10 Common Healthcare Compliance Concerns

Prepared for **MT HFMA & MHIMA 2022 Joint Spring Conference**

April 27, 2022

Presented by:

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Introductions and Project Team

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Carol is a Principal with PYA and provides business valuation and related consulting services to a wide variety of business organizations, primarily in the healthcare industry. Ms. Carden's primary areas of expertise are in finance, valuation, managed care and revenue cycle operations for healthcare organizations. She has performed appraisals of businesses and securities for a wide variety of purposes such as mergers, acquisitions, joint ventures, management service agreements and other intangible assets. She is also a nationally-recognized speaker and writer on healthcare valuation topics.

In addition to being a Certified Public Accountant, she has also earned the Accredited in Business Valuation (ABV) credential from the American Institute of Certified Public Accountants, the Accredited Senior Appraiser (ASA) credential from the American Society of Appraisers and the Certified Fraud Examiner (CFE) credential from the Association of Certified Fraud Examiners. She is the former Chair of the Executive Committee for Forensic and Valuation Services and former Chair of the Business Valuation Committee for the AICPA, was Chair of the 2010 National AICPA Business Valuation Conference and was on the planning committee for the 2011 AICPA National Healthcare Conference. She was inducted into the Business Valuation Hall of Fame of the AICPA in 2013.

Introductions and Project Team

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Traci brings more than three decades of healthcare experience, which includes more than 15 years serving in compliance leadership roles, such as Director of Outreach Services and Compliance, as well as Senior Director of Compliance and Medical Staff. She also has experience as a director of health information management, medical staff, quality improvement, and risk management. Traci works collaboratively with PYA clients, helping them develop and leverage robust compliance programs. She often speaks nationally, regionally, and locally on compliance-related topics.

What do these organizations have in common?

Settlements Due to Compliance Violations

$513M	**Tenet Healthcare Corporation (North Fulton Medical Center and Atlanta Medical Center) | October 2016**
$237M judgment settled for **$72.4M**	**Tuomey Healthcare System Sumter, SC | October 2015 (Hospital sold to third party)**
$84.5M	**William Beaumont Hospital Detroit, MI | August 2018**
$69.5M	**North Broward Hospital District Broward County, FL | September 2015**
$122M	Universal Health Services, Inc., UHS of Delaware, Inc. and Turning Point Care Center, LLC Moultrie, GA | July 2020
$55M	Lancaster Regional Medical Center & Heart of Lancaster Medical Center (HMA) Lancaster, PA | September 2018
$47.2M	Taro Pharmaceuticals USA, Inc., Sandoz, Inc. and Apotex Corporation New York and New Jersey | October 2021
$37.5M	Prime Healthcare Services Ontario, CA | July 2021
$25M	**Columbus Regional Healthcare System Columbus, GA | September 2015**
$22.5M	Doctors Care, P.A. Columbia, SC | April 2021
$18.2M	Flower Mound Hospital Partners, LLC Flower Mound, TX | December 2021
$17M	**Lexington Medical Center West Columbia, SC | July 2016**
$14.25M	**Mercy Health Cincinnati, OH | May 2018**
$16M	Arthrex, Inc. FL | November 8, 2021

Shaded organizations either engaged PYA after settlement, or PYA was selected to serve a Federal Monitor post-settlement.

Key Themes in Government Settlements[1]

- Breakdown in processes and key controls due to growth
- **Reactive** vs. **proactive** compliance program
- Relationships with referral sources
  - Employed physician compensation
  - Multiple medical directors in same specialty
  - “Stacking arrangements”
  - Highly-compensated physicians
  - Disparities in call coverage arrangements
  - Lack of commercial reasonableness (CR)
  - Real estate transactions
  - Paying for services above fair market value (FMV)
  - No evidence of fair market valuation

1. https://www.justice.gov/opa/pr/justice-department-recovers-over-3-billion-false-claims-act-cases-fiscal-year-2019

Healthcare Real Estate

Healthcare Real Estate – Common Challenges

- Hospital leases to physicians at rates that are below FMV or under terms that are not CR
- Hospital leases from physicians at rates that are above FMV or under terms that are not CR
- Terms are extremely long and don’t give the parties the ability to adjust for changing market conditions
- Real estate is held under different company name, and it is not always apparent that it is affiliated with a referral source
- Space creep occurs over time and the physician is using much more space than is being paid for
- Valuations for space rental rates are much too broad (for the area rather than the building), aren’t updated on a timely basis or contain ranges that are too broad to be considered reasonable

Healthcare Real Estate – Common Challenges (cont.)

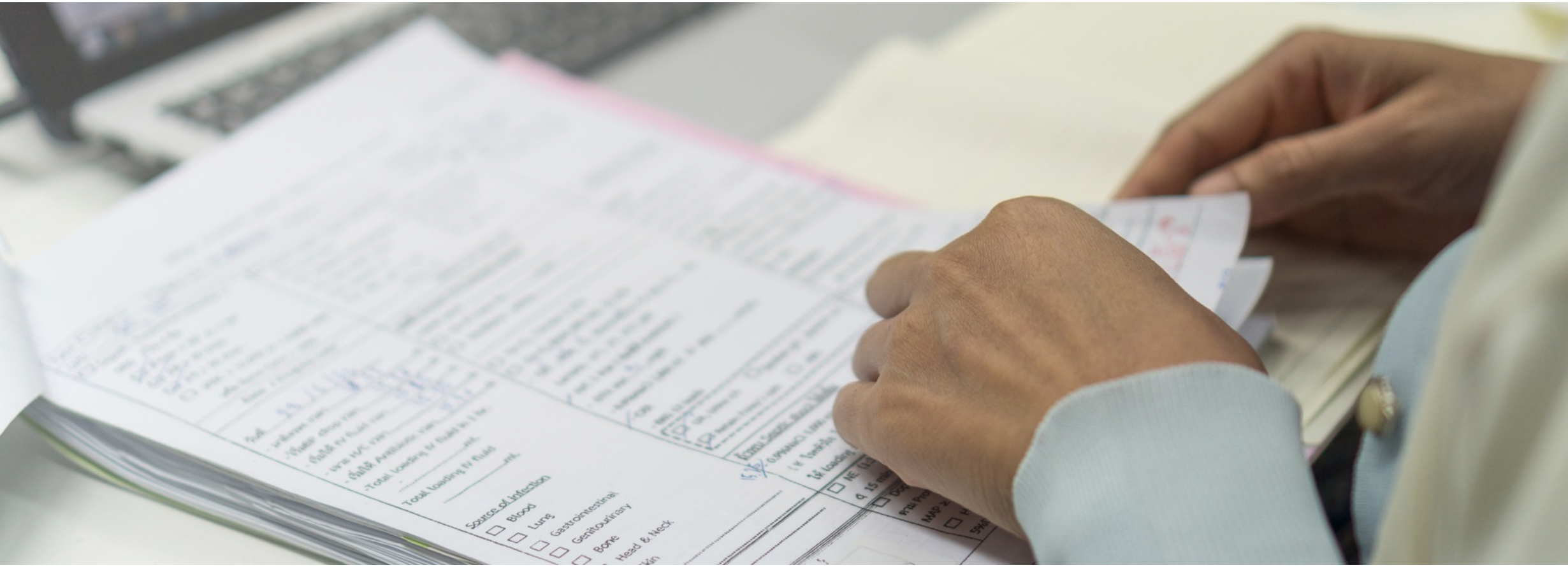
- Hospital does not do a good job of collecting on outstanding rents and does not enforce late fee provisions
- Hospital does not apply rent escalators in accordance with the lease terms
- Tennant improvement allowances are provided in excess of the caps without charging the physician
- Third party property managers can be used to help mitigate risks but must be properly supervised and have healthcare experience to appreciate the risks
- Hospital does not reconcile operating expense and, therefore, does not appropriately charge the physician
- Timeshare leases aren’t properly monitored, and the hospital does not realize the physician is using the space more than the terms of the lease provide for

Collections-Based Compensation Formula

Collections-Based Compensation Formula – Common Challenges

- The resulting compensation when compared on a per wRVU basis significantly exceeds benchmark and market data
- The resulting compensation is not reasonably correlated to the level of effort of the physician
- It is far too easy for DHS revenues to be considered, which even if the level of total compensation is consistent with FMV, can still get a provider in trouble because the methodology is problematic
- Collections based compensation and any highly compensated physicians, regardless of methodology, warrant additional levels of approval and oversight

Administrative Compensation for Physicians/Physician Practices



Administrative Compensation for Physicians/Physician Practices – Common Challenges

- Work is not performed at all, not documented properly or took less time than the physician was paid for
- Payment is made without supporting documentation
- Services are not CR – for example, paying two physicians in the same system administrative pay to develop the same set of protocols
- Administrative compensation needs to be stacked with other elements of compensation to ensure the totality of the compensation package remains consistent with FMV – we will talk about stacking on a later slide

Purchase Price of Entities Acquired from Physicians

Purchase Price of Entities Acquired from Physicians – Common Challenges

- Purchase price that exceeds FMV (the DOJ prosecuted a case where the buy in was higher than the buy out because the purchaser deliberately used different variables, so the buyer bought high and sold low to physicians, which makes no business sense)
- Payment for intangible value is not warranted. This is commonly referred to as goodwill. It can exist in a physician owned entity but needs to be supported by profits over and above reasonable compensation for the physician's services.
- Lack of consideration for the level of physician compensation post sale of the practice. For example, using a lower compensation assumption in the valuation which would result in a higher purchase price, but actually giving the physician a higher level of compensation, essentially a double dip.
- Use of assumptions in the valuation that are specific to a hospital buyer rather than any buyer in the market. For example, the hospital will absorb the billing, so the cost of those personnel are removed from the valuation of the practice therefore increasing the value.

Call Coverage

Call Coverage Common Challenges

- Significant dollars paid to physicians that rarely have to present, for example ENT
- Payments are much higher than benchmark or market data would support
- For employed physicians, it is common to require some amount of gratis call before compensating
- If the physicians are covering more than one panel or more than one hospital location, it is common to reduce the call pay rate for the second panel/hospital or risk overpaying
- Not paying a consistent rate for physicians of the same specialty serving on the same call panel

Compensation “Stacking”

Compensation “Stacking” Common Challenges

- The individual elements (e.g., base compensation, call pay, and medical director) appear consistent with FMV in isolation but the total package is too high or does not make sense from a CR perspective because a single physician could not provide all of those services.
- This is harder to evaluate for community physicians where the hospital does not have sight lines into the total compensation level or the clinical productivity level for services outside of the hospital setting. We saw an instance where physician leaders had very busy private practices (75th percentile level of activity) but when all administrative agreements were totaled, they had more than 2,000 hours of obligation over and above their private practice.
- This can get very tricky for value-based payments that come from commercial payers for physicians employed by the hospital. It will take a while for value-based payment data to make its way into the benchmark survey data which lags by a year at least.

Disproportionate Share (DSH) Strategies

DSH Strategies – Common Challenges

- Hospitals may need to pursue acquisition strategies to help in maintaining the required ratios to prevent these funds from being in jeopardy.
- This is a critical issue for facilities represented here given that many of you operate in rural environments.
- Ensure that if an acquisition strategy is employed, purchase price is not in excess of FMV. Don’t want to trade one problem for another.

Physician Recruitment Agreements/Income Guarantees

Physician Recruitment Agreements/Income Guarantees – Common Challenges

- Ensure that expenses covered in a recruiting agreement are incremental in nature only. For example, if the practice needs to hire a nurse for that physician that is fine, but allocating the cost of an existing resource should not be done.
- Ensure the need for the specialty is documented
- Document why a particular practice was selected for the recruitment agreement if there is another alternative in the market.
- Ensure that all reconciliations are properly done and the subsidy is discontinued when appropriate and consistent with the agreement. Also, if an overpayment occurs, recoup the money.

Hospital-Based Physician Subsidies

Hospital-Based Physician Subsidies – Common Challenges

- It is common for these type of agreements to be on a shift or hourly basis rather than purely on productivity given the nature of the service and the fact that the hospital needs coverage regardless of patient volume.
- Payment for salaries, benefits, malpractice costs and associated overhead is common but ensure the level of compensation associated with each element is reasonable.
- If recruitment will need to be done by the practice, treat this as a pass-through cost and only upon agreement from the hospital that additional resources are needed.
- It is best practice to reconcile to the revenue assumptions used when determining the subsidy.
- It is common now for a portion of the subsidy to be at risk based on pre-determined quality metrics.

Ambulatory Surgery Center (ASC) Distribution Methodology

ASC Distribution Methodology Common Challenges

- Ensure distributions are done in accordance with ownership percentages.
- Ensure the process by which ownership is offered to physicians is not based on the level of patients referred to the associated hospital.
- Make sure there is a process by which someone is monitoring the ASC owners' compliance with the 1/3 rule so you don't end up with passive owners.

Other Issues

Other Areas of Challenge

- **Clinical trials** – Ensure PIs are paid at rates consistent with FMV and adherence to the trial guidelines is ensured.
- **Shared savings distribution methodologies** – Ensure these are determined in ways that reward the parties most responsible for the savings.
- **Personally-performed services** – Look at how MLP work is attributed to physician and any associated payment for supervision. wRVUs should always be personally performed by the physician. Stark issued new guidance in this area in January.
- **Lithotripsy agreements** – Ensure the arrangement is paid at FMV and is CR given the volume of services and not a disguised kick back to urologists who admit patients.
- **Lab agreements** – Be particularly skeptical if marketing firms are involved. These types of agreements have caught the attention of the OIG.

How can we HELP?

Thank You!

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