H4B. Three Ways Best in Class Physician Compensation Processes Lead to Critical Failure

HCCA 25th Annual Compliance Institute
April 22, 2021

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Objectives

- Learn where best in class policies fail to mitigate risk
- Understand how the Stark law changes impact your process
- Strategies to reduce stakeholder frustration and decrease your risk

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Presentation Overview

- Typical Risk Management Approaches
- Overlooked (and Critical) Process Areas
  - Enterprise evaluation of physician compensation arrangements
  - Pre-Review (Arrangement Conceptualized and Negotiated)
  - Review/Approval Process (Often the primary risk control)
  - Post-Approval (Arrangement Operationalized and Monitored)

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TYPICAL RISK MANAGEMENT APPROACHES

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Common Features: Physician Financial Arrangement Controls

- Use of template contracts; written policies and procedures for approval of compensation arrangements
- Focus on FMV:
  - Usually not considering other factors
  - Case by case determinations of FMV for individual
  - No effort to identify enterprise-level outlier patterns
- Focus on justifying arrangement – not independent or critical review/approval framework
- Approvals generally by executives with good reasons for wanting all arrangements to be deemed FMV
- Variability in how/if commercial reasonableness is assessed

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Common Features: Physician Financial Arrangement Controls (cont.)

- Creation of written "justification" for the arrangement
  - May or may not include rationale for determination that arrangement is commercially reasonable
  - File does not include the pre-arrangement emails between the parties, other business analysis related to the compensation level decision such as estimates of downstream referrals, etc.
  - No independence with respect to individuals reviewing

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Common Threads in Cases Where Fraud and Abuse is Alleged

- Allegations of physician overpayment typically surface in the backdrop of bad facts such as:
  - Patterns of questionable behavior
  - Signs that transactions were motivated, even in part, by a desire for referrals
- Allegations of payments above FMV rarely supported by any thorough or objective analysis
- Most defendants had in place some sort of review and approval process.

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Wheeling Example:
DOJ RELEASE SEPTEMBER 9, 2020

- **West Virginia Hospital Agrees to Pay $50 Million to Settle Allegations Concerning Improper Compensation to Referring Physicians**
- ". . . the United States alleged that, from 2007 to 2020, under the direction and control of its prior management, R&V Associates, Ltd. and Ronald Violi, Wheeling Hospital **systematically** violated the Stark Law and Anti-Kickback Statute by knowingly and willfully paying improper compensation to referring physicians that was based on the volume or value of the physicians' referrals or was above fair market value.

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DOJ Signaling to Us in Wheeling Hospital Case Many of Their Enduring Concerns

- Hospital profitability grew primarily as a result of payments to physicians in an effort to create better alignment.
- High payments were generally supported by benchmarking and/or third party FMV reports.
- Independent physicians who generated high referrals were strategically targeted.
- Hospital was inconsistent in its application of benchmarks – they relied on whatever measure appeared to demonstrate FMV.
- Exceptions to standard review processes were made for some highly paid physicians
- Downstream referrals were explicitly measured and discussed

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Missed Risk Management Opportunities: Enterprise Level Evaluation of Physician Compensation Arrangements

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Stark: "Fair Market Value"

- FMV "may not always align with published valuation data compilations, such as salary surveys"
- Rate of compensation set forth in a salary survey may not always be identical to the worth of a particular physician's services
- Independent valuation is NOT required for all compensation arrangements

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FMV Example in Stark Final Rule (84 FR 55799)

- Hospital wishes to meet request for "benchmark wage" of $250,000 relevant to a hypothetical (unidentified) physician
- Fair market value of the physician's compensation may be less than $250,000 per year
- Consider a broad range of factors such as experience, training, cost of living, proximity to good schools and recreation opportunities, declining reimbursement rates, poor payor mix, hospital's tenuous economic position, etc.
- Cannot simply cherry pick those factors supporting higher pay, and disregard factors that indicate lower pay

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Contrasting Compliance Approaches: Physician Arrangements vs. Coding

Program Element	Physician Compensation	Coding and Documentation
Independence	Review and approval by executives who want all arrangements to be deemed proper	By independent reviewers who have no interest in deeming all transactions proper
Pattern Identification	Case by case review of arrangements	Spot review with emphasis on identification of anomalous outlier patterns in the population
Risk Priorities	Process tends to be static	Process changes based on new information regarding risk priorities
Confidential Reporting and Response	Suspected misconduct rarely acted on, or even reported	Reporting and remediation programs are well established

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The FMV Conundrum Highlighted in Stark

- Stark asserts that median wages might be excessive in some cases
- Yet median (and often 75th percentile) is commonly regarded as presumptively FMV
- Analogy: Potential upcoding in E/M services
  - Cannot treat all level 4 (or even level 3) services as presumptively correct
  - Likewise, cannot treat all payments as presumptively FMV, simply because they are below the 75th (or even 50th percentile)
- Compliance in physician compensation, like in coding and documentation, requires, development and testing of controls and pattern identification within a population

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Enterprise Level Controls

- Individual variation is expected, but across an entire group, the level of variation should be less (highly paid balanced against non-highly paid)
- Identify enterprise-level outlier patterns
  - Assign benchmark percentile values for all physicians (total cash compensation, compensation per WRVU, compensation to collections)
  - Expect uniform distribution around market median
  - Monitor for high number of medical directorships and paid hours
  - Investigate WRVU accuracy when disproportionate share of physicians are highly productive
- Most process are designed to cherry pick facts that "justify," and categorically disregard non-supportive facts
- Look for ways to improve independence of reviewers

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Missed Risk Management Opportunities: Pre-Review (Arrangement Conceptualized and Negotiated)

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Pre- Approval Controls

- Ensure recruitment plan is well thought out
- Establish process and guidelines regarding who can conceptualize and negotiate contracts
- Ensure individuals involved in this stage of process are:
  - Well-trained, including regarding communication with physicians
  - Understand their negotiating boundaries
  - See commercial reasonableness as driving principle
  - Coached as to how to handle physician "demands"
- Establish procedures to document the process

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Missed Risk Management Opportunities: Review/Approval Process

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Review/Approval Controls

- Independence is essential
- Not everyone needs to sign/avoid excessive forms
- Review and approval processes must change in response to enforcement priorities and findings from internal risk assessments
- FMV of an individual doctor is only one aspect of review
  - Reduce outlier occurrence, evidenced by enterprise-level risk indicators
  - Enterprise level risk indicators allow for less fixation on rationalization of individual outliers
  - After all, it is a statistical certainty that 25% of doctors in the United States will be paid above the 75th percentile
  - Be skeptical of the claim that "this" market has to pay premium, because nearly all physician employers have the same belief

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Commercial Reasonableness (CR)

- CR is a component in essentially all F&A allegations, and frequently was the causal factor in a case arising
- CR tends to be more difficult to assess than FMV
  - Although FMV involves some subjectivity, it is a well-defined term with established methodologies for measuring it
  - CR is defined inconsistently, and there are no commonly accepted methodologies for measuring
- Commercial reasonableness is really a code of conduct
- Consistently assess and document CR

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Elements of an Internal Assessment of CR

- What legitimate business purpose has been defined in advance, and that does not take into consideration the volume or value of referrals?
- Why are the services necessary to accomplish the legitimate business purpose?
- Why is this arrangement better than the alternatives (including not entering into any arrangement)?
- To the extent any terms that differ from what is customary, what is the rationale?
- Have reasonable performance expectations been defined, and how will performance be monitored and verified?

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Missed Risk Management Opportunities: Post-Approval (Arrangement Operationalized and Monitored)

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Post Approval Controls

- Create process to operationalize
  - What assumptions are in the FMV opinion
  - What monitoring is assumed by opinion
  - Individuals monitoring clearly understand their role and specific monitoring they need to do
- Monitor at an enterprise level
- Consider feedback loop for identified changes in response to new information about enforcement priorities and findings from internal risk assessments

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Final Takeaways

- If common risk management principles are absent in the physician compensation review process, your board might erroneously assume you've done the best job you could
- There is no such thing as having no risk in physician compensation arrangements. If you can't describe your risk profile through a systemwide analysis, it's probably higher than you realize

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Questions?

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