Fair Market Value and Health Care Compliance in Hospital-Physician Transactions

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Introduction

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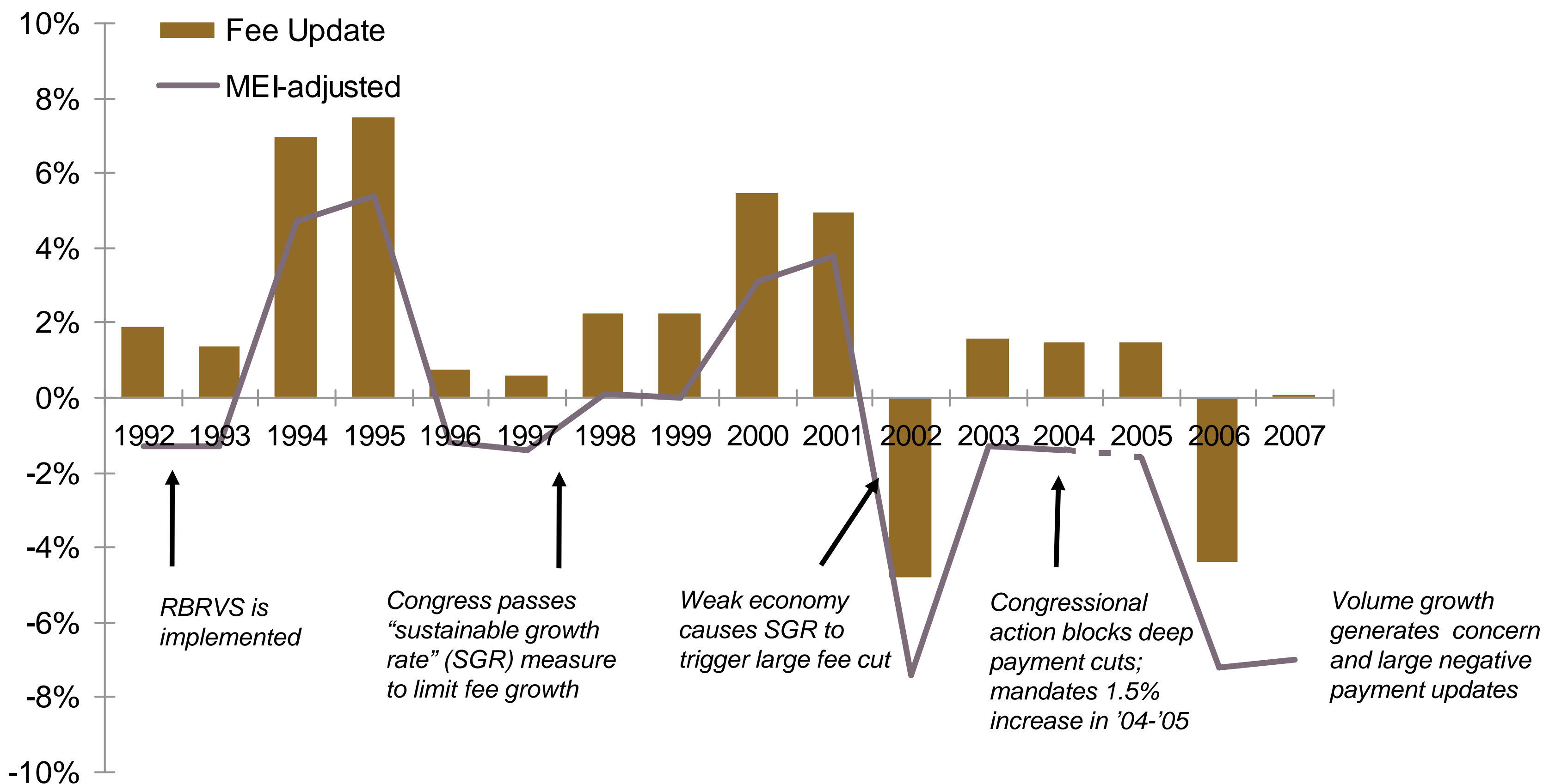
Physician Financial Squeeze

Annual Update in Medicare Physician Fees
US Market, 1992-2007



Sources: MedPac, 2006

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sg2 health care intelligence

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Physician Response to Market Trends

- Increased hours/workload
- Manage to a better case mix – cherry pick patients and payors
- Pursue revenue enhancement strategies
- Seek/demand stipends
  - ED call, coverage
  - Medical directorships
  - Committee participation
- Convert to concierge practice
- Relocate
- Retire early
- Seek employment
- Seek capital/technology partners and joint ventures
- Consolidate
- Align/integrate with hospital or health system

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Hospital Response Competition v. Collaboration

"One Can't Run a Hospital With Doctors, One Can't Run a Hospital Without Them"

Anonymous Hospital CEO

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Hospital Response

- Physician employment/hospital affiliated group practices
- Practice acquisitions and charitable contributions
- EHRs and clinical integration
- Align/integrate with physicians and medical groups

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Competition v. Collaboration

- Existing vs. new services
- Joint ventures that cannibalize existing services rarely "make it up on volume!"*

Hospital		Freestanding	
Net Revenue	$4.0 M	**1/3 More Volume!**	$4.0M
Margin	35%		20%
		Net Income	$800,000
		Ownership	50%
Net Pretax Income	$1.4M		$400,000
Taxes	------		35%
Net Contribution	$1.4M		$260,000

* Kaufman Strategic Advisors, LLC

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Hospital Response: Competition v. Collaboration

- Typical Hospital Strategies
  - Collaboration
    - Defensive
      - 50% of high-end imaging in free-standing setting (30% margin)
      - 40% of outpatient surgery in non-hospital settings (20% margin)
      - Emergence of physician-owned hospitals
    - Offensive
      - Market capture and growth
      - Win-Win ventures

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Multiple Models for Successful Collaboration

- Contracts
  - Physician Employment
  - Recruitment Agreements
  - Professional Service Agreements
  - Practice Acquisition Agreements
  - Practice Support Agreements
  - Clinical Research Agreements
  - AS&T Contracts
- Contractual Venture Models
  - Service-Line Co-Management
  - Gainsharing Arrangements
  - Pay for Quality/Pay for Performance
  - Block Leasing
  - Foundation Model
  - Centers of Excellence Models
  - Modified Under Arrangements Model
- Non-Clinical Joint Ventures
  - Facility development companies
  - Space leasing companies
  - Equipment leasing companies
  - Management companies
  - HIT ventures
  - Medical office building ventures
- Clinical Joint Ventures
  - Whole Hospitals
  - Hospital-Within-a-Hospital
  - Specialty Surgical Hospitals
  - ASCs
  - Ambulatory Facilities
- Physician-Hospital Organizations (PHOs)
  - Participation agreements
  - Payor and P4P contracting
  - Risk contracting
  - Clinical Integration
- RHIO and EHR
- Hospital-Affiliated Group Practices
- 2nd Generation Practice Management Organizations
  - Joint venture MSOs
  - Seeding practice integration
- Participating Bond Transactions
- Captive Insurance Arrangements

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Impact of Recent Legal Developments on Hospital-Physician Relations

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Impact of Recent Legal Developments on Hospital-Physician Relations

- Stark Law
  - Phase III rule (effective December 4, 2007)
  - Additional proposed rules; Incentive Payment and Cost Savings Exception
  - Additional final rules (effective Oct. 1, 2008; Oct. 1, 2009)
- OIG Advisory Opinion 8-10 (August 19, 2008)
- OIG Advisory Opinion 8-16 (October 14, 2008)
- Anti-mark-up rules
- IDTF rules

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Kosenske Case (January 21, 2009)

- Stark Law Case – exclusive anesthesiology agreement with first opportunity to provide pain management services in new outpatient clinic
- No money changed hands – group bills professional component and hospital bills facility/technical component
- Appeals court finds remuneration in-kind and a compensation relationship – *i.e.,* space, equipment, supplies and support services furnished by the hospital at no charge, and the value of exclusivity
  - N.B. – Pain management is not required to be hospital-based; physicians in a position to refer to hospital

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Kosenske Case (January 21, 2009) (cont.)

- Appeals courts finds personal services exception does not apply
  - No contract – only a right of first opportunity for exclusive contract
  - Defendant did not meet burden of proving that the benefits received from the hospital did not exceed *fair market value* of the pain management services rendered (*i.e.,* the price that an asset would bring as a result of bona fide bargaining between well informed buyers and sellers *who are not otherwise in a position to generate business for the other party)*
  - No negotiation, and any negotiation between interested parties is inherently not at arms-length

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Kosenske Case (January 21, 2009) (cont.)

- **Lessons learned—bad facts, bad law**
  - Exclusive hospital-based service arrangements must be in writing.
  - If the service involves physicians who are in a position to refer, then the burden will be on the providers to prove that arrangement is fair market value and meets an applicable Stark Law exception.
  - In third circuit (PA, NJ, DE), billing separate components may be inadequate evidence of FMV (even though market treats it as presumptively FMV based on the method by which those components are established).

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Kosenske Case (January 21, 2009) (cont.)

- **Lessons learned—bad facts, bad law**
  - At least in third circuit, independent appraisal of FMV is advisable (complicated in-kind analysis).
  - Alternatively, hospital can take assignment of professional component and pay FMV for services (more straight-forward FMV analysis).

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Impact on Hospital-Physician Relations

- **Affects space, equipment and block lease/sharing arrangements**
  - Stark prohibition of percentage based space and equipment leases (411.357(a), (b) and (p), effective October 1, 2009)
  - Stark prohibition of per unit service ("per click") arrangements (411.357(a), (b) and (p), effective October 1, 2009)
  - No more FMV exception for space leases (411.357(a) and (p), effective December 4, 2007)
    - Affects "next available room" shared space arrangements
    - Space lease must include period of exclusive use

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Impact on Hospital-Physician Relations

- **Affects investment in “under arrangements” entities and turn-key management or leasing companies**
  - Stark prohibition on ownership interest in entity that performs the DHS (411.351, definition of “entity”, effective October 1, 2009)
    - Exception for under arrangements contract with a single group
    - Exception for ownership interests in rural providers and public companies
  - CMS declines to provide guidance on what it means to “perform” the service (i.e., what combination of providing space, equipment, supplies, non-physician clinicians, administrative staff, executive services)

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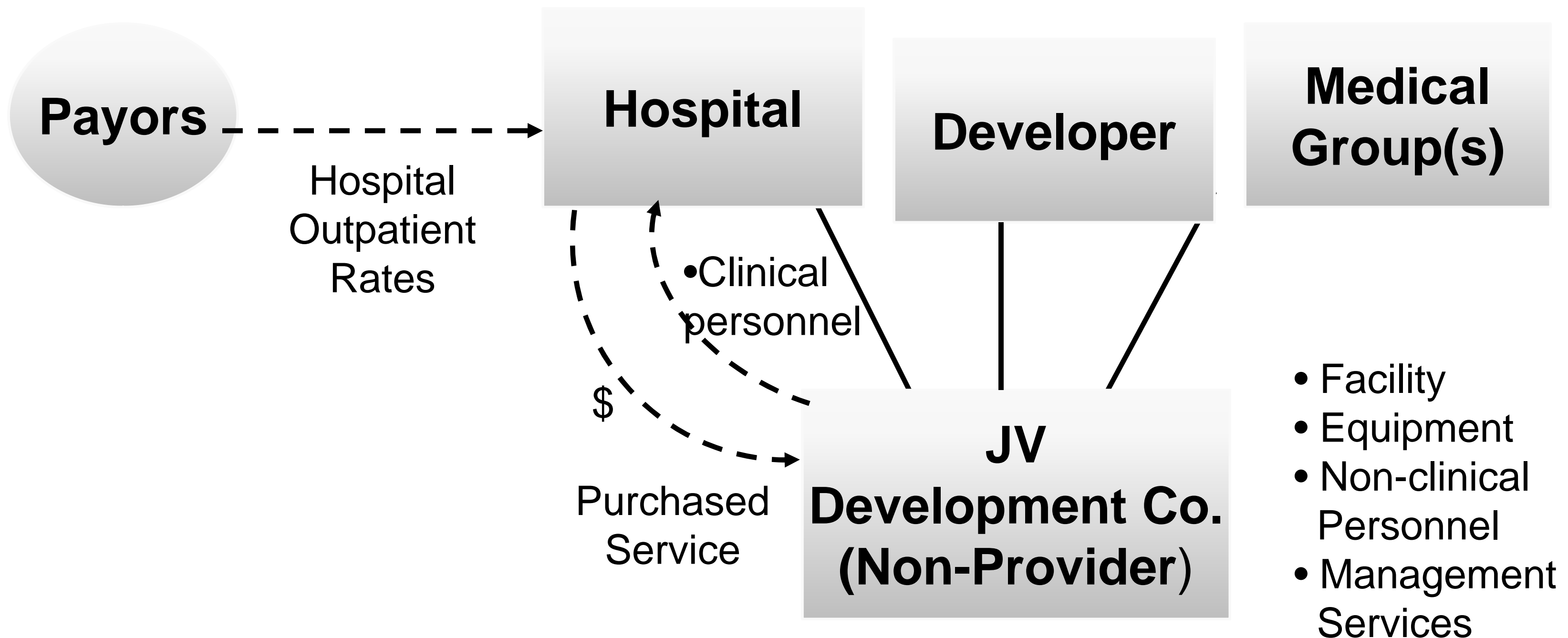
Modified Under Arrangements Model



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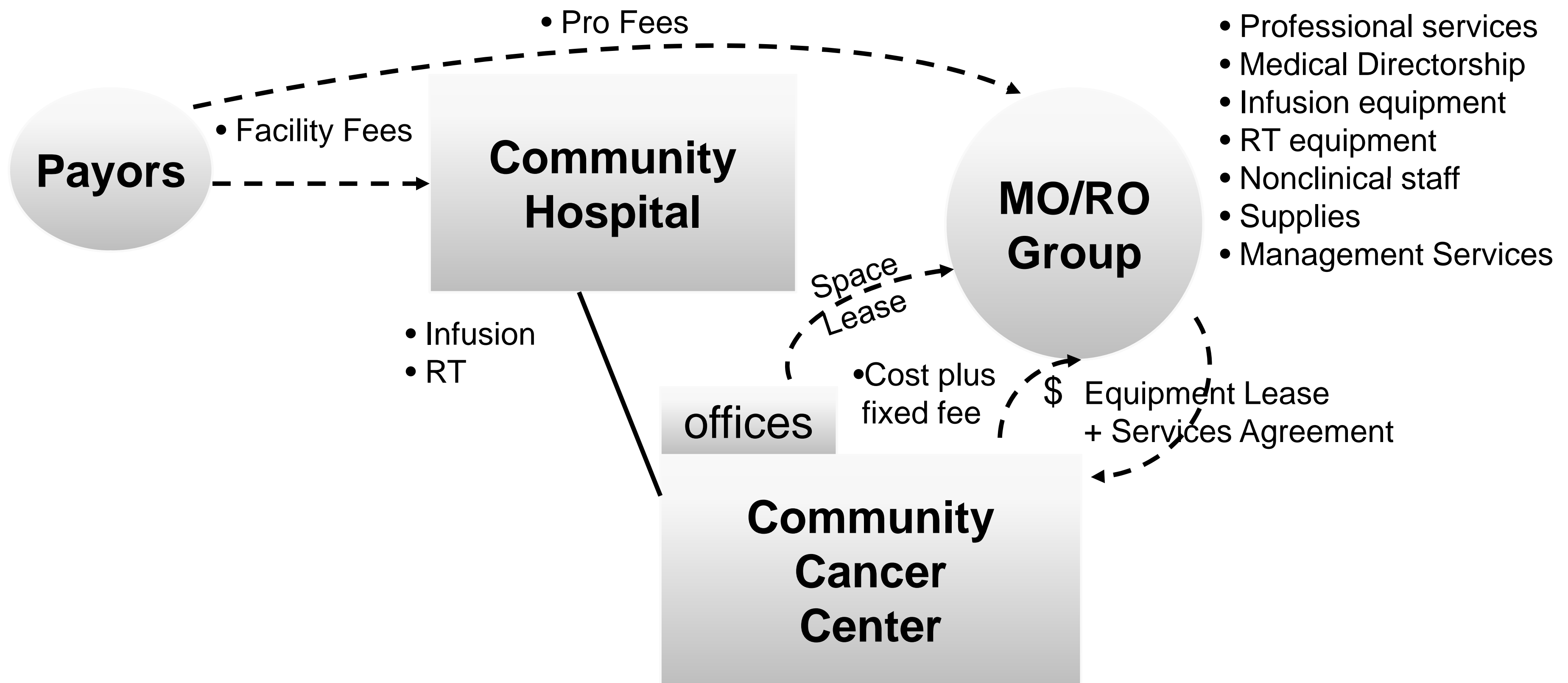
Cancer Center Example
Permissible Under Arrangements Venture



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Impact on Hospital-Physician Relations

- **Affects turn-key management contracts and contractual joint ventures**
  - OIG Adv. Op. 8-10
  - Block Lease of IMRT equipment by MO/RO group to urologists, together with turn-key support services on a fixed, FMV basis, constitutes impermissible contractual joint venture that may violate anti-kickback statute
  - Providing opportunity for urologists to profit may be improper remuneration that is not safe harbored

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Impact on Hospital-Physician Relations

- **New opportunities for quality and efficiency improvement ventures**
  - OIG Adv. Op. 08-16
  - Proposed Stark Law exception for Incentive Payment and Shared Savings Programs (411.357(x))
    - Service Line Co-Management, gainsharing, pay-for-performance, pay-for-quality arrangements

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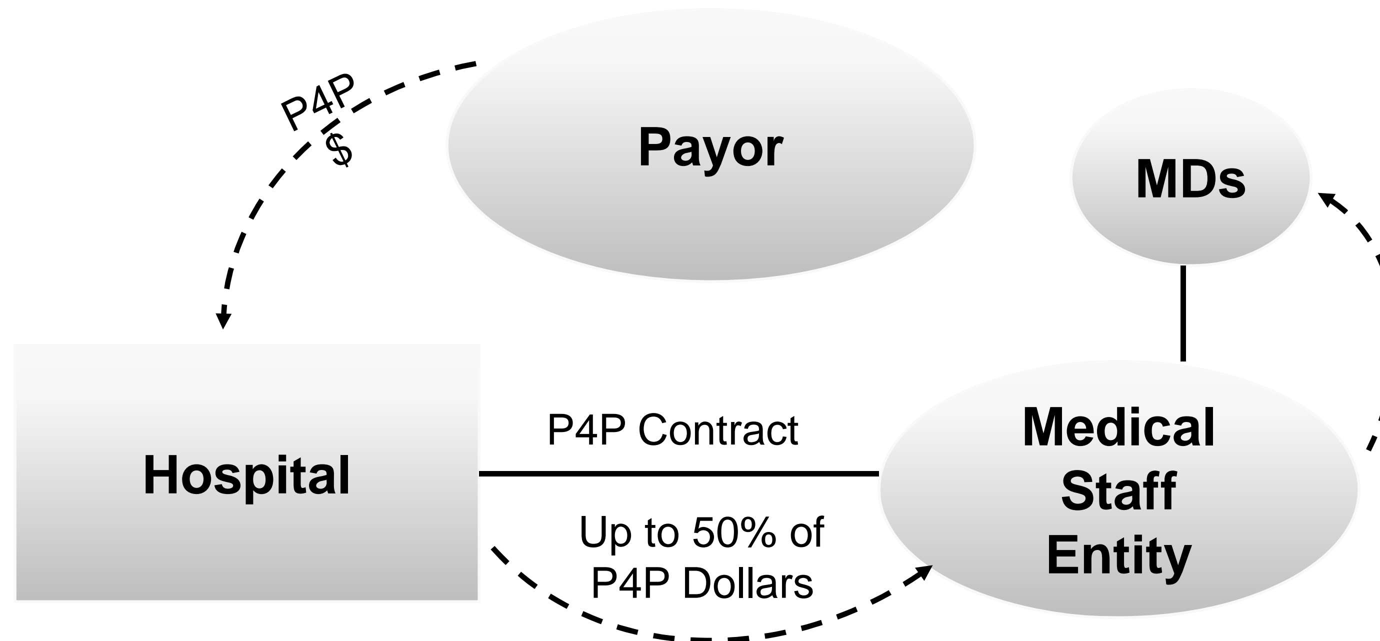
Advisory Opinion 08-16
Pay-For-Quality Arrangement



OIG Adv. Op. 08-16
- Participating physicians are members of Medical Staff for at least one year
- Participating physicians equally capitalize Medical Staff Entity
- Quality Targets are measures listed in CMS' Specification Manual for Hospital Quality Measures
- Payments to Medical Staff Entity are caped at 50% of base year P4P dollars (with inflation adjuster)
- Quality targets and payments renegotiated annually
- Monitoring to protect against inappropriate reduction or limitation in patient care services
- Termination of physicians who change referral patterns (e.g., cherry pick patients) to meet targets
- Maintain records of performance
- Patients informed of Program in writing

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Service Line Co-Management Arrangements

- The purpose of the arrangement is to recognize and appropriately reward participating medical groups/physicians for their efforts in developing, managing, and improving quality and efficiency of the hospital's oncology service line.

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Service Line Co-Management Arrangements

- There are typically two levels of payment to physicians under the service line contract:
  - Base fee – a fixed annual base fee that is consistent with the fair market value of the time and efforts participating physicians dedicate to the service line development, management, and oversight process
  - Bonus fee – a series of pre-determined payment amounts contingent on achievement of specified, mutually agreed, objectively measurable, program development, quality improvement and efficiency goals
  - Pays participating physicians 3-6% of service line revenues

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Sample Surgical Performance Metrics

Incentive	Priority	Allocation	Upper Payment Limit (a)	Current Performance	Performance Target Measurement	Year 1	Year 2
Operational Efficiencies Incentive Compensation (OEIC)							
Standardization of supplies of equivalent quality	1	13.2%	$ 120,000	40%	Order Preferred Items	95.0%	95.0%
Turn Around Time (c)	2	8.2%	$ 75,000	2.56	# Hours	</=1.00	</=1.00
On-Time Starts (1st Case of Day)	2	8.2%	$ 75,000	20%	Improvement On Target	>/= 95%	>/= 95%
Room Utilization	1	13.2%	$ 120,000	76%	# Hours	>/= 85%	>/= 85%
Quality of Service Incentive Compensation (QSIC)							
Infection Rate: Antibiotics Within 30 Minutes Prior to Incision	1	13.2%	$ 120,000	89%	% Compliance	>/=95%	>/=98%
Infection Rate: Insulin Drip for Patients with Blood Sugar Level > 150	2	8.2%	$ 75,000	0%	% Compliance	>/=50%	>/=75%
Return to OR for Post-Op Bleeding	2	8.2%	$ 75,000	2.9%	% Rate of Return to OR	</=2.7%	</=2.5%
Mortality Rate	1	13.2%	$ 120,000	(d)	O/E Rate (b)	</−1.00	</−0.95
Patient Satisfaction	3	7.1%	$ 65,000		Peer Group Percentile	>/=80	>/=85
Peer / Employee Evaluations	3	7.1%	$ 65,000		360° Feedback Scores	Survey Development / Administration	TBD
Total Incentives			**$ 910,000**				
Quality of Service Threshold							
Mortality Rate (e)	Quality Threshold would be required to be met in order for any of the above incentives to be paid out.			2.98%	Gross Mortality % and/or O/E Rate (TBD) (e)	2.98%	Conversion to O/E Rate

(a) Based on maximum total incentives payout of $910,000 **(Subject to Fair Market Value and Legal Approval)**
(b) O/E = Observed v. Expected rate
(c) Turn Around Time Defined as time of incision closure to time of next incision
(d) O/E mortality rate is currently not measured
(e) Assumes Quality of Service Threshold will change from gross mortality % to an O/E rate once available.

For Illustrative Purposes Only

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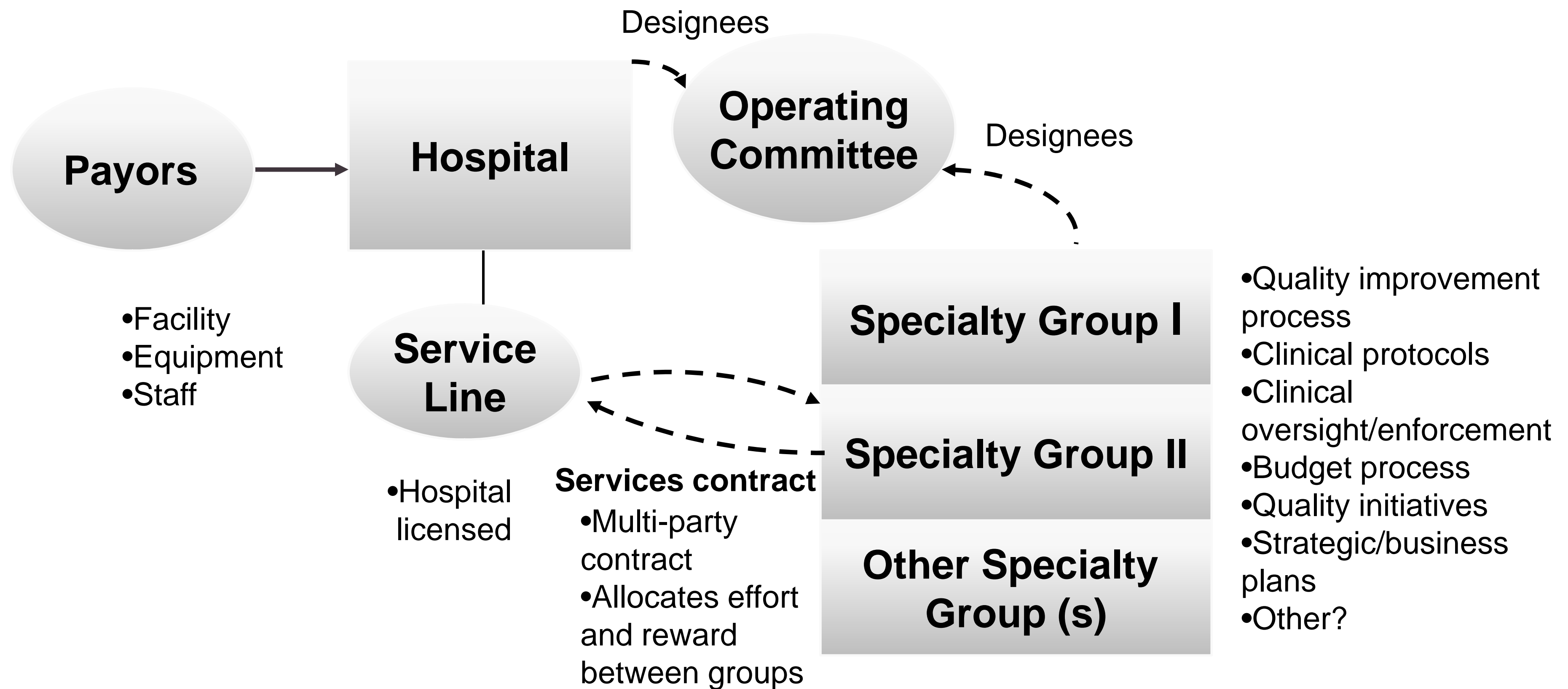
Service Line Co-Management Direct Contract Model



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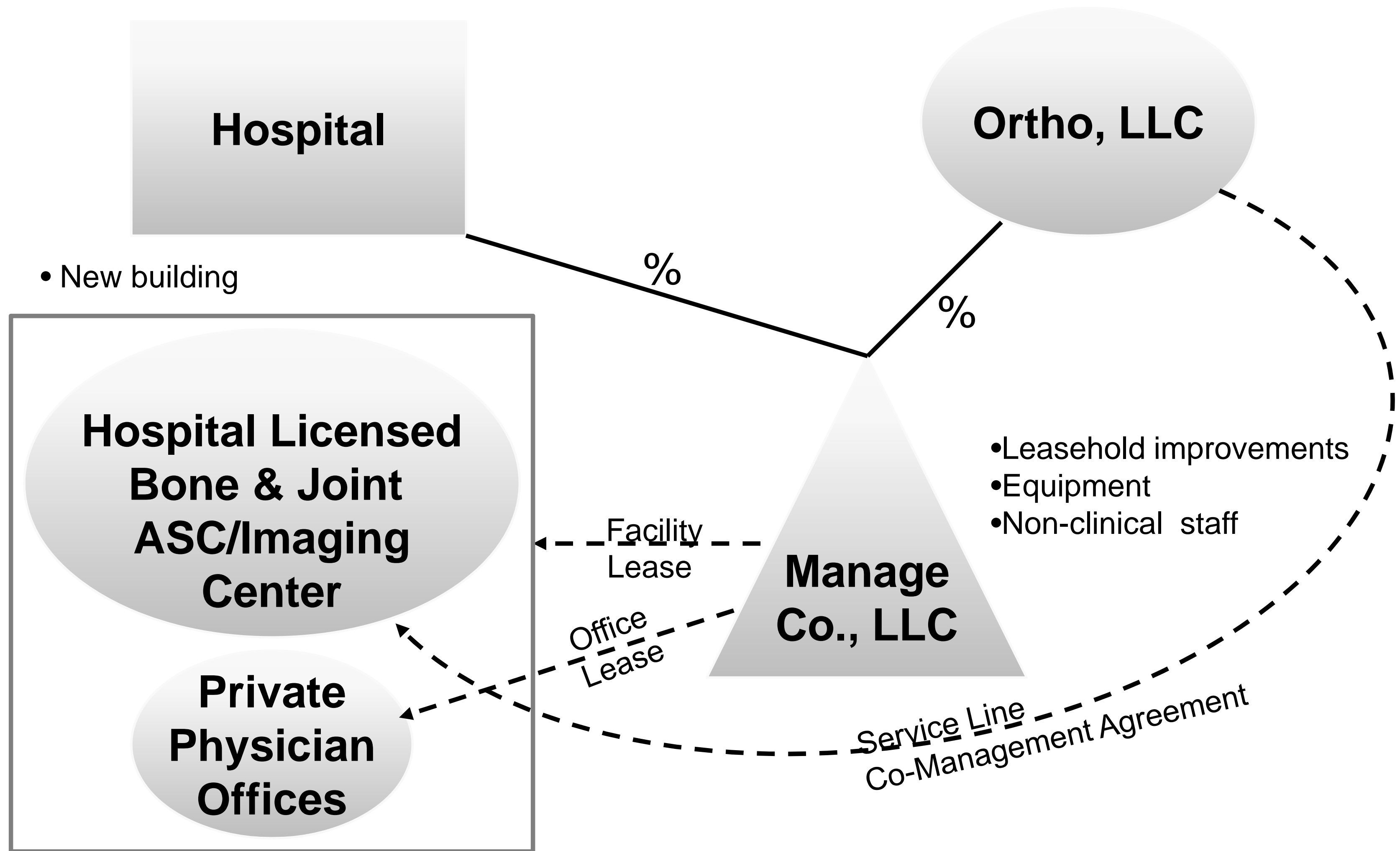
Service Line Co-Management Example
Bone & Joint Center



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Regulatory Considerations

- Cost savings metrics/incentives implicate Civil Monetary Penalty Law
  - Hospital cannot pay a physician to reduce or limit services to Medicare/Medicaid beneficiaries under the physician's care
  - Cannot pay for reduction in LOS or overall budget savings
- Can pay for cheaper not fewer items of equivalent quality[1]?
  - Potential to incent verifiable cost-savings from standardizing supplies or reducing administrative expenses as long as quality is not adversely affected and volume/case mix changes are not rewarded

[1] See OIG Special Advisory Bulletin on Gainsharing (July 8, 1999) and Clarification Letter (Aug. 19, 1999); See also OIG Adv. Ops. 01-1, 05-01-5, 06-22, 07-21, 07-22

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Regulatory Considerations

- Volume/revenue based performance measures implicate the Anti-Kickback Statute and Stark Law
  - Cannot reward increase in utilization, revenue, profits (or change in acuity)

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Proposed Incentive Payment and Shared Savings Exception

- Proposed Stark Law exception for Incentive Payment and Shared Savings programs (e.g., service line co-management, gainsharing, pay for quality programs)
  - Aimed at permitting appropriate quality improvement and cost savings programs while guarding against:
    - Stinting
    - Steering
    - Cherry-picking
    - Gaming
    - Paying for referrals/volume increase
    - Quicker-sicker discharges
  - 16 detailed standards
  - Positive development, but limited utility

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Stark Law Considerations

- Key Constraints of Proposed Exception on Service Line Co-Management Agreements
  - Quality measures must be listed on CMS' Specification Manual for National Hospital Quality Measures – too limited?
  - Applies to "cost savings resulting from reduction in waste or changes in physician or clinical practices"
    - Efficiency gains (e.g., turn-around times, on-time starts) that reduce unit cost, but not overall costs?
  - Performance measures to be judged against Hospital's baseline historic and clinical data – Hospital may not have baseline information for some key measures
  - Targets developed by comparing to national/regional performance norms – may not be available benchmarks
  - At least 5 physicians must participate in each performance measure – service line may have less than 5 physicians

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Stark Law Considerations

- Independent medical review prior to commencement and annually thereafter
- No payment to any physician for using an item if the physician has a financial relationship with the selling manufacturer, distributor or GPO
- Physicians must have access to same selection of items as before commencement of program – implications for standardization initiatives
- Term of no less than 1 nor more than 3 years – implications for attractiveness, durability and continuous quality improvements
- Re-basing – cannot pay for “maintenance” of quality/efficiency gains
- Remuneration set in advance and cannot change during term – no opportunity to set new performance standards and reappraise during multi-year agreement

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Stark Law Considerations

- How useful is the proposed exception?
  - Other potentially available exceptions provide greater flexibility
    - Fair Market Value Compensation
    - Personal Services
    - Indirect Compensation
  - Key is fair market value – independent appraisal
  - Does not propose that more specific new exception "trump" more general existing exceptions
  - Greater assurance of AKS/CMP compliance?

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FMV Considerations in Co-Management Agreements

- By design, these agreements exist between hospitals and referral source physicians.
- Therefore, the relative riskiness may be greater for these arrangements.

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FMV Considerations in Co-Management Agreements

- Overall premise
  - A coordinated "bundle" of services is provided rather than disparate medical director duties
  - Compensation is distinctly divided into "base" and "incentive"
- Valuation approaches
  - Cost Approach: Consider a "build up" of medical director hours
  - Market Approach: Compare the nature and extent of services being provided to other management agreements

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FMV Considerations in Co-Management Agreements

- Other issues
  - Consider the appropriateness of the selected incentive metrics
  - Is the establishment of the incentive compensation reasonably objective?
  - Consider the split of base compensation and incentive compensation
  - Reevaluate FMV periodically

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Practice Acquisitions and Charitable Contribution of Practices

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Regulatory Issues

- Federal issues
  - Federal Anti-Kickback statute
  - Stark Law
  - Tax exemption issues
  - HIPAA
- State issues

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Practice Acquisition: Anti-Kickback Statute

- Is the purchase price a disguised kickback from the buyer (overpayment) or selling medical group (underpayments)?
- Practice acquisition safe harbors
  - Practitioner-to-practitioner safe harbor
    - Sale completion within 1 year
    - Seller not in a position to refer after 1 year

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Anti-Kickback Statute

- Practitioner-to-other entity (hospital) safe harbor
  - Practice acquired is ***located in a HPSA***
  - Sale completion with 3 years
  - Seller not in a position to refer after sale completion
  - Purchaser must use diligent and good faith efforts to recruit a successor within 1 year to take over the practice
- Most practice acquisitions are ***not*** safe-harbored

- Advisory opinions on fair market value issues not available

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Anti-Kickback Statute Issues

- Valuation Issues – independent appraisal of fair market value in arms-length transaction
  - Goodwill – payment for intangibles to physician who continues in a position to refer is suspect (1992 Thornton letter)
    - Professional level goodwill
    - Practice level goodwill
  - Discounted free cash flow/discounted earnings approach takes into account the value of future cash flows
    - Acute issue when selling physicians remain in a position to refer

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Anti-Kickback Statute Issues

- PharMerica settlement
- Other matters affecting value under income approach
  - Salary to selling physicians post sale
  - Overcoding
  - Payment for noncompete
  - Revenue growth assumptions
  - Deferred capital investments
  - Size of practice

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Anti-Kickback Statute Issues

- Other Valuation Issues
  - Existence of true comparables under market approach
    - Same specialty and mix of services?
    - Same market?
    - Same time period?
    - Same context?
    - Private vs. public company transactions?
  - Earnouts

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Practice Acquisitions: Stark Law

- Stark law – purchase price transaction creates financial relationship that will prohibit referrals to hospital buyer (or other DHS entity) unless an exception applies
  - Zero tolerance law
  - Stark analysis has changed due to new “stand in shoes” rule
    - Stock transactions – payment to physician (direct)
    - Asset transactions – payment to medical group (indirect)
    - Direct compensation exception needed for physician owners
    - Direct or indirect compensation exception for titular owners and non-owners

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Stark Law

- Need direct compensation exception
- Isolated transaction exception – compensation exception only (not applicable if stock, warrants, options or other investment interests are part of purchase consideration)
  - Aggregate payments fixed in advance (no earnouts)

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Stark Law

- FMV, not taking into account volume or value of referrals or other business generated between the parties
  - Similar to valuation issues under AKS if selling physicians will continue to be in position to refer
- Payable even if default by buyer (Letter of credit, negotiable note or guaranteed by third party)
- No other transactions for 6 months except:
  - Other Stark Law excepted transactions
  - Commercially reasonable post-closing adjustments
- Advisory opinions on fair market value not available

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Stark Law Issues

- Other Stark Law Issues
  - Sale of lab or DHS services – not permitted if price is valued based on anticipated post-transaction referrals by physician owners
  - Investment interests in buyer – payment by stock, options, secured notes
    - Investment interest exceptions for whole hospital, rural providers, and publicly traded securities

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Practice Acquisitions: Tax Exemption Considerations

- 501 (c)(3) Exemption Standards
  - No inurement
  - Not more than incidental private benefit
- CPE Guidance
  - Obtain appraisal of FMV
  - Agreement with selling physicians to retain goodwill
  - Pay market rate compensation (on the same scale as other employees) or justify higher comp
  - FMV lease of assets retained by practice

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Tax Exemption Considerations

- Revocation authority and intermediate sanctions
  - Modern Health Care Services (d/b/a LAC Facilities) – revocation
  - Carracci case – proposed revocation and intermediate sanctions overturned
    - Inappropriate market approach to valuation based on public company comparables for home care company with no invested capital and no history of profitable operations (no goodwill)

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Exemption Considerations

- Lessons of Carracci Case
  - Select a qualified appraiser with particular expertise and experience
  - Properly take into account third-party payor methodologies and rates
  - Use true market comparables
  - Follow process for rebuttable presumption of reasonableness (to shift the burden to the IRS to establish that appraised value is incorrect)

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Exemption Considerations

- Rebuttable presumption process
  - Approved by board or committee with no conflict of interest
  - Rely on appropriate data as to comparability
  - Determine that the property transfer is at FMV
  - Document basis of decision within 60 days after decision

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Exemption Organization Considerations

- Charitable contribution of practice assets/valuation misstatement cases
  - Charitable deduction for donation of assets with value in excess of benefits received
  - Penalties for valuation misstatements (IRC § 6662)
    - 40% if overvalued by 400% or more and deduction exceeds $5,000
    - 20% if overvalued by 400% or more and deduction does not exceed $5,000
    - No penalty if taxpayer makes good faith investigation and relies on valuation by a qualified appraiser

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Exempt Organization Considerations

- Derby case, T.C.M. 2008-45 (Feb. 28, 2008)
  - Disallowance of claimed charitable contribution to Sutter Medical Foundation (SMF) by physicians associated with Sutter West Medical Group (SWMG)
  - Part of practice consolidation transaction by which SMF purchased tangible assets, guaranteed compensation, and paid sign-on bonus of $35,000/M.D.
  - SWMG physicians did not meet their burden of showing that value of intangibles donated exceeded value of benefits obtained from SMF, notwithstanding independent valuation using DFC method
    - Potentially above market compensation

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Exempt Organization Considerations

- Derby case (con't)
  - Sign-on bonuses
  - No post-termination non-compete; personal goodwill not transferred
  - No valuation misstatement penalties
- Bergquist case, 131 T.C. 2 (July 22, 2008)
  - Tax court reduces charitable deduction of $401.79/share to $37/share for contribution of PC stock, and imposes valuation misstatement penalties

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Exempt Organization Considerations

- Bergquist case (con't)
  - Tax court found that practice should not have been valued as going concern
    - Wind-down and payout of A/R at point of consolidation
    - No tangible assets
    - No non-competes
  - IRS valuator assessed value at $37/voting share using market approach (assets net of liabilities, discounted for lack of control interest and marketability)
  - Penalties imposed because physicians could not unreasonably rely on unreasonable assumption of going concern value when they knew (or should have known) otherwise

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Regulatory Compliance

- Advice
  - Document proper purpose of acquisition: community benefit
  - Disclaim improper purpose: induce referrals
  - No evidence of improper purpose
  - Independent appraisal of FMV
    - Select knowledgeable appraiser who has experience with medical practice valuations and is sensitive to health regulatory issues
    - Diligence appraisal for health regulatory compliance
    - Make sure valuation takes into account all aspects benefits received by sellers in transaction documents
    - Do not value personal goodwill in absence of non-compete
    - Rely on true market comparables
    - Do not use going concern value (income or market approach) for practice that is otherwise going out-of-business

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Regulatory Compliance

- If seller will continue in position to refer, determine and justify valuation on basis that does not take into account future referrals by seller.
  - Do not value professional level goodwill by income method?
  - Do not value DHS by income method
  - Do not pay for unenforceable noncompetes
  - Avoid earnouts
  - Avoid exclusive use agreements
- Follow steps for rebuttable presumption of reasonableness if buyer is a tax-exempt entity.
- Properly value any assets contributed to exempt organization.
  - Assure that charitable deduction is reduced by value of benefits received in connection with donation
- Acquiring entity must be authorized to engage in the practice of medicine.
- Comply with clinic licensure/CON requirements, if applicable.

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FMV Considerations Re: Practice Acquisitions

- Be aware of the difference between the *equity value* of a physician practice and the *transaction consideration* (*e.g.*, cash, receivables and liabilities may be excluded from a transaction)
- Post-transaction physician compensation must be coordinated with the value of the acquired practice

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FMV Considerations Re: Practice Acquisitions

- For solo or small practices, acquisition value may be attributable only to the value of tangible assets and certain other specifically identifiable assets
- Larger practices may have value from:
  - Workforce in place
  - Cost to recreate

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FMV Considerations Re: Employment Arrangements

- Confucius Statistician say…If you torture the data long enough, it will confess to the crime it did not commit.
- MGMA data can be misused in a variety of ways, including:
  - Cherry picking from among different tables (*e.g.*, regional data vs. state data)
  - Failure to consider ownership/ancillary profits that may be inherent in 90th percentile compensation

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FMV Considerations
Re: Employment Arrangements

- Example of misuse of MGMA data:
  - For Orthopedic Surgery: General
  - 90th percentile cash compensation - $799,883
  - 90th percentile wRVUs – 13,147
  - 90th percentile compensation per wRVU - $97.97

  Where is this going?
  - 90th percentile wRVUs x 90th percentile compensation per wRVU = $1,288,000

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FMV Considerations
Re: Employment Arrangements

- Compensation "stacking"
  - Medical director fees, on-call compensation, quality bonuses, etc.
- Consider the data being reported by the compensation surveys (*i.e.,* they include are anticipated to include medical director fees, on-call compensation, quality bonuses, etc.)

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FMV Considerations Re: Employment Arrangements

- Be aware when using RVUs –
  - Don’t confuse *total* RVUs with *work* RVUs
  - Consider possible CMS changes in RVU values
  - Note that CPT procedures subject to certain modifiers result in reduced wRVUs (*e.g.*, assistant at surgery and multiple procedures)

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Establishing FMV Internally vs. Outside Consultant

- Unless required by a CIA or other type of settlement agreement, there is no requirement that FMV be established by an independent third party.
- Consider third-party appraisals for transactions on the “riskier” end of the spectrum (*e.g.*, a pathologist employment arrangement vs. a cardiology co-management agreement).

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Establishing FMV – Internally vs. Outside Consultant

- Regardless of internal vs. external:
  - Be familiar with the definition of *fair market value*
    - FMV is NOT investment value
  - Ensure that appropriate documentation is created
  - Consult multiple data sources and consider multiple approaches
    - MGMA, AMGA, Sullivan Cotter, HCS, Watson Wyatt
  - Ensure that findings are not based on *tainted* market data
  - Ensure that findings are consistently applied (*i.e.,* reproducible)

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Establishing FMV Internally vs. Outside Consultant

- "Cross walk" the arrangement – Consider whether the arrangement can be supported by non-referral (or non-healthcare) arrangements

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Top 5 Reasons to Redouble Your Regulatory Compliance Efforts

5. If it makes sense in any other industry, it is probably illegal in healthcare.
4. If you are sure you have it legally right, you have probably overlooked something.
3. As soon as you truly have it right, the law can and will change.
2. Just because everyone else is doing it doesn't mean you won't get caught.
1. I can assure you that you do not want to do time cleaning toilets with O.J. Simpson at San Quentin.

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