The Compliance Officer’s Role in Physician Contracting

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Curt Chase
Chair, Healthcare Dept
Husch Blackwell LLP

Jim Passey
Director, Compliance & Internal Audit Services
Huntington Hospital

Daniel Stech
Principal
The Pinnacle Group

Goals

1. Identify risk areas and liability trends related to hospital-physician relationships and compensation arrangements

2. Describe key elements of effective compliance strategies (including audit tools) for hospital-physician financial relationships

3. Discuss compliance’s role in addressing hospital / physician contracting and new physician integration strategies (ACO arrangements and other market driven changes)
Preliminary Comments

Where Has Compliance Historically Focused?

- Common compliance areas:
  - Billing Issues
  - HIPAA Privacy and Security Issues
  - Research Issues
  - Conflicts of Interest

- Larger organizations often have dedicated compliance staff in each of these areas
Where Should Compliance Be Focused?

- Compliance is not just a reimbursement issue anymore.
- The largest hospital settlements and government’s fraud and abuse focus is on hospital / physician financial relationships.

Quiz

What do you know about physician contracting?

1. Are physicians employed or independent contractors?
2. Is there a contract approval process and who is involved (board, legal, finance, compliance)?
3. Do physicians have written agreements?
4. How are physicians compensated (production, fixed rate, hourly)?
5. Is FMV determined and documented? How?
6. Is the compensation structure periodically reviewed?
7. Does physician compensation include ancillaries or only personally performed services?
8. Do physicians complete and submit time records for non-clinical time?
9. Do contracts meet a Stark exception? Anti-kickback safe harbor?
10. Is the POS billed correctly for physician services?
Risk Areas and Liability Trends in Hospital / Physician Contracting

Erlanger Medical Center: The “Poster Child”

- $40 Million Stark and Anti-kickback settlement in October of 2005

- The investigation focused on:
  - Physicians’ relationship with hospital
  - Contracts involving physicians who served on the Erlanger Board
  - Board members and possible conflicts of interest
  - Records of hospital’s compliance program
  - Time records / supporting documentation for medical directors

- Erlanger general counsel said activities at Erlanger “were perfectly consistent with what a lot of hospitals have done. It is unfortunate that Erlanger has to be the poster child.” The Chattanooga.com

- As part of this settlement, federal officials said they planned to vigorously prosecute others as well.
Memorial Medical Center and Related Physician Groups

- $5 Million Stark and False Claims settlement
- Began as a whistle-blower claim by a physician that focused on:
  - Payments made by hospital to a non-profit subsidiary that employed ophthalmologists
  - Payments for production, indigent care, and teaching activities
  - However, subsidiary group did not split compensation based on who performed indigent care and teaching, but instead used compensation to retain certain physicians
- Illustrates increased focus on hospital employed physician relationships and “follows the money” to determine if compensation is for actual services rendered

Cardiologists’ Settlement

- Investigation of several cardiologists and a New Jersey hospital’s cardiology program – allegedly a $36 Million kickback scam
- Several cardiologists settled for multiple times their annual salary
- The investigation centered around:
  - Hospital’s failing cardiology program
  - Hospital paid 18 cardiologists as “clinical assistant professors”
  - Cardiologists did not provide the level of academic services required under contract
  - Prosecutors alleged that the arrangements were a scheme to pay for referrals
Texas Settlement

- $1.9 Million Stark and False Claims settlement
- The issue:
  - Orthopedic group utilized space owned by hospital without paying rent
  - Physicians in group referred orthopedic patients, services, and items to hospital
- Hospital self-disclosed arrangement after conducting an internal compliance audit

HealthSouth and Physicians

- $14.9 Million Stark, Anti-kickback, and False Claims settlement
- Settlement involved both HealthSouth and 2 affiliated physicians involved in the arrangement
- Allegation: Physicians received payments above FMV pursuant to sham medical director agreements
- OIG concerned about hidden financial arrangements between healthcare providers that influence where treatment is provided and what treatment is received
Lester E. Cox Medical Centers: The “New” Erlanger

- $60 Million Stark, Anti-kickback, and False Claims settlement
- DOJ compared Cox to Erlanger
- The investigation focused on:
  - Cost reporting violations
  - Inappropriate financial relationships between Cox and its contracted physicians (compensation formula and medical director relationships)
  - Flawed dialysis billing methodology

St. John Medical Center

- $13 Million settlement resulting from a voluntary self-disclosure to OIG
- Involved numerous physician agreements that did not comply with Stark and Anti-kickback laws:
  - Some not in writing
  - Question of whether services provided / documented
  - Fair market value issues
  - Contract term problems – too long
Tuomey

- Qui tam lawsuit brought by whistleblower
  - Alleged that part-time physician employment agreements entered into by Tuomey were above fair market value and not commercially reasonable
  - Notable that Tuomey had obtained fair market value opinions approving the arrangements
- Jury held that Tuomey violated the Stark Law, but not the False Claims Act
- Court subsequently awarded $44.9 million (plus interest) in damages to the government related to Stark Law violations
- Court also ordered a new trial on the issue of False Claims Act liability
  - Up to $275 million in additional damages and fines at stake

Health Alliance of Greater Cincinnati and Christ Hospital

- $108 Million settlement resulting from a qui tam lawsuit brought by a cardiologist
- Government alleged that the Health Alliance of Greater Cincinnati and Christ Hospital violated the Anti-kickback Statute and the False Claims Act due to “pay-to-play” scheme
  - Hospital allegedly limited the opportunity to work at the Heart Station — a center where patients received non-invasive procedures such as electrocardiograms and stress tests — to those cardiologists who referred cardiac business to the hospital
  - Cardiologists were rewarded with a percentage of time at the Heart Station based on their contributions to the hospital’s yearly gross revenues
Detroit Medical Center

- $30 million False Claims Act settlement entered into by DOJ and hospital
- Although some financial relationships covered by the settlement involved compensation that exceeded fair market value, most of the violations were largely “technical” Stark violations
  - Agreements not memorialized in writing
  - Tickets for sporting events and meals provided to physicians that exceeded the annual monetary limits permitted by the Stark Law
  - Some physician contracts not signed

Themes of Stark & Kickback Concerns

- Clear focus on all hospital / physician financial relationships
  - Medical director relationships
  - Part-time deals
  - Call Coverage
  - Joint ventures / under arrangement deals / clinical co-management arrangements
- Employment arrangements are not the safety net – watch for:
  - Long term commitments
  - Fair market value issues
  - Duties well documented
  - Inclusion of ancillary / technical revenue in compensation formulas
  - WRVU arrangements that are not “pure”
  - Payment for quality and other efforts that cannot be documented
Themes of Stark & Kickback
Concerns

• New models require renewed focus on structures and payments to comply with Stark and Kickback – particularly new models being discussed as part of healthcare reform.

• Stark is strict liability and therefore very important to get it right from the start.

• Watch for “bad” documents (i.e., business plans) that are created to support a deal and evidence wrongful intent triggering Kickback scrutiny – “One Purpose Rule”

Key compliance strategies for hospital-physician financial relationships
Compliance Strategies

• Fair Market Value: Just the “VERY” Basics
• Common Arrangements and Considerations
• Tools for Evaluating Compensation Arrangements
  • Key Questions
  • Compliance Hazards
  • Risk Assessment

FMV: The “VERY” Basics

• Applicable in the context of Medicare and IRS compliance.
  • Anti-Kickback Statute, Stark Law and Tax-exempt organizations
  • Exceptions exist to permit and govern financial relationships between hospitals and physicians

• Definition excerpted from Stark:
  • “Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.”

• Valuation Methods
  • Income, Cost and Market
    • Market Approach is generally applied to Professional Service Arrangements
  • Valuation models leverage data and reflect assumptions (quantitative and qualitative) about the arrangement to derive an FMV range
    • Common data sources include MGMA, Hay Group, Sullivan Cotter, AMGA and others
Common Arrangements

- Employment Agreements
- Professional Service Agreements
- Medical or Program Directorship Agreements
- Call or Clinical Coverage Agreements
- Independent Contractor Agreements
- Shared Use or Cost Agreements
- Lease Agreements
- Management Service Agreements

Key FMV and Contract Considerations

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<thead>
<tr>
<th>Employment</th>
<th>ER Call</th>
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<tr>
<td>- Specialty</td>
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<td>- Method of Compensation</td>
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<td>- Productivity / Performance</td>
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<td>- Risk / Incentives</td>
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<td>- Special Qualifications</td>
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<td>- Recruitment Issues</td>
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<td>- Additional Duties</td>
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<td>- Sign-On Bonus</td>
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<td>- Tail Coverage</td>
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<td>- Specialty</td>
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<tr>
<td>- Restricted / Unrestricted / Blended</td>
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<tr>
<td>- Amount of Time On Call</td>
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<td>- Number of MDs in Call Rotation</td>
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<td>- Frequency of Call</td>
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<td>- Acuity of Cases</td>
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<td>- Payer Mix / Uninsured Case Volume</td>
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<td>- Professional Fee Collections</td>
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<td>- Interdependence with Other Services</td>
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<tr>
<th>Medical Director</th>
<th>Management Services</th>
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<tr>
<td>- Specialty</td>
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<td>- Qualifications</td>
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<td>- Duties</td>
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<td>- Time per Month</td>
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<td>- Multidisciplinary Involvement</td>
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<td>- Physician Behavior</td>
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<td>- Quality Influence</td>
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<td>- Scope of Services</td>
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<td>- Prevailing Costs of Services</td>
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<tr>
<td>- Staff, supplies, billing, equipment, etc.</td>
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<td>- Lease / Rental Rates</td>
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<td>- Profit Considerations</td>
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<td>- Reasonable Rate of Return</td>
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Key Questions for Compliance Officers Regarding Financial Relationships with Physicians

1) Are services provided by the physician real and necessary?
- Why do we need them?
- Will they be performed?
- How will the services be tracked?

2) What alternatives were considered?
- Why were the alternatives excluded?

3) Are the payment terms within fair market value?
- What method(s) were used to determine fair market value?
- Is there an independent FMV opinion?
- What data was used in the analysis?
- How long is the FMV valid?

4) Is the arrangement commercially reasonable?
- Are such arrangements common in the industry/market?
- Does it make economic sense?

5) Are the terms of the arrangement consistent with others?
- If they are different, can you explain why?

Top 10 Compliance Hazards in Physician Compensation Plans

10. Total compensation exceeds Fair Market Value.
9. Designated Health Service revenue credited to physician in collections-based compensation models.
8. Using Total RVUs instead of WRVUs in RVU-based comp. models.
7. Modifiers not accounted for in WRVU-based comp. models.
6. Crediting physicians for services rendered by non-physician providers (collections or WRVUs).**
5. Providing an excessive escalation in compensation models with high base compensation and graduated payment formulas.
3. Not accounting for payer mix or collections in Call arrangements.
2. Excluding pay for call, directorships or other duties in FMV evaluation of Total Compensation.
1. Unsigned or expired contracts.
FMV Risk Assessment for Physician Contracts

• See Appendix

Compliance officer’s role in hospital / physician contracting and integration strategies
Practical Challenges

• Turf Issues
  • Compliance officer not traditionally involved in physician contracting
  • Physician contracting often deemed the role of the practice group administrator, CFO, business development or in-house counsel
  • Often viewed as a “business” negotiation, not a compliance concern

• Questioning Authority – Real Examples:
  • CEO “owns” certain contracts and does not allow compliance review
  • General counsel tells compliance officer “I’ve got contracting under control – no need to get involved”

What Not To Do

It is not the compliance officer’s job to:
• Negotiate agreements
• Determine duties
• Set compensation
• Determine FMV
• Make business decisions
What To Do - Effective Physician Contract Compliance Strategy

1. **Document Management** - ensure that a proper document management system is in place (paper and/or electronic)
   - Important to be able to track all contracts for compliance with Stark (master list), respond to government requests, and to update agreements when laws change
   - Organize contracts by type of arrangement
   - Assemble all supporting documents with copy of the contract (e.g., FMV study, board approval, community needs assessment, etc.)
   - Establish triggers for milestones of action (e.g., filing of reports, submission of payment requests, contract renewals, routine review of compensation amounts, etc.)
   - Tailor to the size and complexity of your organization

2. **Education** - Provide or coordinate education for executives who negotiate agreements, set compensation, and manage physician relationships
   - Need constant updates on changes to applicable laws and regulations (i.e., Stark, Anti-kickback, IRS rules, etc.)
   - Acceptable methodologies to use in determining compensation amounts
   - Individuals involved in physician contracting will be held personally responsible
   - Avoid contracting mishaps and having to renegotiate deal terms
3. Audit - Develop and implement an audit process
   • Periodically audit to ensure that the process for contract approval is followed
   • Confirm that payments to physicians follow contract terms and that original arrangement is still being honored (i.e., no “scope creep”)
   • Identify contracts that require updates (both legal and business updates)
   • Determine that contracts not recently reviewed or renewed are still valid and necessary
   • Follow-up with executives on problematic arrangements
   • Report findings to administration and board

4. Review Process - Ensure that an appropriate review process exists
   • Documentation of need for the services
   • Verify that a supportable FMV analysis was performed
   • Compensation formula is appropriate and can be implemented
   • Confirm agreement meets legal requirements
   • Meets rebuttable presumption if organization is a tax-exempt entity
   • Ensure that the arrangement has been approved by the board, committee, or other designated group other than the person negotiating the contract
What To Do - Effective Physician Contract Compliance Strategy

5. Compensation Philosophy - Establish an organizational physician compensation philosophy
   • Promotes consistency
   • Ties compensation in a given arrangement to the mission of the organization or strategic goals
   • Helps explain why and/or how compensation is determined
   • Can provide a backstop for managers in negotiations with physicians

6. Service / Staffing Need - Create protocol for determining physician service / staffing need
   • Devise criteria for common types of physician arrangements
   • Create documentation and historical record of decision-making

What To Do - Effective Physician Contract Compliance Strategy

7. Data Use - Draw upon and use a consistent source of data
   • Consider multiple surveys; know the limitations
   • Set thresholds for additional due diligence or FMV review

8. Exceptions - Define protocol for handling exceptions
   • High value or unique compensation arrangements
   • New or previously uncompensated arrangements
   • Additional due diligence – coding review, quality assessment, independent FMV support, etc.
   • Work with counsel to evaluate arrangement and compensation terms
What’s Next?

New Models

- Healthcare Reform will bring new models and structures for hospitals and physicians
  - New forms of integration
    - Accountable Care Organizations
    - Medical Home approach to providing care
    - PHOs Part II
- New relationships that will need significant compliance focus
  - Current laws and regulations will need to change
    - Implications for Stark, AKS and CMP laws
    - Shared savings arrangements (gainsharing)
    - Shared / global bundled payments (antitrust issues)
New Models

• Many operational issues to facilitate new models are still to be discovered
  • Technology and reporting is central to many clinical quality improvement programs
    • Privacy and data sharing concerns may be elevated
    • Potential for other, new compliance considerations

• Physician contracts and compensation
  • New models will promote different physician behaviors
  • Incentives tied to quality and savings rather than volume

Questions?

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Physician contracts are evaluated to ensure payment terms are within Fair Market Value. If physician contracts that result in compensation exceeding 75th percentile benchmarks are reviewed by an independent appraiser.

Physician contracts that result in compensation exceeding 75th percentile benchmarks are reviewed by an independent appraiser.

Productivity-based physician compensation plans do not pay incentives per WRVU in direct correlation to WRVU productivity (i.e. 75th percentile WRVU productivity does not receive 75th percentile dollars per WRVU credit).

All sources of physician pay (e.g., salary, sign-on bonus, directorships, etc.) are considered when evaluating total compensation for fair market value.

Compensation for emergency call services is only paid when employed physicians provide a disproportionate level of call per month.

Productivity-based FMV evaluations adjust physician productivity for CPT modifiers (e.g., -81, Surgical Assist, etc.).

Productivity-based FMV evaluations adjust physician productivity for WRVUs performed by Non-Physician Providers.

Market-based FMV assessments blend data from multiple published surveys rather than relying on a single survey source.

Compensation guarantees based on FMV assessments are limited to three years or less.

Payment for emergency call considers physician opportunity to generate professional collections for ED cases.

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<th>TOTAL SCORE</th>
<th>RISK ASSESSMENT</th>
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<td>10 to 15</td>
<td>Low – Your organization’s approach to compliance appears very strong.</td>
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<tr>
<td>16 to 20</td>
<td>Moderate – Weaknesses within your approach to FMV compliance may present risk.</td>
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<tr>
<td>20 to 30</td>
<td>High – Time for a complete review of your physician contracting methods and payment terms.</td>
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