A Strategic Approach to Physician Financial Arrangements

HCCA Kansas City Regional Compliance Conference

September 21, 2018

Presented by: **Shannon Sumner, CPA, CHC®**
Principal, PYA

Susan Thomas, MHSA, CHC®, CIA, CRMA, CPC®
Consulting Manager, PYA

Agenda

- Identify physician arrangement review goals and discuss importance of reviews
- Present significant regulatory and additional considerations
- Present key review components, approach, considerations and deliverables
- Describe corrective actions and detail ongoing physician arrangement monitoring and “best practice” processes
- Present “real world” examples

As We Begin . . .

- What are the goals of a Physician Arrangement Review?
  - Overview and oversight of organization-wide contracting practices
  - Uncover potentially non-compliant arrangements, and bring them to the attention of the compliance officer and legal services
  - Examine compensation to assure consistency with fair market value and commercial reasonableness (“CR”)
  - Ensure all arrangements have necessary, accurate supporting documentation
  - Evaluate for duplicative services and agreements
  - Determine whether contract management system(s) are complete and appropriately maintained

Why are Physician Arrangements Reviews Important?

Physician Contracts

- May include vague language
- Legally complex
- Often multifaceted (i.e., more than one service in a single arrangement)

Why are Physician Arrangements Reviews Important?

- Physician arrangement tracking may not be an organizational priority
  - Contract management is essential to assure that arrangements are current and meet organizational and regulatory requirements
- Subject to aggressive regulatory scrutiny
  - Federal regulations directly affect physician reimbursement
  - Oversight agencies have a stated goal to reduce healthcare fraud, waste, and abuse

Significant Considerations

- Regulations
  - Physician Self-Referral Law (The Stark Law)
    - Exceptions
  - Anti-Kickback Statute
    - Safe Harbors
  - False Claims Act
  - Steep Penalties for Non-Compliance
- Additional Factors
  - Special OIG Fraud Alert
  - Medicare Cost Report Certification Requirements
  - Board of Directors' Commitment and Responsibility

Regulations

The Stark Law

- Applies to physicians and their financial relationship with ALL referral sources
- Prohibits referrals between physicians and entities with which they have financial relationships
- Prohibits billing if prohibited referral
- Sanctions include repayment, fines, and exclusion

Anti-Kickback Statute (AKS)

- Criminal penalties against any individual or entity that:
  - Knowingly and willingly offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to any person to induce:
    - Referrals
    - Purchase, order, or lease

AKS (cont'd)

- Sanctions
  - Applies to Medicare, Medicaid, and other Federal Program Payers
  - Applies to **both** sides of a transaction (i.e., Physician and Hospital)
  - Standard of Proof
    - Beyond a reasonable doubt
    - Knowing and willful violation
    - Circumstantial evidence of intent

False Claims Act (FCA)

- Important government tool, if not *the* most important tool, for demanding healthcare providers' compliance with the requirements of the federal healthcare programs[1]
- Payments to hospitals for services (e.g., physician procedures) that violate Stark or AKS could be considered fraudulent
- Creates liability for anyone who knowingly submits, uses, or causes to be submitted or used a false record, statement, or claim for payment to the government
- Acts in purposeful or deliberate ignorance of truth or falsity, acts in reckless disregard of truth or falsity; proof of intent to defraud is NOT required

[1] Source: White Paper. *The Supreme Court's Decision in Universal Health Services v. U.S. ex rel. Escobar: Professor David Freeman Engstrom Answers Critical Legal Questions*, June 17, 2016

Sanctions: Severe Consequences

The Stark Law

- Civil Penalties:
  - Overpayment/refund obligation/FCA liability/Civil monetary penalties (“CMP”) and program exclusion
  - Potential $23,863 CMP for each service and treble damages

Sanctions: Severe Consequences

Anti-Kickback Statute

- Civil/Administrative:
  - FCA liability/CMPs and program exclusion
  - Potential $100,000 CMP per violation and treble damages
- Criminal Offense:
  - Fines up to $100,000 per violation
  - Up to a ten-year prison term per violation

Sanctions: Severe Consequences

False Claims Act

- CMS claims are subject to Federal & State FCA
- Triggers 60-day overpayment rule[2]

[2] While a small-dollar amount exemption has been proposed, at this time, CMS has declined to establish a regulatory minimum threshold amount in the final rule

Additional Considerations

- OIG Special Fraud Alert[3]
  - June 2015
  - Physician Compensation Arrangements
  - May result in significant liability
  - Physicians must be careful to avoid entering into payment agreements that could violate the Anti-Kickback Statute
  - Federal oversight agencies are increasingly pursuing allegations against individual physicians, as opposed to just the hospitals and other organizations that pay them.
  - A reminder that physicians are accountable for arrangements that could be in violation of the law

[3] Source: https://oig.hhs.gov/compliance/alerts/guidance/Fraud_Alert_Physician_Compensation_06092015.pdf

Additional Considerations (cont'd)

- Medicare Cost Report Certification
  - Allocation of Physician Compensation Hours
    - Physician Administrative Time (Part A)
      - Activities that are designed to help the facility manage the treatment of all of its patients
        - Medical Directors
        - Utilization/Quality Review
        - Department Directorship
    - Physician Patient Treatment Time (Part B)
      - Any time or activity where an MD is working on/for an individual patient
        - Chart Review
        - Intervention
        - Progress Notes
        - Research

Additional Considerations (cont'd)

- Medicare Cost Report Certification
  - Hospital and Health Care Complex Cost Report Certification and Settlement Summary:
    - MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.
    - "…to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and the services identified in this cost report were provided with such laws and regulations."

Additional Considerations (cont'd)

- Board of Directors Responsibility for Physician Compensation Arrangements
  - Closer alignment of hospitals and physicians under new models of care delivery required increased board oversight over incentive compensation arrangements.
  - The Yates Memo's[4] theme on individual accountability leaves little doubt that efforts to assert individual accountability will extend to officers and executives who "lead or participate" in what activities are perceived to be illegal conduct.

[4] Source: U.S. Department of Justice. Office of Inspector General. "Individual Accountability for Corporate Wrongdoing." Sally Quillian Yates. September 9, 2015.

Types of Physician Compensation Arrangements

- Employment
- Professional Services
- Income Guarantee/Support
- Loan Repayment
- Recruitment
- On-Call Pay

- Administrative (e.g., Medical Director Services, Medical Staff Officer)
- Program Advisor
- Committee Work
- Co-Management
- Supervision
- Joint Venture
- Facility and Equipment Lease

Arrangement Review Overview

- First, identify physician arrangement review “team”
- Next, define/refine the review process and approach
  - Understand the current process for arrangement reviews and determine who is responsible for daily management of physician arrangements
- Then, inventory and evaluate!

Review Process and Approach

- Identify the purpose and scope of review
- Define the role of counsel, compliance officer, consultants
- Develop a review work plan
  - Regular team meetings/calls
  - Approved arrangement review checklist
- Identify information needed
  - Contract reports/analysis
  - Access to contracts and supporting information
  - Payment data – A/P, payroll, 1099
- Obtain confidential information in a secure manner

Inventory and Evaluate Arrangements

- There is a written arrangement in place that is signed by both parties
  - Physicians who are bona fide employees do not require a written arrangement, but . . .
    - A written arrangement may help document compliance with other required elements.
    - Recent Stark Law updates allow for the “in-writing” requirement to be satisfied by “a collection of documents”, such as board meeting minutes, written communication between parties, fee schedules, etc.
  - Physicians who are not employed (i.e., independent contractors) must have an arrangement in writing and signed by both parties before compensation is paid or services performed.

Inventory and Evaluate Arrangements

- The arrangement is current
  - An independent contract or agreement to continue performance after the arrangement expired if certain conditions are met, *but*…
    - Failure to have a current written agreement with referring independent contractors could violate Stark.

Inventory and Evaluate Arrangements

- The arrangement for payment is set in advance
  - Compensation formula must be set in advance if physicians will refer services to the organization with which they are under contract
  - The compensation formula for independent contractors must always be set in advance and must not be adjusted retroactively
  - For personal services agreements, the aggregate compensation—not just the compensation formula—must be set in advance

Inventory and Evaluate Arrangements

- The arrangement was negotiated at arm's length
  - The compensation must be fair market value and a result of arm's length negotiations between the two parties
- The term of the arrangement is at least one year and there are no amendments that have changed rate of payment within first year
- There are no implications in the arrangement that indicate there is payment of any kind for referrals
- The service provided is defined in sufficient detail

Inventory and Evaluate Arrangements

- The payment amounts match the terms of the arrangement
- Non-monetary compensation provided to the physician is tracked and reported appropriately
- The terms and conditions of the arrangement are being followed by all parties

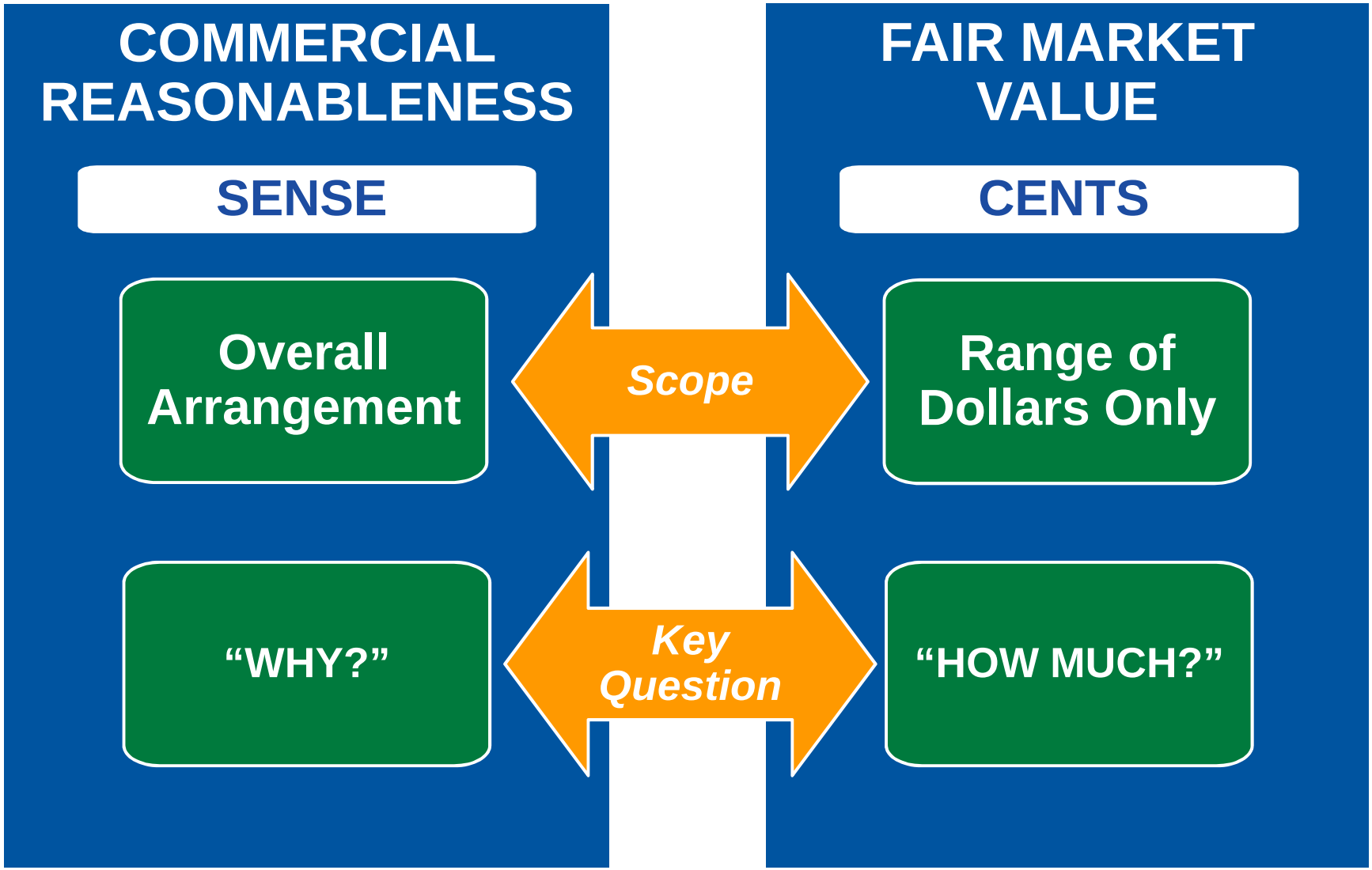
Inventory and Evaluate Arrangements

- There is an approved fair market value ("FMV") process in place
  - Physician compensation philosophy, including approval process
  - Tracking of valuation periods
  - FMV is documented and maintained with arrangement
- The compensation rate is within FMV
  - Consistent with identified services
  - Phase III rule of the Stark Law states that "a reference to multiple objective, independently published salary surveys remains a prudent practice for evaluating fair market value"
  - Benchmarks do not tell the whole story, but instead offer insight

Inventory and Evaluate Arrangements

- There is an approved Commercial Reasonableness (“CR”) process in place
  - Documented best practice for supporting a transaction makes business sense in the absence of a referral stream
  - Quantitative and qualitative considerations
- The arrangement is commercially reasonable
  - Detailed supporting analysis if compensation exceeds collections
  - Is the proposed arrangement reasonably necessary to accomplish a rational business purpose?
  - Are the particular nature of the duties and the corresponding amount of accountability under the proposed arrangement clearly defined and reasonable?
  - Are patient demands, the number of hospital patients, and/or the community need sufficient to justify the services?

Inventory and Evaluate Arrangements



Deliverables

- Contract review analysis summary
  - Provide the background, the scope, the approach, and a synopsis of results
- Identified findings
  - Detail the discoveries sufficiently in order to proceed with action plans
  - Prioritize each finding by evaluating the risk to organization
- Recommended corrective action
  - Based on the level of risk to the organization and risk appetite of governance
- Necessary education and policies
  - The review should identify missing or deficient policies and processes
- Amount of repayments or refunds
  - If the physician was compensated inappropriately, payment for any associated services must be analyzed to determine if repayments or refunds are required

Corrective Actions, Ongoing Physician Contract Monitoring, and "Best Practices"

- Corrective Action is required for non-compliance
  - Termination or amendment of arrangements
  - Implementation of new arrangements
  - Consideration of potential refund or disclosure obligations
- Ongoing Contract Monitoring
  - Physician arrangements must be managed regularly to assure compliance
  - Contract reviews must be a regular part of the compliance work plan
- Best Practices
  - Organizations must stay abreast of current regulations and have a process in place to receive updates
  - Compensation must account for current payment methodologies (i.e., value based purchasing, quality initiatives)

Physician Compensation Settlements

- Mercy Health (Ohio - 2018) [1]
  - Improper relationships with referring physicians
  - Six employed physicians (one oncologist and five internal medicine physicians)that exceeded the fair market value of their services
  - $14.25 million to settle allegations
- Lexington County Health Services District (South Carolina - 2016)[2]
  - Compensation arrangements that did not satisfy all the requirements of any applicable exception to Stark's referral and billing prohibition
  - Caused LMC to submit fraudulent claims to Medicare for designated health services referred by these physicians in violation of the FCA
  - $17 million to resolve liability under FCA
- Mercy Springfield (Missouri - 2018)[3]
  - Improper financial relationships with referring physicians
  - Submitted false claims for chemotherapy services referred by oncologists whose compensation took into account the value of their referrals to the infusion center
  - $34 million to settle allegations

1. https://www.justice.gov/opa/pr/ohio-hospital-operator-agrees-pay-united-states-1425-million-settle-alleged-false-claims-act
2. https://www.justice.gov/opa/pr/south-carolina-hospital-pay-17-million-resolve-false-claims-act-and-stark-law-allegations
3. https://www.justice.gov/opa/pr/missouri-hospitals-agree-pay-united-states-34-million-settle-alleged-false-claims-act

Physician Compensation Settlements

- Columbus Regional Healthcare System (Georgia - 2015)*
  - Excessive Salary and Medical Directorship Payments
  - False Claims Act in violation of Stark
  - $25 million
- North Broward Hospital District (Florida - 2015)*
  - "…awarding lavish employment contracts to physicians with salaries far exceeding fair market value"
  - Stark Law Violation
  - $69.5 million
- Adventist Health System (North Carolina - 2015)*
  - Improper compensation arrangements with referring physicians
  - False Claims Act violation – without Stark Law litigation
  - $115 million

* Source: https://www.bryancave.com/en/thought-leadership/recent-false-claims-act-settlements-highlight-physician.html

Questions?

Thank you!

Shannon Sumner
CPA, CHC®
Principal
ssumner@pyapc.com

Susan Thomas
CHC®, CIA, CRMA, CPC®
Manager
sthomas@pyapc.com

PERSHING YOAKLEY & ASSOCIATES, P.C.
800.270.9629 | www.pyapc.com

ATLANTA | KANSAS CITY | KNOXVILLE | NASHVILLE | TAMPA