Can’t See the Forest for the Trees
The Misapplication of Economic Theory to the Increasing Regulatory Trend Against Vertical Healthcare Integration

David Grauer, Esq.
Partner, Jones Day

Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA
Chief Executive Officer, HEALTH CAPITAL CONSULTANTS

Jessica Bailey-Wheaton, Esq.
Vice President & General Counsel, HEALTH CAPITAL CONSULTANTS
Disclosure Information

- **David Grauer, Esq.**
  - Disclosure of Relevant Financial Relationships
    - I have no financial relationships to disclose
  - Disclosure of Off-Label and/or Investigative Uses
    - I have no financial relationships to disclose

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- **Jessica L. Bailey-Wheaton, Esq.**
  - Disclosure of Relevant Financial Relationships
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**Presenter Bio**

**David Grauer**, Esq., concentrates his practice on serving clients in the health care industry on a broad range of complex transactions and matters including mergers and acquisitions, joint ventures, national and regional provider and payor networks, clinically integrated networks and accountable care organizations, managed care and bundled payment negotiations, Medicaid and Medicare reimbursement, fraud and abuse issues, medical staff bylaws and governance, and professional and business licensure matters.

Trained as a pharmacist, and with more than five years of experience in hospital department and operations management, David brings his health care clients a particularly well-informed perspective and deep health care industry experience in representing hospital systems, financial institutions, post-acute care providers (home health care, hospice, and retail and specialty pharmacies), large long-term care providers, and large medical groups in sophisticated business transactions.

David is a member of the American Health Lawyers Association. He has spoken and written extensively on emerging health care industry trends and regulations.
Robert James Cimasi, MHA, ASA, MCBA, FRICS, CVA, CM&AA, serves as Chief Executive Officer of HEALTH CAPITAL CONSULTANTS (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including valuation consulting and capital formation services; healthcare industry transactions, including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and certificate-of-need and other regulatory and policy planning consulting.


In 2006, Mr. Cimasi was honored with the prestigious “Shannon Pratt Award in Business Valuation” conferred by the Institute of Business Appraisers (IBA). He serves on the Editorial Board of the Business Appraisals Practice of the IBA, of which he is a member of the College of Fellows; and, as Chair Emeritus of the American Society of Appraisers Healthcare Special Interest Group (ASA HSIG). In 2011, he was named a Fellow of the Royal Institution of Chartered Surveyors (RICS).
Jessica L. Bailey-Wheaton, Esq., serves as Vice President and General Counsel of HEALTH CAPITAL CONSULTANTS (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993.

Ms. Bailey-Wheaton conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions, and provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services.

Ms. Bailey-Wheaton is a member of the Missouri and Illinois Bars and holds a J.D., with a concentration in Health Law, from Saint Louis University School of Law, where she served as Fall Managing Editor for the Journal of Health Law & Policy.
Overview of Presentation

• Description of the *Practice Loss Postulate* (PLP)
• Description of Vertical Integration
• Arguments Against the PLP
  • Economic Arguments against the PLP
  • Failure of the PLP’s Commercial Reasonableness Argument
• Conclusion: PLP is Misguided and Imprudent
“Plentie is nodeintie, ye see not your owne ease. I see, ye can not see the wood for trees.”

- John Heywood, 1546
Description of the Practice Loss Postulate
The Practice Loss Postulate

- Regulators have increasingly challenged healthcare vertical integration transactions pursuant to the Anti-Kickback Statute (AKS), Stark Law, and False Claims Act (FCA)

- An increasing volume of cases are based, in part, on the Practice Loss Postulate (PLP)

  - The acquisition of a physician practice, which then operates at a “book financial loss”, is dispositive evidence of the hospital’s payment of consideration based on the volume and/or value of referrals

The Practice Loss Postulate

- Thresholds for satisfying Fraud and Abuse laws
- Vary by:
  - Type of integration in question
    - Horizontal Consolidation
    - Vertical Integration
  - Regulatory scheme
    - Stark Law
    - Anti-Kickback Statute (AKS)
The Practice Loss Postulate

- Compensation details under the **Stark Law** – Vary based on whether compensation arrangement is **Direct** or **Indirect**
  - **Direct Compensation Arrangement** – “if remuneration passes between the referring physician (or a member of his or her immediate family) and the entity furnishing DHS without any intervening persons or entities” – 42 C.F.R. § 411.354(c)(1)(i)
  - **Indirect Compensation Arrangement** - Consists of Three Parts - 42 C.F.R. § 411.354(c)(2)
    - “Between the referring physician (or a member of his or her immediate family) and the entity furnishing DHS there exists an unbroken chain of any number (but not fewer than one) of persons or entities that have financial relationships...between them”
    - “The referring physician (or immediate family member) receives aggregate compensation from the person or entity in the chain with which the physician (or immediate family member) has a direct financial relationship that varies with, or takes into account, the volume or value of referrals or other business generated by the referring physician for the entity furnishing the DHS, regardless of whether the individual unit of compensation satisfies the special rules on unit-based compensation”
    - “The entity furnishing DHS has actual knowledge of, or acts in reckless disregard or deliberate ignorance of, the fact that the referring physician (or immediate family member) receives aggregate compensation that varies with, or takes into account, the volume or value of referrals or other business generated by the referring physician for the entity furnishing the DHS”
- **Employment and Indirect Compensation Exceptions BOTH Require:**
  - Fair Market Value (FMV)
  - Commercially Reasonable

The Practice Loss Postulate

- Compensation details under the **Anti-Kickback Statute**
  - **Employment Safe Harbor** – “‘remuneration’ does not include any amount paid by an employer to an employee, who has a bona fide employment relationship with the employer, for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.” – 42 CFR § 1001.952 (2015)
  - No consideration of *direct* or *indirect* compensation arrangement
  - Safe Harbor does **not** require arrangement to be:
    - *Fair Market Value* (FMV)
    - *Commercially Reasonable*
The Practice Loss Postulate

- Employment Arrangement – Case Study

(A) Physician Payments Under Fraud and Abuse Laws

(B) Stark Law

(C) Neither Direct nor Indirect Compensation (for example, flat annual salary from Captive PC)

(D) No Requirement of:
  - Fair Market Value
  - Commercial Reasonableness

(E) Direct Compensation (Employment)

(F) Indirect Compensation

(G) Requirement of:
  - Fair Market Value
  - Commercial Reasonableness

(H) Anti-Kickback Statute

(I) Direct Compensation (Employment)

(J) Indirect Compensation

DISTINCTION NOT APPLICABLE – EMPLOYMENT SAFE HARBOR

(K) Any Compensation Under the Employment Safe Harbor

(L) No Requirement of:
  - Fair Market Value
  - Commercial Reasonableness
The Practice Loss Postulate

• Employment Arrangements are merely one potential integration strategy available, as there are other integration strategies (e.g., professional services arrangements, clinical co-management arrangements, or joint ventures) which may also implicate separate regulatory exceptions and safe harbors.

• In particular, the Stark Law has evolved into a web of rules that may complicate providers’ efforts toward regulatory compliance

“It seems as if, even for well-intentioned health care providers, the Stark Law has become a booby trap rigged with strict liability and potentially ruinous exposure—especially when coupled with the False Claims Act.”


The Practice Loss Postulate

- Case Law Implicating Practice Loss Postulate

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<td>Full-Time Employee; Independent Contractor</td>
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The Practice Loss Postulate

  - Relator alleged that Tuomey paid 19 part-time physicians an amount beyond FMV by taking into account the volume or value of referrals
    - 10-year contract for part-time employment
    - Productivity bonus
    - Incentive bonus
  - Physician productivity fell between the 50th and 75th percentile, but compensation was over the 90th percentile

The Practice Loss Postulate

  - In considering the allegations, the U.S. District Court for the District of South Carolina received expert testimony from the relator and the DOJ’s expert witness Kathleen McNamara, who utilized the PLP as follows:

  "Case documents I examined and the testimony I reviewed shows that Tuomey took into account the value and volume of anticipated physician referrals by...Acknowledging that the hospital’s technical and facility fees earned each time the physicians performed an outpatient surgery are reasonable "off-sets" for its $1.5 [million] annual operating losses. Notably because Tuomey’s technical and facilities earned [sic] are deemed to be the physicians’ patient referrals.” [Emphasis Added]"
The Practice Loss Postulate

- *U.S. ex rel. Parikh v. Citizens Medical Center (2013)*
  - Citizens Medical Center allegedly paid bonuses and financial incentives to physicians who referred patients for treatment
  - Physicians’ income more than doubled when they became employed by Citizens Medical Center
The Practice Loss Postulate

- **U.S. ex rel. Parikh v. Citizens Medical Center (2013)**
  - In a 2013 order denying CMC’s motion to dismiss the relator’s claims that CMC violated the AKS and Stark Law, Judge Gregg Costa of the U.S. District Court for the Southern District of Texas stated:

  “[I]t would make little apparent economic sense for Citizens to employ the cardiologists at a loss unless it was doing so for some ulterior motive—a motive Relators identify as a desire to induce referrals.”

The Practice Loss Postulate

• **U.S. ex rel. Reilly v. North Broward Hospital District (2015)**
  
  • Relator alleged that Broward Health purposely tracked referrals from physicians to the hospital for *ancillary services and technical component* (ASTC) in “Contributive Margin Reports,” which were then used to cover the “massive direct losses” from excessively compensating physicians in violation of the AKS and Stark Law.

  • The complaint alleged that these reports track “the revenue from every admission, every ancillary, anything that’s done to patients of employed physicians”

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The Practice Loss Postulate

  - The complaint against Broward Health relies heavily on the PLP and Broward Health’s alleged utilization of the “Contributive Margin Reports” in developing the claims of Stark Law and AKS violations, noting:

  “Broward Health's strategic scheme of paying employed physicians more than fair market value and more than they can ever hope to collect for their personal services is not a commercially sustainable business model. This practice is only sustainable by anticipating and allocating hospital referral profits to cover the massive direct losses from excessive physician compensation.” [Emphasis Added]

The Practice Loss Postulate

  - Relators alleged that Adventist repeatedly authorized *non-commercially reasonable* compensation arrangements that exceeded FMV with employed physicians such that the hospitals would have been forced to operate at a “book financial loss”
  - Relators alleged multiple Adventist hospitals overcame these book financial losses through the referrals generated by the employed physicians and by tracking these referrals
  - Alleged that Adventist considered these referrals when entering into the arrangements

The Practice Loss Postulate


  • The allegations against Adventist assume that hospitals and physician practices operate as stand-alone economic enterprises that, individually, must be able to survive independent of the other affiliated service lines in the vertically integrated health system:

  “[Adventist] Hospitals are thus compensating the doctors whose practices they have purchased at levels that not only exceed what [Adventist] can rationally pay while maintaining a physician practice that could be economically viable on its own merits.” [Emphasis Added]

The Practice Loss Postulate

- Together, these four cases reflect increasing utilization of the PLP in the regulatory scrutiny of vertically integrated health systems

- Under federal *fraud and abuse* laws, healthcare transactions must be demonstrated to both: (a) not exceed FMV; and, (b) be *commercially reasonable*, in order to be deemed legally permissible
  
  - A failure to meet these two thresholds may result in Stark Law or AKS violations, in particular, with regard to FMV under these statutory edicts
  
  - The judicial leap, e.g., assuming that “*payments exceeding FMV are in effect deemed ‘payment for referrals’*,” irregardless of the totality of the facts and circumstances regarding the total economic benefits of the vertical integration transaction under which these payments were made, illustrates a regulatory propensity to “deem” isolated payment transactions exclusive of their synergistic role with the whole of the enterprise.

Summary of the Practice Loss Postulate

- The PLP treats vertically integrated physician practices as stand-alone economic enterprises, which, when stripped of their ASTC revenue, and relying solely on professional services, i.e., work relative value unit \([wRVU]\) related revenue, and paying physicians at FMV, are almost certain to generate “book financial losses”

- The PLP then asserts that the hospital’s subsequent losses derived from the operation of the professional practice of the employed physicians is not a subsidy supporting vertical integration
  - Instead, the hospital’s sufferance of “book financial losses” are viewed as compensation, remuneration, or consideration being paid to the hospital’s employed physicians for the referrals of ASTC services to the hospital
  - Such referrals require a physician’s authority (i.e., the “power of prescription”) to order admission, diagnostic tests, drugs, durable medical equipment, and other services for their patients.
Summary of the Practice Loss Postulate

- In maintaining the economic delineation between physicians and hospitals, the PLP focuses *exclusively* on *immediate* and *direct* financial (cash) returns on, and returns of, investments by healthcare organizations related to *vertical integration* transactions.
- The PLP ignores other economic benefits associated with vertical integration in healthcare:
  - Social benefit and qualitative gains
  - Avoidance of cost and efficiency gains
Summary of the Practice Loss Postulate

(A)  
Physician wRVU Cash Compensation  
Retirement Bonus  
Medical, Retirement, etc. Benefits  
Nose Coverage

(B)  
Physician wRVU Related Economic Operating Expense  
Physician wRVU Related Economic Capital Expense

(C)  
Total Physician wRVU Related Expense

(D)  
“Receipts” to Hospital  
Total Physician wRVU Reimbursement from all Payors

(E)  
Unallocated Financial Deficit  
Attributed under PLP as “Practice Losses”
## Summary of the Practice Loss Postulate

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<tr>
<th>Non-Monetary Benefits</th>
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<tr>
<td><strong>Avoidance of Cost</strong></td>
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<td><strong>Create Operational Efficiencies</strong></td>
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<td><strong>Economies of Scope</strong></td>
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<td><strong>Economies of Scale</strong></td>
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<td><strong>Diversify Supply Chain</strong></td>
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<td><strong>Organization as a Factor of Production</strong></td>
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<td><strong>Social Benefits</strong></td>
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<td><strong>Provide Continuum of Care</strong></td>
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<td><strong>Achieve Care Coordination</strong></td>
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<td><strong>Satisfy the <em>Triple Aim</em></strong></td>
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<td><strong>Improve Population Health</strong></td>
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<td><strong>Complimentary and Requisite Care Mapping of Services</strong></td>
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(E) **Unallocated Financial Deficit**

Attributed under PLP as “Practice Losses”
Consequently, under the PLP, a “book financial loss” on a physician practice borne by a vertically integrated health system, when viewing that practice as a stand-alone economic enterprise, is viewed as evidence of legally impermissible referrals under the Stark Law.

This regulatory conjecture hinders the ability of a vertically integrated health system to withstand fraud and abuse scrutiny, and erects a barrier to satisfying the threshold of commercial reasonableness.
Description of Vertical Integration
Description of Vertical Integration

• Across all industries, vertical integration may be defined as “[t]he combination in one firm of two or more stages of production normally operated by separate firms”

• In healthcare, *vertical integration* describes the “integration of providers at different points along the continuum of care, such as a hospital partnering with a skilled nursing facility (SNF) or a physician group”

Potential Benefits of Vertical Integration

• In most industries, vertical integration may provide certain benefits to an organization, including:
  • Economies of Scale
  • Economies of Scope
  • “Organization” as a factor of production, which, if considered properly, can lead to production efficiencies

Potential Benefits of Vertical Integration

• In healthcare, the potential benefits of vertical integration may include, but are not limited to:
  • Satisfaction of the *charitable mission* of the enterprise
  • Achievement of higher levels of *care coordination*

Potential Benefits of Vertical Integration

- In healthcare, the potential benefits of vertical integration may include, but are not limited to (continued):
  - Utilization of complimentary and requisite care mapping of services, which can:
    - Provide organizations with the size necessary to justify certain services and employ certain physicians in the instance where, separately, they would not have the patient volume or financial resources to employ a specialist or service; and,
    - Allow for the management of an enterprise to exert a span of control across the *continuum of patient care* and implement those strategies which are more likely to result in the most beneficial patient outcomes

Potential Benefits of Vertical Integration

• In healthcare, the potential benefits of vertical integration may include, but are not limited to (continued):
  • Creation of operational efficiencies
    • Reduction of duplicative treatments
    • Capitalizing on firm synergies to create more efficient provider/patient contact
    • Reduction in transportation costs for patients and their medical service providers
  • The integration of the healthcare information technology (HIT) across multiple sites of service
Potential Benefits of Vertical Integration

- In healthcare, the potential benefits of vertical integration may include, but are not limited to (continued):
  - Achievement of Pay for Performance (P4P) goals
  - Satisfaction of the “Triple Aim”
    - Improving patient experience of healthcare
    - Improving population health
    - Reducing health expenditures per capita

Potential Benefits of Vertical Integration

• In healthcare, the potential benefits of vertical integration may include, but are not limited to (continued):
  • Mitigating providers’ risk by:
    • Allowing health systems to diversify their supply chain
    • Allowing health systems to spread the risk of participation in global payment mechanisms over a larger population
  • Satisfaction of continuum of care requirements under state licensing regulations and Certificate of Need (CON) laws

Potential Benefits of Vertical Integration

- Many of the economic benefits of vertical integration in healthcare are **non-monetary (non-cash)** benefits that can provide **utility** to the enterprise, in contrast to **monetary (cash)** benefits.

- Although these benefits may not provide immediate **monetary (cash)** returns on and of the investment, they may still provide **utility**, i.e., “the ability of a product to satisfy a human want, need, or desire.”

- This distinction is essential to understand, as it highlights a primary difference between **financial economics**, which focuses on a broader sense of **utility**; and, **accounting conventions**, which only focus on **financial (cash)** considerations.

### Potential Drawbacks of Vertical Integration

- In most industries, vertical integration may have certain drawbacks
  - **Antitrust** implications due to the potential for price discrimination
  - Increasing the capital requirements associated with market entry
  - Potential fraud and abuse violations, if the consideration provided is based on the volume or value of referrals
Potential Drawbacks of Vertical Integration in Healthcare

Vertical integration in healthcare does not always result in improved costs, care coordination, and quality:

“The key feature of integrated delivery systems is that, to be successful, the primary focus must be the clinical effectiveness and profitability of the system as a whole, as opposed to each individual element. This emphasis requires a much higher level of administrative and clinical integration than is seen in most organizations; more important, it requires that managers of the system’s individual elements place their own interests second to that of the overall system.” [Emphasis Added]

Potential Drawbacks of Vertical Integration in Healthcare

• Antitrust Scrutiny – *St. Luke’s (2015)*
  • 9th Circuit Court of Appeals Opinion, resulted in divestiture of the acquisition of Saltzer medical practice, located in Nampa, ID, by St. Luke’s Hospital, approximately 20 miles east in Boise, ID
  
• 9th Circuit Analysis Relevant to Vertically Integrated Healthcare Systems
  • Relevant Market
  • Market Share
  • Potential Benefits of Vertical Integration in Healthcare

“Saint Alphonsus Medical Center-Nampa, Inc. v. St. Luke’s Health System, Ltd.” 778 F.3d 775 (9th Cir. 2015).
Potential Drawbacks of Vertical Integration in Healthcare

  - Relevant Market
    - Product: Adult Primary Care Services Sold to Commercially Insured Patients
    - Geographic Market: Nampa, ID
      - Court considered either Boise, ID, or Nampa, ID
      - Dependent on Ability of Health Insurers to Develop Adequate Network of Primary Care Physicians
      - Court noted 68% of Nampa residents obtain primary care services from local physicians, with only 15% of residents obtaining the same from nearby Boise

Potential Drawbacks of Vertical Integration in Healthcare

  - Market Share
    - Combined market share of St. Luke’s and Saltzer primary care physicians accounted for almost 80% of adult primary care services in Nampa
    - St. Luke’s and Saltzer documents indicated that both parties viewed the consolidation important because of increase in leverage to obtain higher payment rates

Potential Drawbacks of Vertical Integration in Healthcare

  - Discussion of Potential Benefits of Vertical Integration
    - Court noted that St. Luke’s provided little to no evidence to support St. Luke’s theory that it needed Saltzer primary care physicians to successfully transition to integrated care
  - Court also noted that St. Luke’s did not prove that practice acquisition is required to implement electronic medical records
  - Court noted that, although vertical integration is a worthy goal, providers still need to obey antitrust regulations

Transactional Initiative Types

• A FMV analysis assumes a hypothetical transaction involving a universe of typical buyers, sellers, owners, and investors.

• Similarly, the application of the PLP to a particular integration transaction may call into question the validity of the commercial reasonableness analysis of the transaction.

• These analyses would necessarily include consideration of whether the hypothetical (or in the case of a commercial reasonableness analysis, prospective) buyers, sellers, owners, and investors are pursuing the transaction based on the objective of horizontal consolidation or vertical integration.
Transactional Initiative Types

• “Vertical integration [in healthcare] refers to integration of providers at different points along the continuum of care, such as a hospital partnering with a skilled nursing facility (SNF) or a physician group” [Emphasis added]

• Horizontal consolidation may be defined as “combining two or more enterprises at the same stage of production”

Transactional Initiative Types

• In healthcare, a contrast is drawn between horizontal consolidation, “which integrates organizations providing similar levels of care under one management umbrella, [and] vertical integration[, which] involves grouping organizations that provide different levels of care under one management umbrella”
Government Initiatives Regarding Vertical Integration in Healthcare

- Due, in part, to the potential benefits of vertical integration, certain governmental agencies, such as the Centers for Medicare and Medicaid Services (CMS) and Office of Inspector General (OIG), have undertaken initiatives promoting or requiring vertical integration in healthcare.
Government Initiatives Regarding Vertical Integration in Healthcare

- Comprehensive Care for Joint Replacement
  - Mandatory CMS bundled payment model that holds hospitals accountable for all of the care associated with hip and knee replacement surgeries
  - Includes tools for hospitals to integrate with other providers along the continuum of care
    - SNFs
    - Physician and Non-Practitioners
    - Long-Term Care Hospitals
Government Initiatives Regarding Vertical Integration in Healthcare

- **Accountable Care Organizations (ACO)**
  - ACOs integrate multiple providers along the continuum of care, and hold integrated providers accountable for defined populations, as an incentive to improve population health
  - Instituted as part of the *Patient Protection and Affordable Care Act (ACA)*
Government Initiatives Regarding Vertical Integration in Healthcare

- OIG Guidance on Physician Executive Arrangements
  - Physician Executive Arrangements often hold physician executives accountable for quality
  - Types of physician executives
    - Medical Directors
    - Service Line Co-Managers
      - Can help to achieve goals of *vertical integration* (e.g., improvements in quality and efficiency)
      - Note: Documentation of gains is important
Government Initiatives Regarding Vertical Integration in Healthcare

• The OIG has favorably opined on physician executive arrangements, so long as the compensation:
  • Is provided for services actually rendered
  • Does not exceed FMV
  • Does not vary with the volume of services rendered by the physician executive
Continuum of Care Requirements Under State Licensing and CON Laws

- Many state CON programs require hospital enterprises to provide a full range of services along the *continuum of care*, as a condition of facility licensure.

- Influences hospitals to increase the scope of services offered to the community at different points along the *continuum of care*.
Implementation of Vertical Integration

- As a result of government initiatives promoting, and sometimes requiring, *vertical integration* in healthcare, providers have engaged, or are currently engaging, in *vertical integration* transactions in the marketplace.

“The driving force behind these systems is the motivation to offer a full line of coordinated services, and hence to increase the overall effectiveness and lower the overall cost of the services provided.”

Implementation of Vertical Integration

Vertical Integration as indicated by Physician Employment

- A 2005 survey by Medical Group Management Association (MGMA), entitled “Physician Compensation and Production Survey: 2005 Report Based on 2004 Data,” reported that over half of physicians were working in entities owned by physicians.
- The 2015 version of the same survey (based on 2014 data) reported that less than one third of physicians were working in entities owned by physicians.
- Over the same time period (i.e., 2004-2014), share of physicians working in hospitals and health systems more than doubled.

Arguments Against the Practice Loss Postulate
Economic Arguments Against the PLP

• The PLP contraindicates established and accepted economic thought on several points, most notably in that:
  • The PLP does not satisfy the basic requirements for economic assumptions
  • The PLP reflects a misapplication of fundamental economic principles
  • The PLP runs contrary to established and accepted economic theories
The PLP Does Not Satisfy the Basic Requirements for Economic Assumptions

- The PLP does not meet the fundamental requirements of an economic assumption, as stated by Joan Robinson in 1932
  - The assumption must be “tractable” (i.e., it is “manageable” by economic analytical techniques)
  - The assumption must “correspond to the real world”

“Economics is a Serious Subject: The Apologia of an Economist to the Mathematician, the Scientist and the Plain Man” By Joan Robinson, W. Heffer & Sons Ltd.: Cambridge, England, 1932, p. 6.
The PLP Does Not Satisfy the Basic Requirements for Economic Assumptions

- First requirement of economic assumptions – is the PLP “tractable” (i.e., it is “manageable” by economic analytical techniques)

- PLP may have arisen so aggressively, and typically uncontested, on the false premise that it is tractable, without due consideration as to whether it is realistic, i.e., whether the economic assumption “correspond[s] to the real world.”

- PLP has dramatically oversimplified the nature of vertically integrated physician practices

“Economics is a Serious Subject: The Apologia of an Economist to the Mathematician, the Scientist and the Plain Man” By Joan Robinson, W. Heffer & Sons Ltd.: Cambridge, England, 1932, p. 6.
The PLP Does Not Satisfy the Basic Requirements for Economic Assumptions

- Second requirement of *economic assumptions* – does the PLP “correspond to the real world”
  - The PLP treats *vertically integrated* practices as independent enterprises
  - However, benchmarking data indicates that *vertically integrated* physician practices do not operate in the same way as *independent* physician practices
    - *Vertically integrated* hospital owned practices do not retain ASTC revenue
    - *Vertically integrated* hospital owned practices lack immediate control over their economic expenses
The PLP Does Not Satisfy the Basic Requirements for Economic Assumptions

• Second requirement of economic assumptions – does the PLP “correspond to the real world” (continued):
  • Typical operational differences between vertically integrated practices and independent practices:
    • Vertically integrated physician practices provide significantly more charity care than independent practices
    • Vertically integrated physician practices provide more services to Medicaid beneficiaries, and relatively fewer services to patients covered by commercial insurance, than independent practices
    • Vertically integrated physician practices operate with relatively fewer non-physician practitioners per physician than independent practices

The PLP Does Not Satisfy the Basic Requirements for Economic Assumptions

- Second requirement of *economic assumptions* – does the PLP “correspond to the real world” (continued):
  - Together, these characteristics of *vertically integrated* physician practices may lead to reduced revenues for these hospital-acquired practices relative to the revenues generated by *independent* physician practices
  - Note that different *vertically integrated* systems may distribute revenues or operational control differently, depending on the dominant party in the system
The PLP Misapplies and/or Ignores Fundamental Economic Principles

- **Scarcity**
  - *Scarcity* and *utility* underlie the entire valuation endeavor
  - “No object, including real property, can have value unless *scarcity* is coupled with *utility*” [Emphasis Added]

- Principle of Scarcity
  - The first principle of economics
  - The inability to satisfy all of our wants

- Economic actors must choose what they *consume* and what they will *forego*

- As a property interest becomes more scarce, the value of the subject property interest increases

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- **Scarcity**

“What each one of us can get is limited by time, by the incomes we earn, and by the prices we must pay. Everyone ends up with some unsatisfied wants. What we can get as a society is limited by our productive resources. These resources include the gifts of nature, human labor and ingenuity, and tools and equipment that we have produced. . . . Our inability to satisfy all our wants is called **scarcity**.”

[Emphasis Added]

-Michael Parkin

The PLP Misapplies and/or Ignores Fundamental Economic Principles

- **Scarcity**

  - Due to the fact that physicians are becoming increasingly scarce, providers seeking to integrate with physicians must incur increasing expenses in order to retain a physician’s services, which may result in a “book financial loss”

- The PLP fails to recognize this reality, and therefore ignores the *Principle of Scarcity*
The PLP Misapplies and/or Ignores Fundamental Economic Principles

• Utility

  • The economic foundation for analyzing an individual's anticipated utility pay-off from consumption patterns of different bundles of goods

  • Defines the criteria by which individuals choose preferences

  • Model for utility maximization allows economists to identify a consumer’s preferred consumption bundle
The PLP Misapplies and/or Ignores Fundamental Economic Principles

- **Utility**
  - Utility is defined as “the ability of a product to satisfy a human want, need, or desire”
  - Rational economic actors will attempt to maximize their expected *utility*
  - Types of *utility* accruing to healthcare organizations
    - *Social Benefit*
    - *Avoidance of Cost*
    - *Monetary (cash)* Benefits

The PLP Misapplies and/or Ignores Fundamental Economic Principles

• Utility
  • For example, if an individual is relieved of an expense, than this would increase his or her stock of utility
  • An individual’s stock of utility is offset by their sources of disutility
  • Pain and pleasure are experienced uniquely by each individual
The PLP Misapplies and/or Ignores Fundamental Economic Principles

• **Utility**
  
  • The PLP asserts that vertically integrated systems offset the financial losses associated with integration support payments related to physician labor through the revenues associated with legally impermissible referral.
  
  • However, this assigns no utility to the potential benefits of vertical integration, and indicates that the PLP conflates “utility” with direct and immediate financial (cash) return.
  
  • The PLP misapplies the Principle of Utility by construing utility as equivalent to monetary, or financial (cash) gain, in contrast to “the ability of a product to satisfy a human want, need, or desire.”
The PLP Misapplies and/or Ignores Fundamental Economic Principles

- **Substitution**
  - Defined as: “The price of a desired substitute, or one of equal utility, sets the ceiling of value for a particular good or service”
  - An individual or organization seeking to maximize *utility* will seek to select from the universe of possible bundles of goods and services that allocation which generates the greatest possible *utility* for that individual or organization

The PLP Misapplies and/or Ignores Fundamental Economic Principles

- **Substitution**
  - The PLP alleges that *integration support payments* are evidence that hospitals would be irrational to prefer *vertical integration* to continued operation in the service area, *independent* of physician practices, unless the hospitals received revenues from legally impermissible referrals.
  - However, the *Principle of Substitution* implies that an alternative route to gaining the benefits that *vertical integration* may provide (e.g., meeting *continuum of care* requirements, satisfaction of the *Triple Aim*) would be selected by market participants and policymakers, if the alternative required a lower cost than the cost of *vertical integration*. 
The PLP Misapplies and/or Ignores Fundamental Economic Principles

• **Substitution**
  - Based on current implementation of *vertical integration* in the healthcare industry, healthcare organizations, acting as rational economic actors, are selecting *vertical integration* as the most efficient method to achieve these benefits
  - The PLP ignores the choices of rational actors in selecting *vertical integration* as the optimal alternative under the *Principle of Substitution*
The PLP Runs Contrary to Established Economic Theories

- Economists propose economic theories based on the accepted economic principles that were established by previous investigators into the discipline of economics, allowing “…the individual student [to] speak with the authority of his science.”

- Economists have long studied the topic of organization and integration in the marketplace, and developed complex economic theories, which theories have been analyzed and accepted as models that accurately describe economists’ observations of the real world.

The PLP Runs Contrary to More Complex Economic Theories

- Edgeworth’s 1881 *Contract Curve*
  - The use of contracts or cooperation (in favor of individual action) maximizes the aggregate utility of all parties involved

- Bonbright’s 1937 *Avoidance of Cost*
  - The *avoidance of cost* is equivalent to *utility*

The PLP Runs Contrary to More Complex Economic Theories

- Coase’s 1937 *Nature of the Firm*
  - Individuals organize into firms because one entity coordinating scarce resources is **more efficient** than forcing all resources to be bought and sold by independent actors in an open market
  - Operation of an open market incurs **transaction costs**, which integrated firms avoid
  - If firms are *not* more efficient than the market (i.e., if the cost of the firms’ operations is greater than transaction costs), then the economic actors involved may revert to using the open market

The PLP Runs Contrary to More Complex Economic Theories

• Enthoven and Tollen, 2005

“There is more to safe, appropriate, affordable health care than what is evident to a patient in an encounter with an individual provider. We need systems to ensure that health care providers are...deployed in the appropriate...numbers and specialties to meet a population’s needs efficiently; current on evidence-based practice and supported by tools (such as monitoring and reminders) to overcome widespread practice variations and quality failures; ...supported by teams of colleagues sharing goals, work processes, and information and able to coordinate care across multiple settings; supported by a system that records test results, diagnoses, and treatments and transmits orders accurately; practicing in facilities with equipment selected based on evidence of safety and efficacy; and supported financially and logistically to participate in common efforts such as guideline development...which [is] important for evidence-based practice.”

The PLP Runs Contrary to More Complex Economic Theories

• Porter, 2008

“It is true that economic and social objectives have long been seen as distinct and often competing. But this is a false dichotomy; it represents an increasingly obsolete perspective in a world of open, knowledge-based competition. Companies do not function in isolation from the society around them. In fact, their ability to compete depends heavily on the circumstances of the locations where they operate... The more a social improvement relates to a company’s business, the more it leads to economic benefits as well.”

The PLP Runs Contrary to More Complex Economic Theories

• Together, the aforementioned economic theories demonstrate that, by organizing into coordinated firms, individual actors can maximize aggregate utility and reduce costs.

• Equivalent to the creation of utility.

• As reflected under the Principle of Substitution, rational economic actors are choosing to engage in vertical integration transactions in order to maximize aggregate utility related, in part, to non-monetary (non-cash) benefits.
The PLP Runs Contrary to More Complex Economic Theories

• The PLP assumes that specific and immediate “book financial losses” on *vertically integrated* physician practices constitute dispositive evidence of the payment of compensation, remuneration, and consideration based on the volume and/or value of legally impermissible physician referrals.

• With this assumption, the PLP ignores the benefits of organizing into vertically integrated firms to maximize aggregate utility and reduce costs, and thereby ignores the conclusions of an established and accepted canon of economic literature.
Failure of the PLP’s Commercial Reasonableness Argument

- Losses on vertically integrated physician practices do not contraindicate the threshold of commercial reasonableness.

- Hospitals routinely invest in initiatives, service lines, and uses of capital that do not immediately (or may never) yield direct monetary (cash) returns on or of their investment.
Failure of the PLP’s Commercial Reasonableness Argument

- Examples of hospital investments in initiatives, service lines, and uses of capital that do not immediately (or may never) yield direct financial returns on or of their investment include:
  - Emergency rooms, trauma services, pathology labs, and *neonatal intensive-care units* (NICU)
  - Research labs and clinical studies
Failure of the PLP’s Commercial Reasonableness Argument

- Examples of hospital investments in initiatives, service lines, and uses of capital that do not *immediately* (or may never) yield *direct* financial returns on or of their investment include (continued):

  - Principal research investigators, medical directors, and other types of physician executives
  - Education of residents
  - Artwork and other aesthetics that aim to generate therapeutic benefits for the hospitals’ patients.
Failure of the PLP’s Commercial Reasonableness Argument

- These investments may allow hospitals to reap other forms of *utility* aside from *financial (cash)* gains
  - Avoidance of cost
  - Generation of *social benefits*
- Despite the lack of *immediate* or *direct financial (cash)* return on, or return of, certain investments by healthcare entities, these services may nevertheless satisfy the threshold of *commercial reasonableness*
Failure of the PLP’s Commercial Reasonableness Argument

- For example, the investment may be “necessary” for the continued operation of the healthcare entity, or may satisfy a “business purpose” of the healthcare enterprise apart from obtaining referrals, such as:
  - Meeting its charitable mission
  - Providing for population health
  - Satisfying regulatory requirements (e.g., licensing, CON)
Conclusion
PLP is Misguided and Imprudent

- The PLP is flawed from an economic perspective for numerous reasons, specifically in that:
  - The PLP does not meet the basic requirements for an economic assumption
  - The PLP is unsupported by fundamental economic principles
  - The PLP runs contrary to established and accepted economic theory
- Additionally, the PLP represents a less than rational interpretation and application of the commercial reasonableness threshold
PLP is Misguided and Imprudent

• Should the PLP continue to evolve into accepted “legal doctrine,” and ultimately the “law of the land,” the result may be to impede the development of innovative new structures of emerging healthcare organizations to the extent that it would cause significant harm to the healthcare economy, such as the losses of both:
  • Operating cost-related efficiencies
  • Qualitative benefits that vertical integration can provide
    • Satisfaction of charitable mission
    • Improvements in care coordination
    • Promotion of population health
    • Achievement of the *Triple Aim*
PLP is Misguided and Imprudent

• Arguments relying on the PLP are based on *accounting conventions*, which focus only on *monetary (cash)* considerations

• In fact, Stark and AKS laws are based on questions of FMV and *commercial reasonableness*
  • These concepts involve *utility*, not simply *monetary (cash)* considerations
  • FMV and *commercial reasonableness* are specializations within the broader discipline of *financial economics*
PLP is Misguided and Imprudent

“[I]t does not at all follow that economists should refrain from giving governments the benefit of their advice. If there is no doctor in the neighbourhood, it is better to ask a physiologist what is wrong with the patient than to ask an engineer...

Governments [have been led] to prefer the advice of bankers, industrialists, and other practical men. But it is certainly better for the patient to ask the physiologist what is wrong with him than to ask the advice of the first man he meets. For the first man that he meets may be an undertaker who has his own view of the course that the disease ought to follow.”

- Joan Robinson, “Economics is a Serious Subject: The Apologia of an Economist to the Mathematician, the Scientist and the Plain Man” p. 13-14
Questions?