS FOR FMV/CR ERM

- A Well-Managed Contract Database Serves as a Platform to Support Ongoing Management and Compliance Reviews
- The Government's Decision to Intervene and the Size of the FCA Damage Assessment is Based in Large Part on the Compliance-Orientation of the Organization and the Existence and Effectiveness of Compliance Programs and System
- FMV and CR are Not a One-and-Done, Check-the-Box Activity, but Must Contemplate that Facts and Circumstances Change Over Time

## THE GOVERNMENT'S VIEW OF PRACTICE LOSSES

- "And, finally, just use your common sense. The only reason that it makes sense to [pay] these doctors a million and a half dollars a year is to save the eight to $12 million a year in referrals. And even Paul Johnson, the Tuomey's CFO, acknowledged on cross-examination or, excuse me, on direct examination that really, yeah, the hospital was getting back for all that money was referrals."
- "Would the hospital have done this, would the hospital have entered into these contracts if it weren't for the referrals? Well, the evidence showed that the only way that deal made any sense is if there were referrals. The hospital is losing one-and-a-half million dollars a year, was losing one-and-a-half million dollars per year, and it raises the question why."

Tuomey 2 Trial - government counsel closing argument.



## THE ANATOMY OF PHYSICIAN PRACTICE LOSSES

- The Government's View on Practice Losses
  - Losses are a definitive indication that compensation is above FMV
  - Losses are only justifiable and rational by taking into account referrals
- In Reality, Hospital Losses on Physician Practices Are Driven by:
  - Local market conditions
  - Health system strategies and decision-making
  - Business decisions driven by physicians
  - Physician practice entity revenues
  - Practice overhead
  - Provider contracting

## THE ANATOMY OF PHYSICIAN PRACTICE LOSSES

- Local Market Conditions Affecting Physician Practice Profits
  - Local market economy and industry conditions
  - Community physician need and medical staff development plan
  - Payer policies and local market reimbursement implications
  - Payer mix implications of local conditions
  - Hospital charity care policies
  - Local practice consolidation and hospital employment trends



## THE ANATOMY OF PHYSICIAN PRACTICE LOSSES

- Health System Strategies and Decision-Making Affecting Practice Profits
  - Defensive or anti-competitive decisions for unnecessary services allowed to take precedence over legitimate business reasons
    - Buying a business of little strategic or community benefit other than referrals
    - Buying redundant, used, or outdated equipment
    - Entering a stagnant market or service line
  - Deferred decisions on practice divestitures

## THE ANATOMY OF PHYSICIAN PRACTICE LOSSES

- Health System Strategies and Decision-Making Affecting Practice Profits (cont'd)
  - Health system profitability focus over professional practice profits
  - Physician leadership engagement level
  - Practice management resources
    - Executive leadership
    - Practice management personnel
    - Technology resources



## THE ANATOMY OF PHYSICIAN PRACTICE LOSSES

- Physician-Driven Business Decisions Affecting Practice Profits
  - Hospital-physician ventures and arrangements
  - Incentive compensation structure
  - Location, facilities, equipment, and service offerings
  - Supplier relationships
  - Personnel

## THE ANATOMY OF PHYSICIAN PRACTICE LOSSES

- Physician Practice Entity Revenue Implications for Practice Profitability
  - Acquisitions in which ancillaries are stripped out and converted to HOPD
  - Managed care contract provisions and negotiation
  - Declining fee-for-service reimbursement
  - Revenue cycle policies and processes
  - Collection lag for startup practices
  - Low or declining physician professional productivity



## THE ANATOMY OF PHYSICIAN PRACTICE LOSSES

- Practice Overhead Implications for Practice Profitability
  - System-wide accounting and budgeting practices
  - Non-provider personnel compensation and benefit policies
  - Non-physician personnel staffing levels

## THE ANATOMY OF PHYSICIAN PRACTICE LOSSES

- Provider Contracting Implications for Practice Profitability
  - Outdated and inconsistent physician contracts and compensation provisions
  - Physician and non-physician provider compensation in excess of FMV
  - Extravagant fringe benefit offerings

ANKURA CONSULTING



HORNE CPAs & BUSINESS ADVISORS

## THANK YOU.

TIMOTHY SMITH, CPA/ABV

*Ankura Consulting*

*tim.smith@ankuraconsulting.com*

(214) 200-3693

GREGORY D. ANDERSON, CPA/ABV, CVA

*HORNE LLP*

*greg.anderson@hornellp.com*

(601) 620-5101

ANKURA CONSULTING



HORNE CPAs & BUSINESS ADVISORS


HORNE
CPAs & BUSINESS ADVISORS
ANKURA
CONSULTING
100