

Remedies and prescriptions for health care providers and life science companies in financial distress



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Today's rapidly changing health care environment is infected with symptoms of higher anxieties, rising costs, more litigation, greater regulatory scrutiny, tighter budgets, declining numbers of the insured, and a general sense of dis-ease about the future.

When health care providers and life science companies find themselves in financial distress due to market forces or regulatory actions, a number of remedies can be prescribed to help cure what ails them. Without the sound diagnosis and informed treatment of industry specialists, however, many providers and companies may face dire — or even terminal — consequences later on.

The best advice always begins with preventative medicine. But when the financial wellbeing of an organization or a company is in jeopardy, acting early and swiftly can help to restore vigor to the institution. A number of current conditions in the marketplace may require the attention and experience of specialists, in order to get the best treatment leading to financial health.

Medicare outlier litigations

Hospitals and other health care providers face increasing scrutiny from federal and state regulators and prosecutors due to the growing number of alleged suspicious or questionable payments made by the Medicare and Medicaid programs to providers. One such area of concern on the Medicare front is "outlier reimbursement" for hospital inpatient services.

The Medicare program reimburses hospital inpatient services under its prospective payment methodology. Reimbursement is calculated by using diagnostic related group (DRG) codes which are determined by patient-specific diagnostic and procedure codes. The Medicare program does provide for additional amounts to be paid over and above the DRG reimbursement when the cost of treating a patient exceeds predetermined cost thresholds by a "large" amount.

"The real costs of treatment, however, can be very difficult to measure," noted Rob Cepielik, a partner with Deloitte Financial Advisory Services LLP (Deloitte FAS). According to Cepielik, Medicare regulations prescribe a formulaic approach to determining costs, based upon gross charges associated with the medical service provided, and applying historical cost-to-charge ratios to convert charges to cost data.

"This is where some facilities get into trouble," Cepielik said. "Regulators and prosecutors have accused providers of rapidly increasing charges from year to year, allegedly creating more Medicare outlier payments than they are entitled to."

The best advice always begins with preventative medicine

Deloitte's experience in medicare outlier investigations

- Experience with large Medicare outlier disputes
- Experience in assisting negotiating with the DOJ
- Forensic discovery capabilities
- Extensive Medicare pricing experience
- Medicare outlier calculations
- Hospital finances modeling
- Hospital restructuring experience
- Experience with hospital operations and strategic structuring

A threshold of suspicion

Cepielik noted that the Department of Justice (DOJ) has conducted multiple investigations into charge-setting practices of providers when it believes there was reason for suspicion. The DOJ has taken an interest in circumstances known as "Turbo Charging," when charges are substantially increased in excess of an increase in costs associated with inpatient care. Additionally, many of these investigations follow the filing of a whistleblower complaint.

"The potential damages being sought in repayment to Medicare can be large — into the hundred millions of dollars — a 'break-the-bank' issue for many facilities," Cepielik said. "These facilities face a potentially long road with many phases, in order to deal with the challenges that accompany an outlier investigation."

Cepielik outlined four general phases, the first of which involves a period of rapid response for the provider. "It's very important for these facilities to quickly select appropriate legal counsel and financial consultants, so that they can start the process on the right track," said Cepielik.

The first phase includes responding to document requests, electronic discovery, and even some reflection on potential defense or negotiation strategies. Additional phases of the

investigation can include an analysis of potential damages, an assessment of the financial impacts of a settlement on the provider, and an analysis of operational improvements which may be required in order to survive, according to Cepielik.

When addressing Medicare outlier litigation issues, providers who react quickly by assembling a team of qualified legal, forensic and financial specialists to investigate both the allegations in the presenting matter, and the long-term implications of the issue are generally in a better position to address the ongoing, short-term and long-term needs of their organizations, Cepielik said.

Distressed hospitals: Operating in cash flow triage

The financial health of the nation's hospitals is in a state of crisis.

"More than half of the hospitals in the United States are now technically insolvent or at risk of insolvency," said John Sordillo, a partner in the Reorganization Services group of Deloitte Financial Advisory Services LLP. "More than 2,000 of the nation's 4,900 acute-care hospitals do not make a profit treating patients. Of the profitable hospitals, approximately 1,000 do not generate sufficient cash flow to fund essential, nondiscretionary capital expenses necessary to comply with regulations, or to remain competitive with increasingly dominant academic medical centers," Sordillo added.

What are the causes of this financial illness?

"Many of those hospitals must rely on alternate and generally unstable sources of funding, including governmental subsidies and philanthropic contributions," Sordillo said. "As states and municipalities begin to limit spending in the face of slumping tax revenues and a weakening economy, the financial health of many hospitals is likely to deteriorate further," he added.

"Hospitals not earning a profit on patient care are more likely to become insolvent when they can no longer sell or borrow against assets, or receive emergency governmental aid to fund losses," Sordillo added. The result of these circumstances can lead to marginal earnings or even chronic operating losses, the inability to make needed capital expenditures and improvements. "Many providers may encounter serious liquidity crises and face the prospect of radically restructuring — or worse — shutting their doors."

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Sordillo contended that regional issues and demographics in the nation's Northeast could be aggravating the pressures, including a high percentage of uninsured or under-insured patients, a high percentage of Medicaid-dependent patients, an excess of hospital bed capacity, high labor costs, and a high average length-of-stay by hospital patients. "In addition, many hospitals are competing with the entrance of new specialty hospitals into the marketplace," Sordillo added.

"Zone of insolvency"

"All this operational distress can lead to strained liquidity, significant expenditures of cash, underfunded capital expenditures, shortfalls in pension obligations, and the loss of financial flexibility," said Sordillo. These pressures can, in turn, lead the hospital into what he described as "a zone of insolvency," characterized by depleted cash reserves, a looming liquidity crisis, an unsustainable balance sheet, violations of covenants, and the loss of employee and patient confidence. "Turnover of staff and doctors at the hospital are one of the early, tell-tale signs of trouble," he said.

"At Deloitte FAS we have assisted troubled providers by helping them conduct 'wellness checks,' and arresting early signs of financial distress, and have helped facilities reorganize their operations — taking remedial steps towards improving cash flow and the development of a viable business plan, a sound balance sheet, and the consensual resolution of interests," Sordillo said.

"In most cases," Sordillo said, "the goal is to avoid Chapter 11 bankruptcy proceedings if possible, since that process can be time-consuming and costly, and since an internal reorganization effort is driven by management — rather than a bankruptcy court. However, an out-of-court reorganization effort can be difficult to accomplish without court oversight and the benefits can be more difficult to achieve."

"In some cases," Sordillo said, "a facility might want to consider a so-called 'pre-packaged bankruptcy,' an abbreviated, court-approved process that generally involves lower restructuring costs and less business disruption — but also has some disadvantages, including difficulty in dealing with contingent claims and the rejection of contracts, and a compressed time frame for making operational improvements."

Hospital-physician arrangement investigations

As "gatekeepers" into the medical system, non-hospital-employed physicians who have arrangements with certain hospitals are often in a position to refer patients to those hospitals. Such arrangements might include admitting privileges for the external physicians, agreements that lease office space to outside physicians, and certain joint venture business arrangements between hospitals and external physicians.

In recent years, the Office of the Inspector General (OIG) and the DOJ have been aggressively enforcing existing Anti-Kickback statutes and physician self-referral statutes (the "Stark Law") in connection with such arrangements.

"The concern is that these arrangements, if structured beneficially for the physician, might influence medical decisions, and the regulators want to prevent the involved parties from gaining financially by making such medical decisions," said Gary Keilty of Tampa, a principal at Deloitte Financial Advisory Services LLP.

According to Keilty, hospitals can face many challenges in managing their physician arrangements, including expired contracts, the lack of written contracts, undocumented modification of payment terms, contracts incorrectly outlining services to be provided, and payment terms in leasing agreements that do not meet fair-market value.



Deloitte services to hospitals in operational or financial distress

- Analyze underlying cause of distress
- Help develop and assess business plans and financial forecasts
- Quantify impact of regulatory changes in strategic planning
- Assess liquidity position and advise on cash management
- Assess strategic options
- Assist with the development of stabilization programs to arrest cash hemorrhaging and help minimize losses without impairing the ability to rehabilitate
- Cash flow forecasting and management.
- Assist with the short-term liquidity improvement

Deloitte services for hospitals in the “Zone of Insolvency”

- Help determine debt capacity
- Analyze refinancing and recapitalization options
- Assist in negotiations with lenders, note holders, unions, doctors, and other interested parties
- Help develop the reorganization plan, either in or out of court
- Provide assistance to debtors or their stakeholders in Chapter 11 bankruptcy proceedings
- Help manage sale of business, in whole or in part, through a 363 auction process
- Fresh start accounting

Deloitte experience in hospital-physician-arrangement Investigations

- Experience derived from several large investigations
- Providing assistance in negotiating with the OIG and the DOJ
- Dedicated health care fair market value practice
- Experience in monitoring Integrity Agreements
- Multidisciplinary teams including professionals with regulatory, consulting, and financial advisory experience

Investigations expected to increase

“Government enforcement agencies show no sign of slowing down their investigations and inquiries into hospital-physician arrangements,” Keilty added, noting that “the OIG has set such investigations as a priority.”

In addition, Keilty reported that the CMS may begin an initiative to gather existing physician-arrangement information from approximately 500 hospitals across the country — likely to lead to inquiries and investigations.

“The potential financial damages from these investigations can be quite large, and the ongoing compliance requirements post-settlement just as painful”, Keilty added. “And the publicity associated with such investigations can be damaging, too.”

In addition, whistleblower statutes give hospital employees a strong incentive to report alleged regulatory violations — potentially as much as 30 percent of any penalties the government collects can end up with the whistleblower, Keilty reported.

If hospitals take a proactive approach to address any potential concerns, external specialists can assist with internal investigations as a preventative measure against a potential investigation. “We can help the hospitals by analyzing internal policies and practices, interviewing key stakeholders, developing sampling studies to document physician arrangements by various categories, identifying areas to enhance the hospital’s current compliance program, and by identifying potential regulatory violations that may require a self-disclosure.”

Once a government investigation is already under way, Keilty said that assistance to the hospitals takes a different approach. “We can help the hospitals in responding to subpoenas and other information requests, documenting the facts of the contractual arrangements at issue, analyzing and quantifying alleged damages, assisting the client and outside counsel in developing appropriate defense strategies, and developing expert reports and preparing for trial — if it comes to that.”

Usual customary and reasonable charges

When health insurance companies provide payment for services to doctors outside of their networks, they may rely on a method to set payment rates to those doctors known as “usual customary and reasonable charges (UCR).”

Many health insurers rely on a database developed by Ingenix (a unit of United Health) to profile provider’s charges and used by insurers to help calculate “reasonable” payment rates. Recently the Attorney General of New York launched an investigation into the methodology that health insurers use to calculate their UCR rates for out-of-network providers.

The New York investigation alleges that the Ingenix database is incomplete and inaccurate, centering on the contention that the rates in the database are not truly representative of actual charges for treatment. According to the claim, certain discount charges may have been factored into the data, while rates from certain higher-charging providers may have been excluded.

“The impact is that the health insurer might rely on lower ‘reasonable charges’ — resulting in allegations of lower payments to providers and the patient left paying a higher proportion of the provider’s charge,” said Mark Abernathy, a partner at Deloitte Financial Advisory Services LLP.

A series of adverse affects

“If the New York attorney general’s allegations are found to have merit, this could become a national issue for all payers that use the Ingenix database,” Abernathy said, noting that the result could be a series of adverse affects: “Reimbursements to providers from payers would increase, leading to higher insurance premiums for employers that insure their employees.”

In turn, Abernathy predicted that some employers may drop health insurance coverage for their employees altogether — leading to an increase in the uninsured population. That, in turn, would lead insurance companies to increase premiums as the insured population continues to decrease, resulting in a downward spiral of insured and an upward spiral of premium costs.

“As insurance companies face investigations, we can assist them by conducting what is ostensibly a ‘shadow investigation’ of the attorney general’s claims,” Abernathy said. “This can include an independent analysis of the data used by the insurer to develop usual, customary and reasonable charges.”

Such an analysis can help the insurer to develop billing profiles from claims data; to obtain data from the health insurer, Medicare, and Medicaid; to develop profiles that are geographically sensitive to account for regional variances, and are specialty-specific to account for market differences between the specialties.

The goal of the analysis, according to Abernathy, is to assist in assessing the accuracy of the data used to establish UCRs for the insurance provider — whether in the Ingenix database, or in the independently determined method.

Life science companies: improving gross-to-net revenues

Life science companies face special financial challenges since their revenues often depend on complex contractual arrangements in the supply chain.

As companies manage the constant changes in their industry, they often need assistance in addressing inefficiencies in the supply chain and with trying to recoup lost assets, thereby improving gross-to-net revenues and overall profitability.

“We continue to assist these companies to understand the complex web of these factors, advising them on how to improve their financial situation and risk management strategies, thus increasing shareholder return on investment and enhancing their relationships with business partners,” said Yogesh Bahl, a partner with Deloitte Financial Advisory Services LLP.

Bahl cited a list of ways that companies can estimate how their net revenues can be diluted by misreporting of items such as product returns, cash discounts, chargebacks, and rebates in the sale and distribution of products.

The impact is that the health insurer might rely on lower ‘reasonable charges’

Many companies operate on reserves based on expectations about the number of products that will be returned, Medicare and Medicaid reimbursements, prompt payment discounts, and price adjustments. Any errors in estimates or reporting can impact the tracking of revenues greatly. Further, these issues can be magnified when the complexity of the supply chain at the international level is taken into account.

Helping companies estimate potential losses

As specialists help life science companies estimate the potential losses in misreporting of gross-to-net components, numerous factors are taken into account. Bahl says one must analyze and be familiar with the provisions in contractual arrangements with wholesalers, the shelf-life or expiration date of each product, and analysis of historical trends in inventory movement patterns. Similar considerations can help many companies maintain accruals around cash discounts for prompt payments, and reserves to allow for historical losses relating to uncollected revenues.

Companies also continue to be challenged by the struggle to manage chargebacks — amounts claimed by wholesalers as a result of difference between contract and wholesale prices. “Under these arrangements,” Bahl said, “companies need to keep tight control around pricing and inventory movement, especially considering transactions that generate negative chargebacks.”

Bahl indicated that rebates are another component in the gross-to-net calculation, and can take the form of volume or pricing rebates provided to organizations like independent pharmacies, managed care organizations, and group purchasing organizations (GPOs).

Bahl reported that such complex contractual arrangements coupled with the unpredictability of the marketplace make it imperative for life science companies to consult appropriate specialists that are familiar with the life science supply chain in order to improve gross-to-net revenues.

Further, the issues discussed above become more complex in the context of international strategic alliances where culture and different business practices can impact the return on investment of such deals.

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Deloitte experience with usual customary and reasonable charges

- Experience in development of UCRs and issues in litigation between insurers and providers
- Experience in data mining in claim payment information, and in applying knowledge of claims processing systems and provider contracting
- Knowledge of payment issues with respect to contracted versus non-contracted providers
- Experience with the development of econometric and statistical based models to develop supportable analysis of UCRs as a basis used in the development of reimbursement practices

Deloitte experience with life science companies

- Gross-to-net advice
- Assistance on contract advice and investigations
- Experience working with distributors, wholesalers, and GPOs
- Broad experience in life sciences and health care
- The Center for Health Solutions — a consulting arrangement involving Deloitte Financial Advisory Services LLP and thought leaders in the industry

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