Navigating Your Way Through Clinical Management Agreements

HCCA Compliance Institute: Session 510
Valerie Cloud, Assistant Regional Corporate Responsibility Officer

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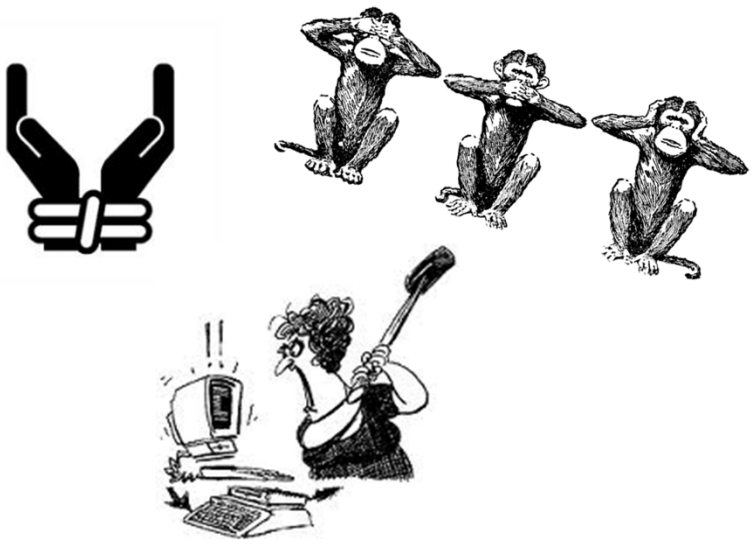
Ever Feel Like…



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Session Objectives

- Keeping an Eye to the Sky: Background and Overview
- Riding the Waves: Regulatory Considerations and Pitfalls
- Compass Pointing Due North: Industry Trends
- Don't Walk the Plank: Best Practices for Effective Collaboration

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Background and Overview

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Types of Agreements

- Medical director
- Co-medical director
- Call coverage
- Independent contractors
- Co-management
- Professional/personal service agreements
- Joint operating agreements

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On the Rise

- Prevalence of agreements with physicians continues to increase due to ongoing changes to health care delivery model (Affordable Care Act)
- Health care entities are looking for ways to capture market share and referrals (organic growth)
- Physicians wish to avoid the burden of operating a private practice in the current environment (healthcare climate)
- Seemingly natural progression for physicians commonly utilizing a particular health care entity

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Potential Trouble on the Horizon

- Cloudy Skies: seems like a good idea, so why the fuss?
- Rough Seas: overlapping contractual obligations
- Compass Malfunction: Fair Market Value ≠ Commercially Reasonable and Existing Community Need
- Iceberg Ahead: OIG Fraud Alert

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20201

Fraud Alert: Physician Compensation Arrangements May Result in Significant Liability

June 9, 2015

Physicians who enter into compensation arrangements such as medical directorships must ensure that those arrangements reflect fair market value for bona fide services the physicians actually provide. Although many compensation arrangements are legitimate, a compensation arrangement may violate the anti-kickback statute if even one purpose of the arrangement is to compensate a physician for his or her past or future referrals of Federal health care program business. OIG encourages physicians to carefully consider the terms and conditions of medical directorships and other compensation arrangements before entering into them.

OIG recently reached settlements with 12 individual physicians who entered into questionable medical directorship and office staff arrangements. OIG alleged that the compensation paid to these physicians under the medical directorship arrangements constituted improper remuneration

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Regulatory Considerations

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Anti-Kickback Statute

Prohibits offering, paying, soliciting, or receiving anything of value to induce or reward referrals or generate Federal health care program business.

Referrals from anyone

Intent: Must be proven (knowing and willful)

Penalties:

- Criminal – fines up to $25,000 per violation; up to five (5) year prison term per violation
- Civil/Administrative – False Claims Act liability; civil monetary penalties (CMP) and exclusion; potential $50,000 CMP per violation; civil assessment of up to three (3) times amount of kickback
- Exclusion from participating in Federal and State funded healthcare programs

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Stark Law

Prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies; prohibits the designated health services entity from submitting claims to Medicare for those services resulting in a prohibited referral.

Referrals from a physician

Intent: No intent standard for overpayment (strict liability); Intent required for civil monetary penalties for knowing violations

Penalties:

- Civil – overpayment/refund obligation; False Claims Act liability; civil monetary penalties and program exclusion for ***knowing*** violations; potential $15,000 CMP for each service; civil assessment of up to three (3) times the amount claimed

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False Claims Act

Imposes liability on any person who submits a claim to the federal government that he or she knows (or should have known) is false.

Includes *qui tam* action.

New Penalties:

- For submitting false statements/records that are material to a false claim or on enrollment application ($50,000)
- For entities that do not provide the government with timely access to the records during an audit ($15,000/day)
- Overpayments - Providers have 60 days to return overpayments once identified or the overpayment may be considered a false claim subject to penalties under the False Claims Act.
- Held Payments – Payments may be held for a provider being investigated under the False Claims Act.
- Liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000 plus three (3) times the amount of damages which the Government sustains because of the act of that person
- Exclusion from participating in Federal and State funded healthcare programs

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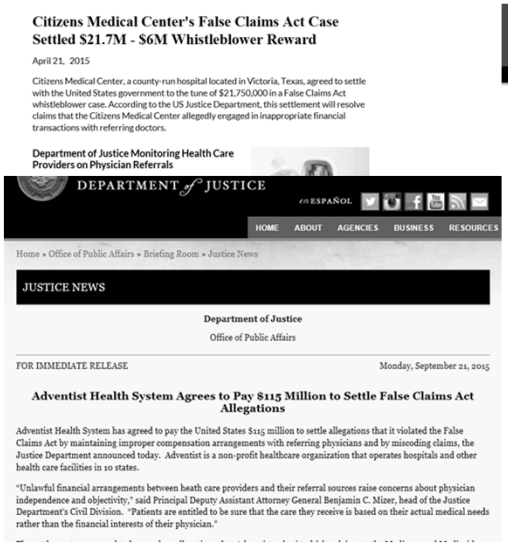
Recent Case Examples



Citizens Medical Center's False Claims Act Case Settled $21.7M - $6M Whistleblower Reward

April 21, 2015

Citizens Medical Center, a county-run hospital located in Victoria, Texas, agreed to settle with the United States government to the tune of $21,750,000 in a False Claims Act whistleblower case. According to the US Justice Department, this settlement will resolve claims that the Citizens Medical Center allegedly engaged in inappropriate financial transactions with referring doctors.

Department of Justice Monitoring Health Care Providers on Physician Referrals

DEPARTMENT of JUSTICE

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JUSTICE NEWS

Department of Justice
Office of Public Affairs

FOR IMMEDIATE RELEASE — Monday, September 21, 2015

Adventist Health System Agrees to Pay $115 Million to Settle False Claims Act Allegations

Adventist Health System has agreed to pay the United States $115 million to settle allegations that it violated the False Claims Act by maintaining improper compensation arrangements with referring physicians and by miscoding claims, the Justice Department announced today. Adventist is a non-profit healthcare organization that operates hospitals and other health care facilities in 10 states.

"Unlawful financial arrangements between heath care providers and their referral sources raise concerns about physician independence and objectivity," said Principal Deputy Assistant Attorney General Benjamin C. Mizer, head of the Justice Department's Civil Division. "Patients are entitled to be sure that the care they receive is based on their actual medical needs rather than the financial interests of their physician."

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Florida health system to pay $69.5 million over Stark, False Claims allegations

By Lisa Schencker | September 15, 2015

A Florida taxing district that operates hospitals in Broward County will pay the government a record $69.5 million to settle allegations that it illegally paid nine

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Attorney General Olens announces settlement with Columbus Regional Hospital System to resolve overbilling and kickback allegations

September 4, 2015

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Recent Case Examples

- ***Adventist Health*** – agreed on 9/21/15 to pay $118.7 million to settle allegations that it violated the FCA by maintaining improper physician compensation arrangements under Stark and AKS
- ***North Broward Hospital District*** – DOJ announced on 9/15/15 a $69.5 million settlement regarding a *qui tam* case alleging Broward was liable under FCA for providing excessive compensation in violation of Stark and AKS
- ***Columbus Regional Healthcare System*** – DOJ announced settlement with CRHS and Dr. Pippas on 9/4/15 for collective total up to $35.425 million to resolve allegations of FCA violations based on upcoded claims and AKS and Stark violations

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Common Pitfalls

- FMV determinations may not be accurate or reliable if based on erroneous underlying information
- Commercial reasonableness when FMV is not the primary issue
- Documentation!
- Consideration of reasonableness of total compensation, to include:
  - Amount of bonuses
  - Potentially duplicative payments
  - Non-cash compensation (reimbursement for personal vehicles)
  - Salaries and other expenses that would otherwise be the obligation of the physician

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Best Practices

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Best Practices

Avoid “badges of fraud”

- Productivity bonuses that include a percentage of the facility fee
- Shopping for legal opinions
- Closing a deal without fully vetting Stark/compliance implications
- Tracking referrals without a compelling, legitimately benign reason
- Full-time benefits for part-time work
- Use of a valuation expert with little/no Stark FMV terminology knowledge
- Identifying conflicts of interest in the due diligence process (pre-acquisition)

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Best Practices

Ensure commercial reasonableness

- Makes commercial sense if entered into by a reasonable healthcare provider entity of similar type and size, and
- A reasonable physician (or group thereof) of similar scope and specialty,
- Even if there were **NO** potential business referrals between parties.
- Pre-transaction due diligence and documentation clearly sets forth strategic objective and business purpose

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Best Practices

- Organization policies
- Organization compensation standards
- Consider a pre-transaction document that memorializes the rationale for the financial arrangement upfront; this will show deliberation, detachment, and judgment
  - Set forth strategic objectives
  - Demonstrate community need for the specialty/service
- Conduct periodic reviews of current arrangements
- Request business validations for current contracts
- Utilize a monitoring tool

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Conclusion

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Practical Application

Example of a timesheet instruction checklist:

- Provide clear guidance to physicians on expectations of information to be captured within timesheets submitted
  - Use timesheet included within contract
  - Complete documentation within timeframe established in contract
  - Do not round up on amount of time spent in duties
  - Entries should be meaningful and detailed
  - Sign and date your timesheet
- Provide clear guidance to managers, directors, and executives on expectations of information they should confirm
  - The contract is current
  - The hours submitted are within the contractual limits set
  - Timesheet is submitted in a timely fashion per the contract
  - Timesheet is dated and signed by the physician

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Practical Application

Example of a monitoring tool:

- Contract terms
- Compensation terms/limits
- Payment reconciliation
- Review process compliance
- Business purpose validation
- Deviations reviewed by Legal
- Action items defined
- Review and certification by hospital management and compliance

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Merritt Hawkins: 2014 Review of Physicians and Advanced Practitioner Recruiting Incentives

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Anti-Kickback Statute - 42 USC § 1320aa-7b(b)

Stark Law – 42 USC § 1395M

False Claims Act – 31 USC §§ 3729-3733

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Contact Information

Valerie Cloud, MBA, CHC, CHPC
Catholic Health Initiatives
Assistant Regional Corporate Responsibility Officer
valeriecloud@catholichealth.net
(502) 587-4103

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