Show Me the Money!

Auditing Alternative Physician Compensation Arrangements

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PYA, P.C. is a national healthcare advisory services firm providing consulting, audit, and tax services including:

- Regulatory compliance
- Risk assessments
- IT advisory
- Mergers and acquisitions due diligence
- Fair market value assessments
- Business valuations
- Strategic planning
- Operations optimization
- Tax, audit, and assurance

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- Banking and financial services
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- Corporate and business transactions
- Data privacy and cybersecurity
- Education law
- Employee benefits
- Energy law
- Environmental law
- Governmental affairs
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- Higher education
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- Labor and employment
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- Nonprofit and tax-exempt organizations
- Real estate
- Special districts
- Tax credit finance and opportunity zones
- Tax, trusts, and estates
- White collar defense and investigations

Introductions:
Beyond the Suit…Tynan Kugler

Tynan O. Kugler
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Consulting Principal

PYA

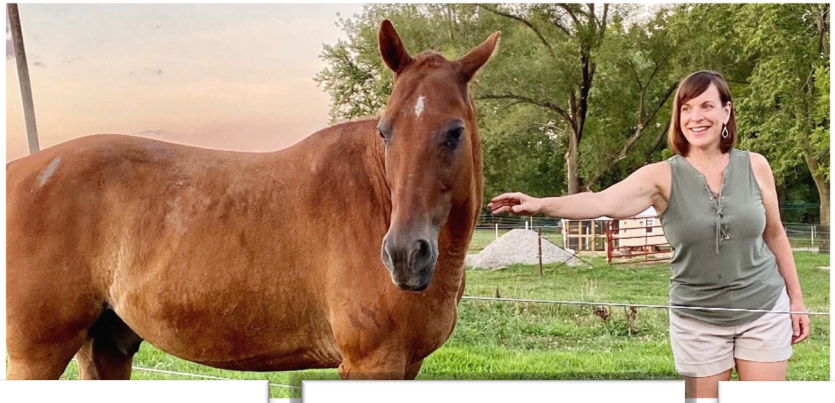
Introductions:
Beyond the Suit…Julie Roth

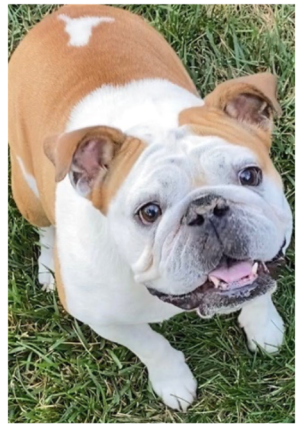
Julie Roth

MHSA, JD, RHIA

Partner

SpencerFane®

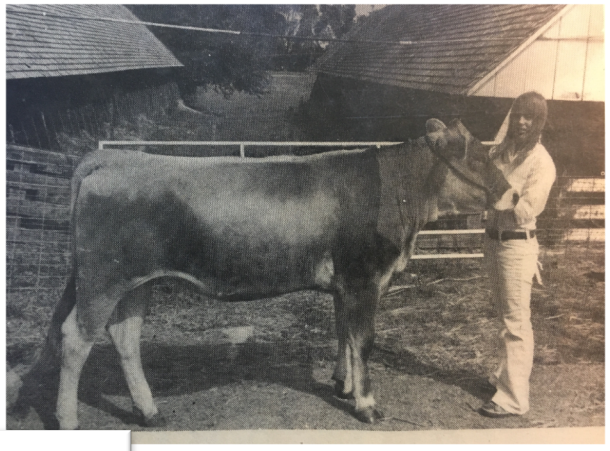


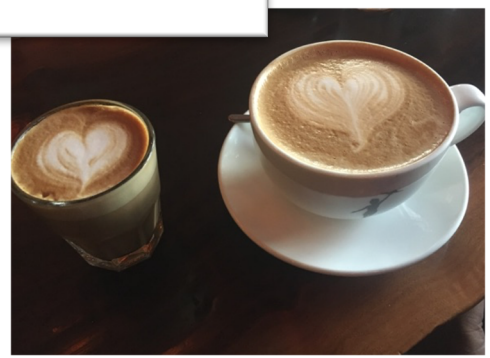


Introductions:
Beyond the Suit…Susan Thomas

Susan Thomas
MHSA, CHC, CIA, CRMC, CPC, CCSFP, CHIAP
Senior Manager

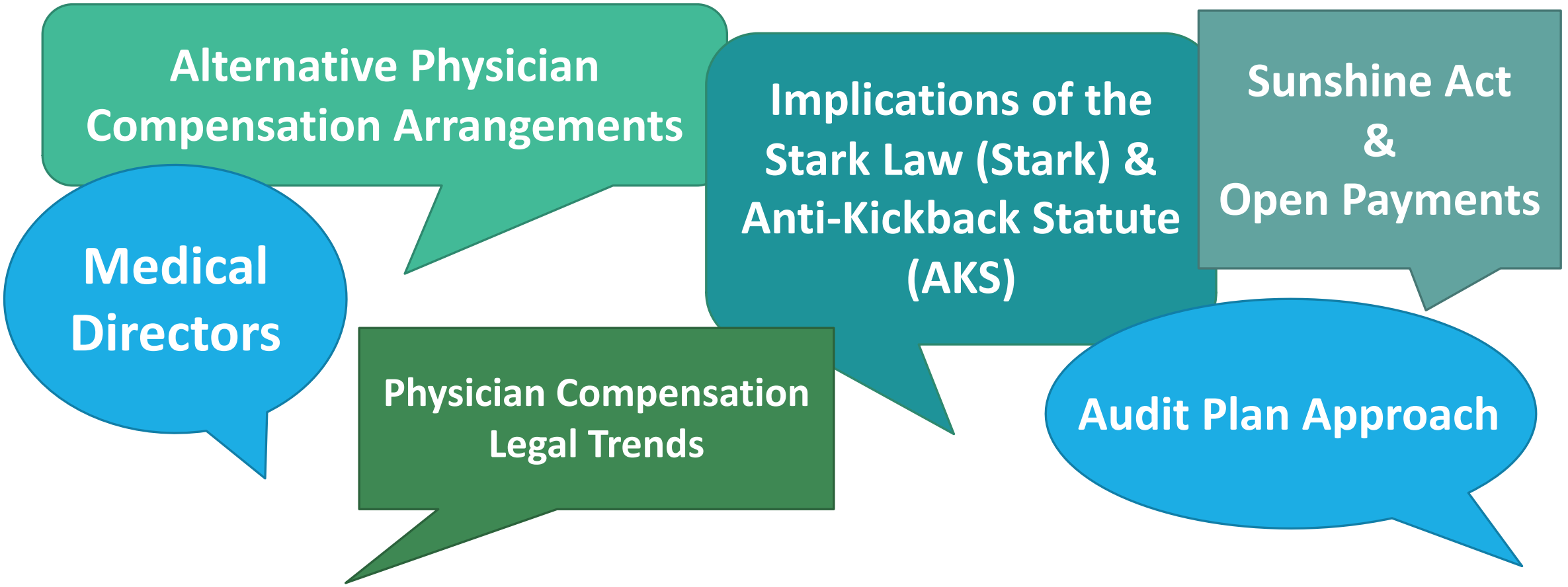
PYA





Polling Question #1

Topics of Discussion



The Tale of Physician Compensation Arrangements . . .

Image Source: Shutterstock.com

What is Currently Happening in Healthcare Regarding Physician Compensation?

Alternative Physician Compensation Arrangements

- ✓ Medical Director
- ✓ On Call Coverage
- ✓ Administrator
- ✓ Vice President of Medical Affairs
- ✓ Chief Medical Information Officer
- ✓ Chief Medical Officer

- ✓ Chief of Staff
- ✓ Section Chief
- ✓ Department Director
- ✓ Teaching Physician
- ✓ Locum Tenens
- ✓ Chief Transformation Officer
- ✓ Chief Administrative Officer

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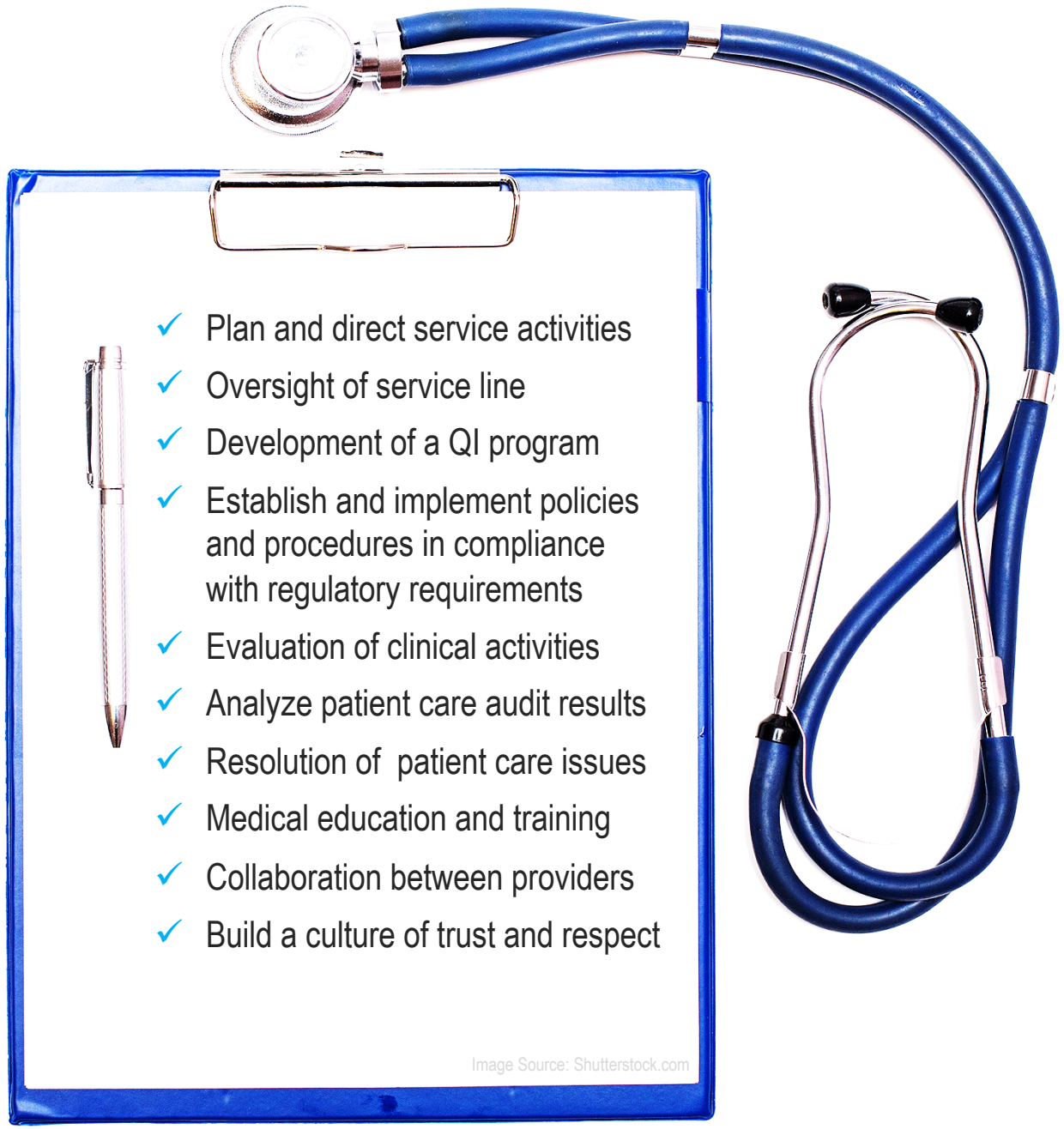
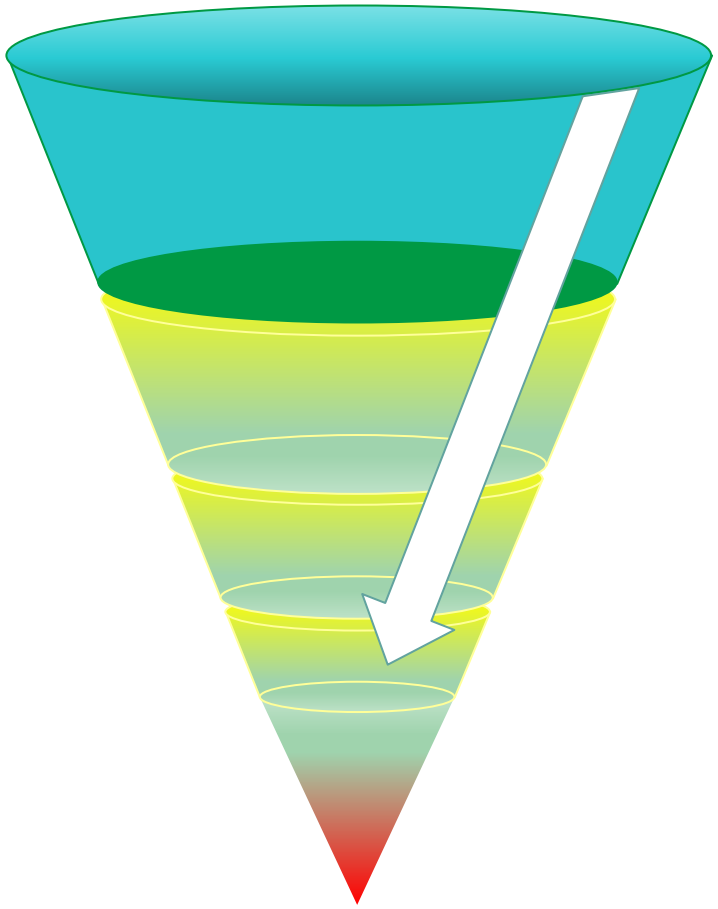
Polling Question #2

Medical Directors

Roles and Expectations



Medical Directors: Need Determination



Determine which medical director positions are required by federal and/or state law and/or otherwise required for regulatory or accreditation purposes.

Evaluate whether market comparisons are available for each identified position. Consider the number of hours provided, the size of the department, and the number of locations overseen by the medical director. Consider additional criteria including, but not limited to, robustness of duties, perceived value to hospital etc.

Consider whether any of the medical directorships cannot be adequately supported based on the information available.

Create the Outline First. . .

- Review, refine, and document the current medical directorship philosophy, focusing on the following:
  - The mission of hospital's medical director program.
  - The process for determining the need for a medical director
  - Maintenance and management of the medical director program, including but not limited to:
    - A policy that requires times sheets for all medical directors be completed and audited monthly
    - A process for when compensation is included in base compensation versus under a separate agreement
    - An annual review of individual medical director arrangements focused on **1)** supporting reasons for continued need, **2)** amount of physician time incurred, and **3)** the resulting accomplishments versus identified expectations
- Create a defined process for determining the need for a medical directorship position versus a managing physician or program director role.
  - Identifying the primary responsibilities for each role and creating a clear distinction in responsibilities for each role eliminates potential for overlapping responsibilities between administrative positions.

Polling Question #3

Stark & AKS

$1.25 MILLION	$3.6 MILLION	$35 MILLION	$85 MILLION	$575 MILLION	$2.6 BILLION

Anti-Kickback Law

"In some industries, it is acceptable to reward those who refer business to you.

However, in the Federal health care programs, **paying for referrals is a crime**."

– The U.S. Department of Health and Human Services Office of Inspector General ("OIG")

AKS

In a nutshell:

- It's illegal to ask for or receive (or to offer or give) anything of value to induce or reward referrals of federal healthcare program business.

Examples of "value" include:

- Cash
- Free rent
- Expensive hotel stays and meals
- Excessive compensation
- Gifts, gratuities, business courtesies
- Free services (e.g., labor, education, computers)

"One-Purpose" test:

- The intent to induce referrals does not need to be the primary or sole reason for the remuneration, but need only be one among many, otherwise legitimate, reasons.
  - See US v Greber, 760 F.2d 68 (3d Cir. Pa. 1985).

Penalties:

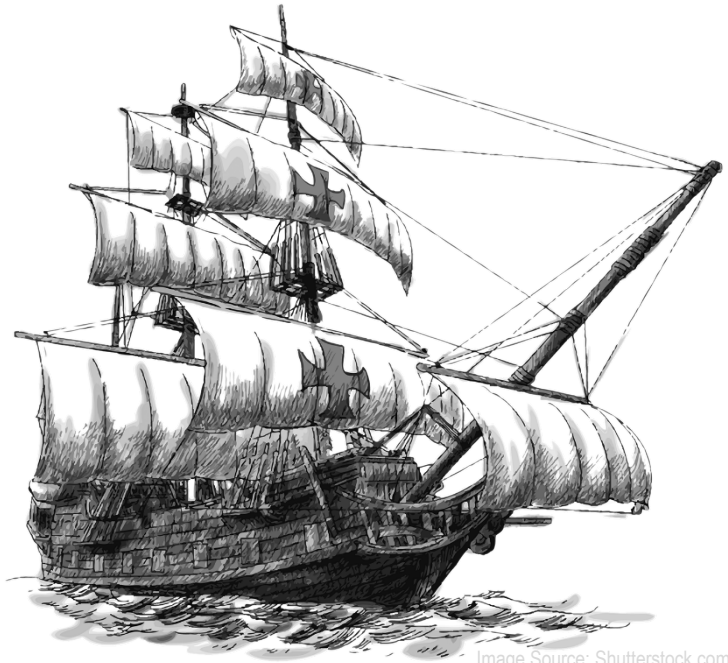
- Civil monetary penalties + ***treble damages***
- Incarceration
- Exclusion from federal healthcare programs

Examples of Problematic Arrangements

- Paying a referral sources for a medical directorship, but no evidence of services provided
- Providing free or below Fair Market Value (FMV) services to referral source
- Relieving referral sources of financial burdens they would otherwise incur (e.g., free off-site CME, paying for advertising)

AKS “Safe Harbors”

- Arrangements that fit within certain “safe harbors” are protected (e.g., space rental, management services)
- Arrangements that do not fit within a “safe harbor” are not automatic violations, but subject to scrutiny
- Themes of safe harbors:
  - FMV transaction
  - Commercial reasonableness
  - Compensation set-in-advance,
    - **NOT** tied to volume or value of referrals or other business
  - Written, signed agreements



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Polling Question #4

Anti-Kickback Headlines

KAN. REFERRAL ARRANGEMENT VERDICT:
GUILTY DECISION MAY PROMPT HOSPITAL EXECS TO REVIEW CONTRACTUAL RELATIONSHIPS, SET UP LEGAL SAFEGUARDS

(Modern Healthcare, April 12, 1999)

West Virginia Hospital Agrees to Pay $50 Million
to Settle Allegations Concerning Improper Compensation to Referring Physicians

(US Department of Justice, Sept. 9, 2020)

Physician Self-Referral Law (Stark Law)

In a nutshell:

- Prohibits a hospital (and other "Designated Health Service" (DHS) entities) from billing Medicare for certain services referred by physicians with whom the hospital/DHS entity has a financial relationship, unless that relationship satisfies one of the law's statutory or regulatory exceptions.

Penalties:

- Strict liability applied (intent not relevant)
- Amount of reimbursement for prohibited claims
- Civil Monetary Penalties of $15K per claim
- Treble damages

Examples of Exceptions:

- Employment agreement
- Lease of space, equipment
- Personal services arrangement

Common Themes of Exceptions:

- FMV
- Compensation not tied to volume or value of referrals or other business
- Commercial reasonableness
- Compensation set-in-advance
- Signed writing
- Terms of at least 1 year

Common Stark Compliance Issues

Failure to have written, signed agreement in place

Failure to follow the compensation terms set forth in the agreement

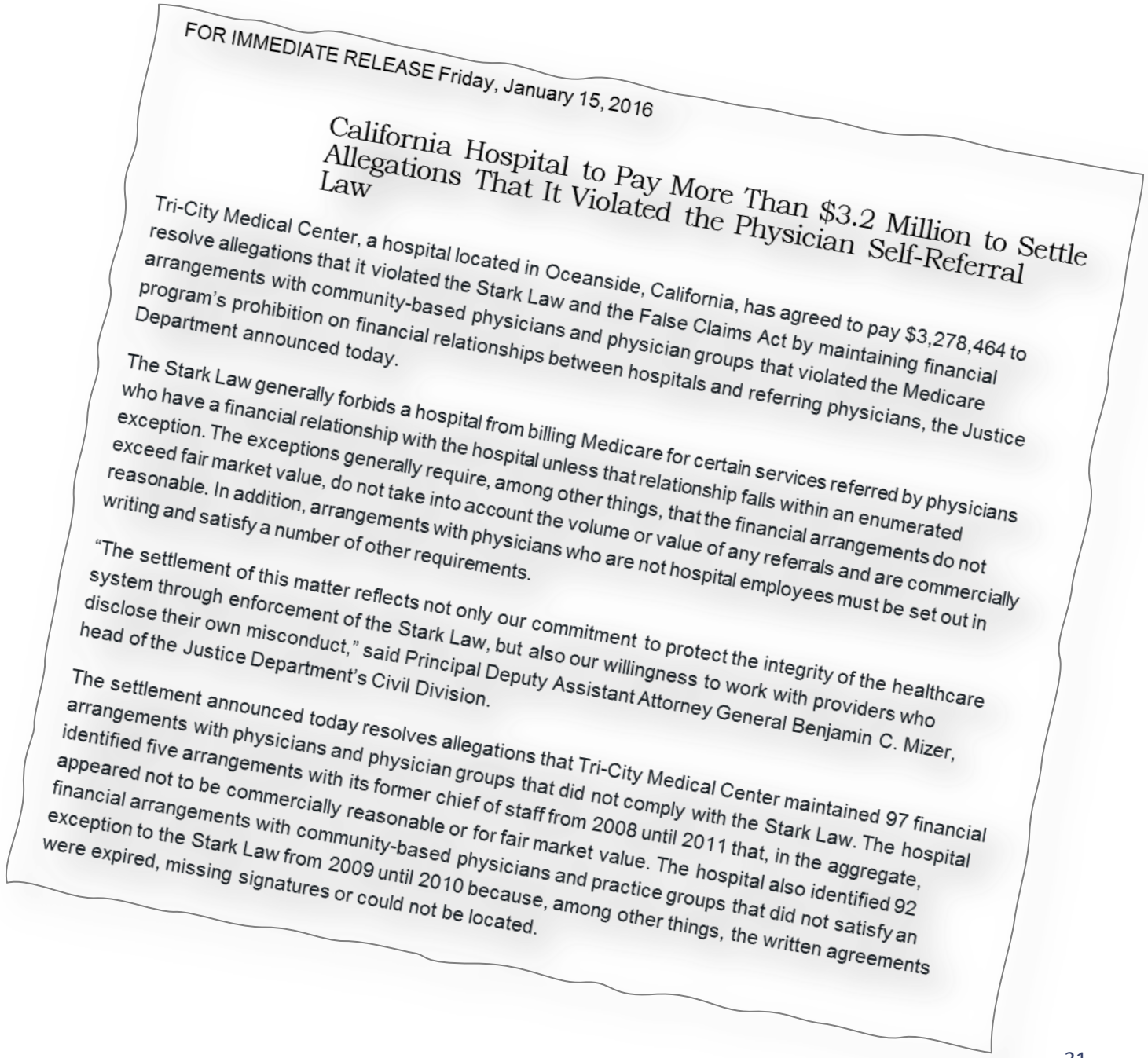
Failure to keep time logs (if required)

Change in leased premises that is not reflected in the agreement or in the leased space

Payment above FMV or in a manner that is not commercially reasonable

Polling Question #5

In the News…



FOR IMMEDIATE RELEASE Friday, January 15, 2016

California Hospital to Pay More Than $3.2 Million to Settle Allegations That It Violated the Physician Self-Referral Law

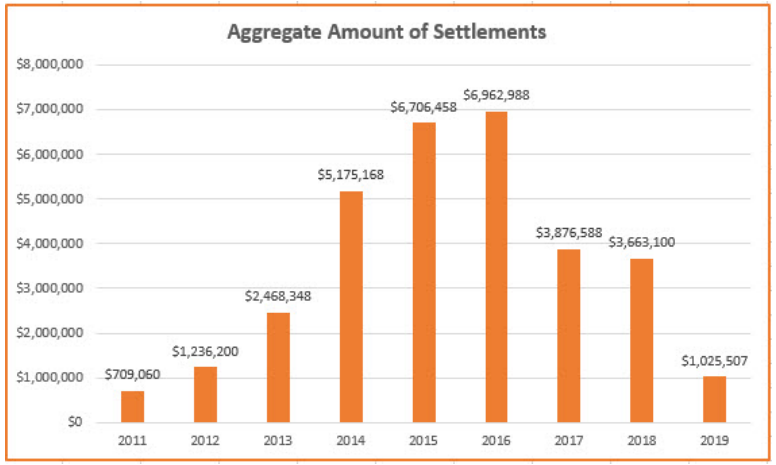
Tri-City Medical Center, a hospital located in Oceanside, California, has agreed to pay $3,278,464 to resolve allegations that it violated the Stark Law and the False Claims Act by maintaining financial arrangements with community-based physicians and physician groups that violated the Medicare program's prohibition on financial relationships between hospitals and referring physicians, the Justice Department announced today.

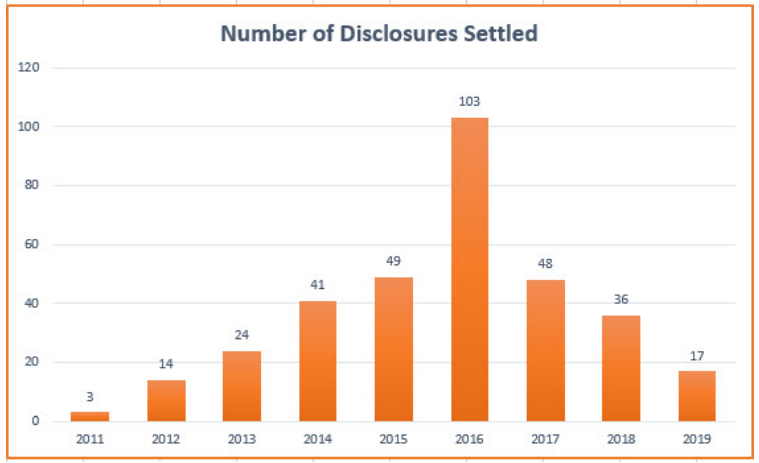
The Stark Law generally forbids a hospital from billing Medicare for certain services referred by physicians who have a financial relationship with the hospital unless that relationship falls within an enumerated exception. The exceptions generally require, among other things, that the financial arrangements do not exceed fair market value, do not take into account the volume or value of any referrals and are commercially reasonable. In addition, arrangements with physicians who are not hospital employees must be set out in writing and satisfy a number of other requirements.

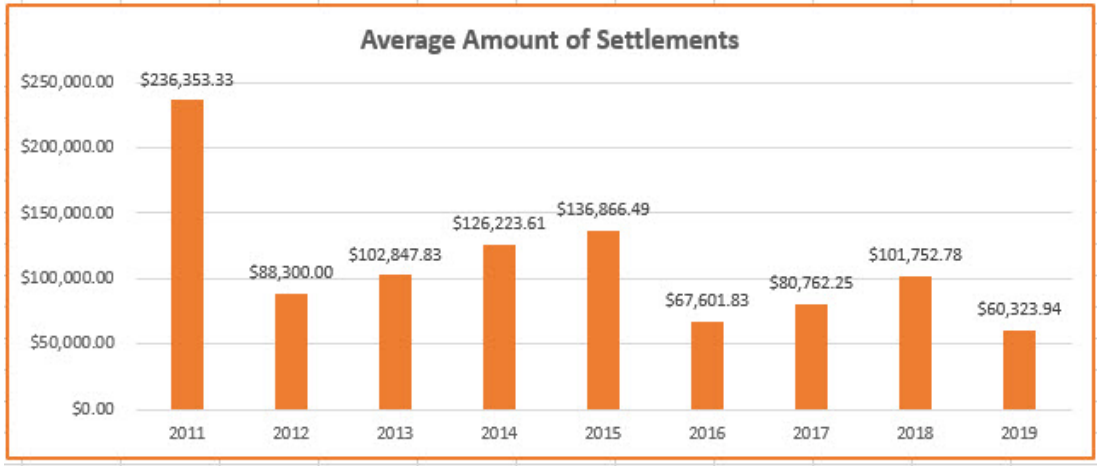
"The settlement of this matter reflects not only our commitment to protect the integrity of the healthcare system through enforcement of the Stark Law, but also our willingness to work with providers who disclose their own misconduct," said Principal Deputy Assistant Attorney General Benjamin C. Mizer, head of the Justice Department's Civil Division.

The settlement announced today resolves allegations that Tri-City Medical Center maintained 97 financial arrangements with physicians and physician groups that did not comply with the Stark Law. The hospital identified five arrangements with its former chief of staff from 2008 until 2011 that, in the aggregate, appeared not to be commercially reasonable or for fair market value. The hospital also identified 92 financial arrangements with community-based physicians and practice groups that did not satisfy an exception to the Stark Law from 2009 until 2010 because, among other things, the written agreements were expired, missing signatures or could not be located.

Trends in Physician Compensation







The Sunshine Act

(Here comes the sun, do-do-do-do-do…)

Sunshine Act Background

- Financial relationships between physicians and medical product manufacturers are common:
  - Include everything from free meals, to consulting or speaker fees, to direct research funding
  - Can have many positive outcomes—particularly in the context of consulting and research funding—but can also create conflicts of interest

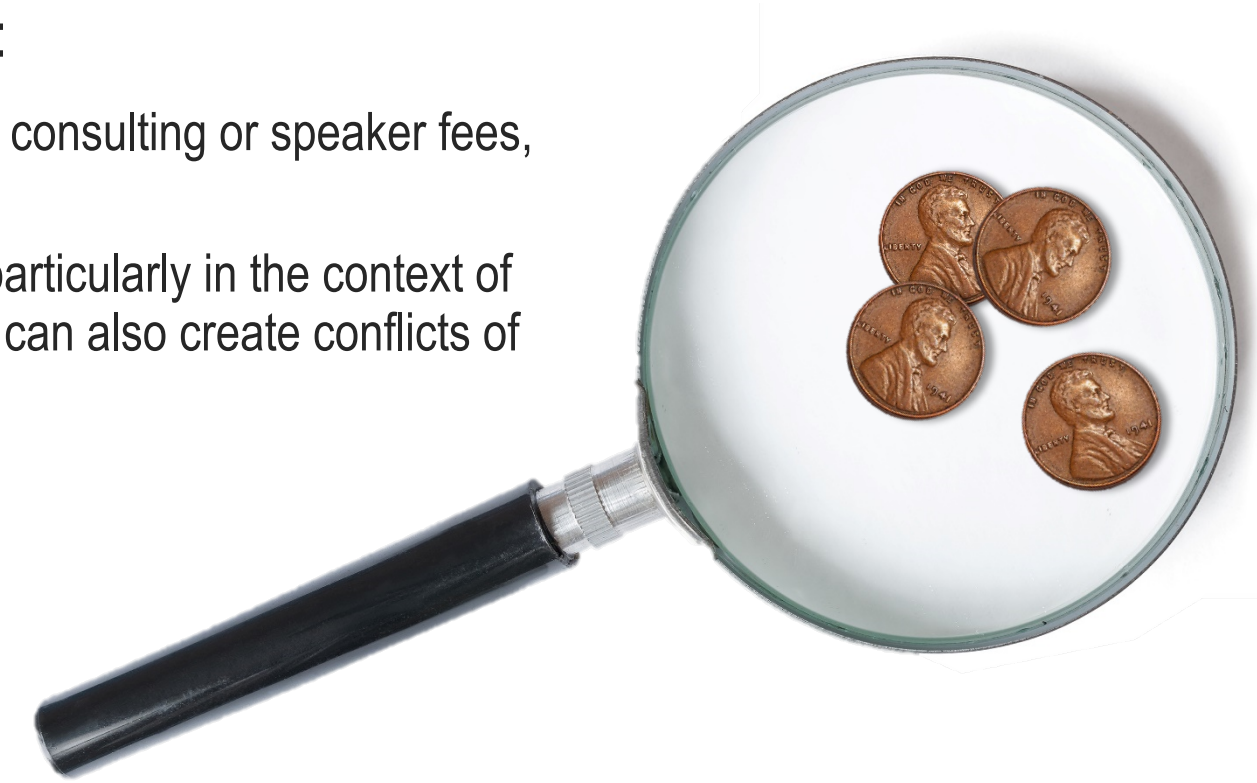


Image Source: Shutterstock.com

Sunshine Act Background

- An estimated 80% of physicians have had some form of financial interaction with manufacturers of drugs, devices, biologicals, and medical supplies
- There is a growing awareness among researchers and policy makers of the ways that physician-industry relationships can bias physician decision making, encourage inappropriate prescribing, and undermine the clinical independence and validity of research
- Over the past decade, many healthcare organizations and professional associations have implemented conflict-of-interest policies aimed at mitigating industry influence on health decision making
- There have been attempts to increase transparency around these financial relationships, in the hopes that disclosure would help to reduce their negative consequences without unnecessarily blocking constructive partnerships

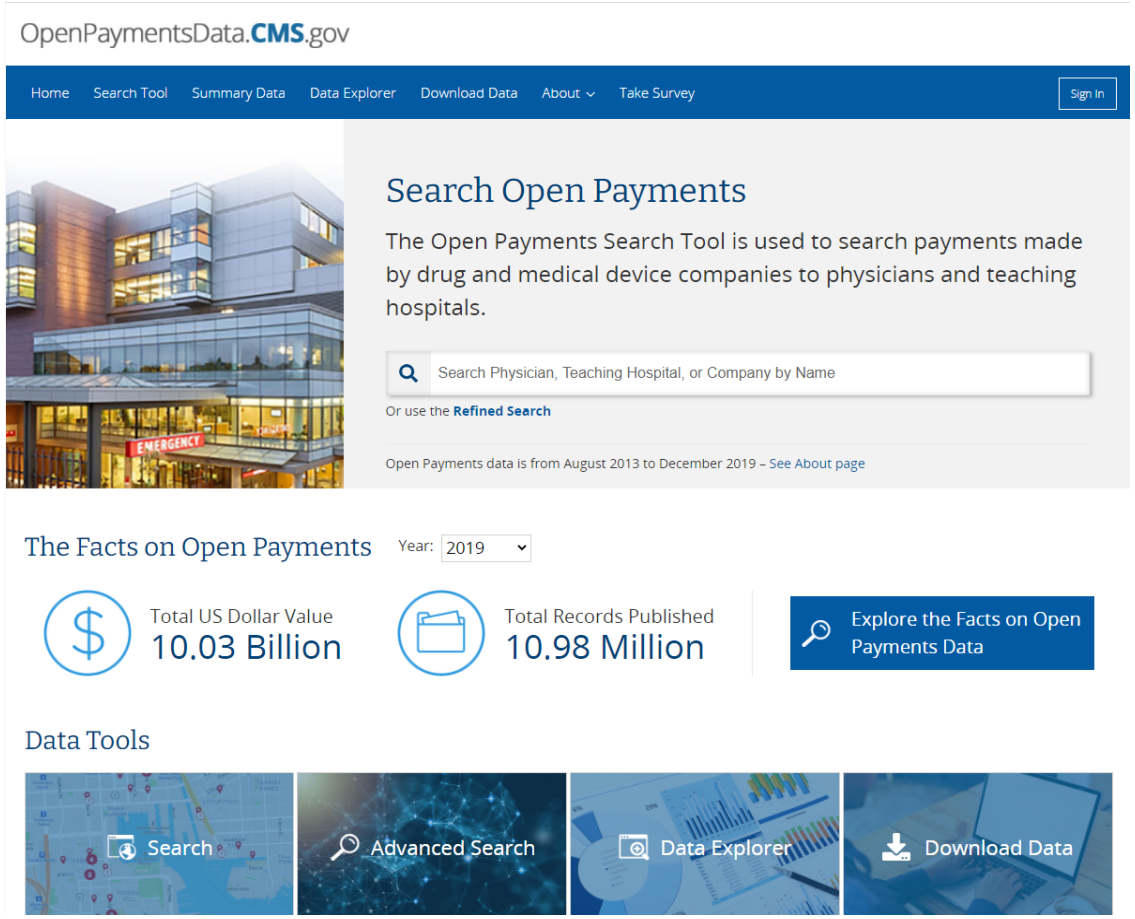
Sunshine Act Reporting Process

Who must report payments?	▪ All drug, biologic, and medical device manufacturers who manufacture one or more products that are covered for payment under Medicare, Medicaid, or CHIP ▪ GPOs and physician-owned distributors of medical devices
What kind of providers must be reported on?	▪ All licensed physicians – MDs, DOs, Dentists, Podiatrists, Optometrists, Chiropractors ▪ Teaching hospitals that receive direct or indirect GME funding from Medicare
What must be reported?	▪ General payments, in-kind items or services, consulting and speaker fees, gifts, honoraria, travel and entertainment expenses, meals, education, charitable contributions, and grants ▪ Ownership or investment interests by physicians and immediate family members ▪ Research payments for clinical investigations
What does not need to be reported?	▪ A payment less than $10, unless total payments exceed $100 per year ▪ Product samples, discounts and rebates, in-kind for charity care, educational materials for patients, loaned devices for research, warranty services share in publicly traded mutual funds
What is the timeline for reporting?	▪ Manufacturers and GPOs must complete their reporting by the 90th day of the following calendar year—usually March 31
What are the consequences for failure to report?	▪ Manufacturers and GPOs may be fined $1000-$10,000 per unreported payment up to an annual maximum of $150,000 ▪ For deliberately failing to report, fines can be $10,000-$100,000 per payment up to a maximum penalty of $1,000,000 per year

Polling Question #6

Open Payments Database

Open Payments Database Demo



Available at:

https://openpaymentsdata.cms.gov/

Polling Question #7

Audit Plan Approach

Audit Communication

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COMPLIANCE SERVICES

PYA

PROCESS

PYA obtained an understanding of the Plan process through interviews and review of supporting documentation. Key controls were evaluated in the following areas:

- Inventory control of all physician compensation agreements
- Pre-payment controls to confirm payments are consistent with the terms of current compensation agreements
- Consistent application and documentation of decisions related to compensation plan revisions
- Determination of fair market value (FMV), commercial reasonableness and community need for all
- Methods associated with the calculation, assignment and/or allocation of work Relative Value Units
- Supervision of physician extenders (e.g., nurse practitioners and physician assistants) and impact on
- Application of allocation methodology for work RVUs related to Stark Designated Health Services
- Quality assurance and monitoring of high utilization to validate work RVU production
- Documentation associated with paid administrative duties (e.g., medical directorships)
- Content and frequency of any internal monitoring of compensation plan administration

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COMPLIANCE SERVICES

PYA

SUMMARY OF KEY FINDINGS

Based on the comparison of Expected Controls and Current State findings in the following Control Environment Assessment Tables, significant issues are summarized as follows:

- Insufficient monitoring and auditing of the Plan processes
- Lack of Stark and other regulatory training
- Complexity of Plan design and required recalculation schedule
- Lack of documented policies and procedures for Plan processes, including Plan governance oversight.

The following graph illustrates the distribution of the 42 recommendations noted in the Assessment Tables, on pages 6 - 2

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APPENDIX A

PYA

Example Authority Matrix	Board	Compensation Oversight Committee	Designated Executive(s)	Physician Leadership
Compensation Program				
Adoption of Physician Compensation Philosophy and Committee Charter	Approve	Recommend	Develop	Review, Input and Liaison
Adoption of Physician Compensation Policy and Plan	Receive Report	Approve and Report to Board	Develop and Recommend	Review, Input and Liaison
Annual adjustment of work RVU tiers and conversion factors, including confirmation of consistency with market	Receive Report	Approve and Report to Board	Recommend	Review, Input and Liaison
Deviations from Compensation Plan with respect to particular physician employees			Approve after consult with CEO	Consultation as deemed appropriate
Physician Employment Agreements				
Adoption of template Physician Employment Agreements and ongoing review		Approve	Recommend	Review, Input and Liaison
Execution of new or renewal Employment Agreements for physicians whose projected Total Compensation will exceed XXth percentile of market data (for their specialty)		Approve	Recommend	
Execution of new or renewal Employment Agreements for other physicians, per templates			Approve	

Polling Question #8

Questions?

Thank You!

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August 29-September 1, 2021

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San Antonio Marriott Rivercenter