Best Practices for Managing Hospital – Physician Relationships to Reduce Risk

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Agenda

1. Industry Update.
2. Hospital/Physician Contracting Risk.
3. Focus Arrangements.
5. Q&A.
Introduction

Dara Quinn, MHA, CHC, CHPC, RHIA
Vice president Compliance and Internal Audit & Chief Compliance Officer
CarePoint Health

- Over 16 years of healthcare audit and compliance experience.
- Chief compliance and privacy officer, University Hospital [formerly University of Medicine and Dentistry of New Jersey (UMDNJ)].
  - Developed and implemented compliance program and Corporate Integrity Agreement (CIA) with the NJ DHS-OIG.
- Former executive compliance officer, Hospitals UMDNJ.
  - Oversaw compliance operations and CIA requirements for hospitals.
- Former compliance specialist, Meridian Health.
- Former compliance specialist, Staten Island University Hospital.
- Former co-chair NJ HFMA Compliance, Audit, Risk, and Ethics Forum.
- Member Planning Committee for the Health Care Compliance Association (HCCA) New York Regional Annual Conference.
- Board member New England Healthcare International Auditors, Inc.

Introduction

Bret S. Bissey, MBA, FACHE, CHC, CMPE
Senior vice president, Compliance Services

- Thirty years of diversified healthcare management, operations and compliance experience.
- Former SVP, chief of ethics and compliance officer at UMDNJ.
  - Credited with re-engineering the compliance program of the nation’s largest free-standing public health sciences university.
  - Successfully led the compliance program to adhere to CIA with DHHS/OIG that occurred following a Deferred Prosecution Agreement.
- Chief compliance and privacy officer at Deborah Heart and Lung Center.
  - Compliance program recognized by HCCA as a “Best Practice.”
- Certified in HCCA and the Medical Group Management Association.
- Author of The Compliance Officer’s Handbook.
Industry Update

Compliance Risk Areas of Concern for Governance

- Federal claims for services (hospital, physician, etc.).
- Physician arrangements with hospitals.
- Contracts with ancillary services tied to referrals.
- False Claims Act implications.
- Quality – accurate measurement and accurate information.
- Regardless of federal or private payers, risk remains.
Peter Drucker on Healthcare:

“Even small Healthcare institutions are complex, barely manageable places… Large Healthcare institutions may be the most complex organizations in human history.”

Regulatory Sanctions

- Many times regulatory sanctions, such as: fines, penalties, CIAs, etc., have nothing to do with “intentional” actions.
- Rather, they are due to a lack of effective business processes to mitigate risk and enhance efficiencies.
- You didn’t know about the risk or didn’t have the resources to adequately address the risk and are not advised on actions to take in this area.
Why Do We Need to Discuss Relationships in 2015?

Is Stark Applicable to Employed Physicians?

Yes, indeed.

Too many hospital executives think they don’t have to worry about paying employed physicians in excess of fair market value or in relation to referrals. That is a mistake!
Top Five Healthcare Fraud Issues in 2015 (BNA’s Health Care Fraud Report)

According to BNA’s Health Care Fraud Report, the following are the top issues to watch in 2015:

1. Increase in False Claims Act cases involving Stark issues, Medicare Advantage and managed care and pharmaceuticals.
2. Increase in prosecutions of healthcare executives.
3. Increase in cases alleging fraud within the insurance exchanges.
4. Expansion of fraud enforcement into Medicare Part C and Part D.
5. Increased scrutiny of Open Payments data and the CMS Part B database.

Source: http://www.bna.com/look-crystal-ball-b17179921946/

Healthcare in 2015 and Into the Future

- Federal budget shortfalls.
- State and federal enforcement actions increasing.
- Increase in budget on initiatives to identify fraud, waste and abuse.
- Medicare insolvent in 15 years.
- State budget shortfalls.
- Much attention by U.S. Attorneys, Department of Justice and OIG.
- Rules remain complex.
Stark Law and the Anti-Kickback Statute

Always seek the advice of a skilled healthcare attorney.

Stark Law and the Anti-Kickback Statute, Continued

**Stark**

Prohibits physicians from making referrals for designated health services payable by Medicare to an entity in which he or she (or a family member) has a financial relationship.

**Anti-Kickback Statute**

Establishes criminal penalties for offering, providing or receiving inducements for the referral of business reimbursable under federal healthcare programs.
What Is Implicated Under Stark?

Stark applies only to Designated Health Services and physicians.

- Incentive compensation.
- Professional services agreements.
- Nonmonetary compensation.
- Leases/Subleases.
  - Office space.
  - Equipment.
  - Personnel.

Penalties for Stark Violation

- Penalties for violations of the Stark Law include fines, as well as exclusion from participation in all federal healthcare programs.
Anti-Kickback Statute

Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate federal healthcare program business

- It includes referrals from ANYONE.
- It includes ANY services or items.

Both parties to an impermissible kickback transaction may be liable.

Penalty for Anti-Kickback Violation

- It is a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal healthcare program.
- Criminal penalties for violating the Anti-Kickback Statute may include fines, imprisonment or both!
Hospital/Physician Contracting Risks

Physician Financial Arrangements Overview

- Healthcare organizations must ensure professional services agreements with physicians, medical groups, physician-owned entities and other focused arrangements, including laboratories, ambulance companies and research, are in compliance with applicable laws.
- These laws are broad in reach and complex in nature and require consistent policies and procedures to address and mitigate risks.
- Physician financial relationships set forth basic expectations for such organizations’ policies and procedures.
June 2015 – OIG Fraud Alert Focuses on Physician Compensation Arrangements

- Targeted at physicians and directs that all compensation arrangements need to be fair market value and reflect payment for bona fide services that have been provided.
- If any purpose of the arrangement is to compensate a physician for past or future referrals, the potential does exist for violation of the Anti-Kickback Statute.
- This could result in possible criminal, civil or administrative sanctions, including but not limited to exclusion from the federal healthcare programs and potential draconian penalties via the False Claims Act.

Common Kickback Scenarios

- Hospital gives physician or his or her family member free office space.
- Hospital pays physician or family member under a suspect arrangement, i.e., “ghost” medical directorship or consulting agreement.
- Referring physician or immediate family member has an interest in a company with which the hospital is doing business.
- Hospital stocks ambulances with supplies, provides transporters with free food or other “benefits.”
- Contract never makes it completely through the hospital’s contract review process … (time-sensitive/forego the bureaucracy of the “suits”).
Common Risk Areas

- False, inaccurate or lack of time and effort reporting.
  - Charges for persons not contracted to work on a project.
  - Work described in contract is not actually performed.
- Improper cost sharing – direct vs. indirect costs.
- Inadequate accounting policies.
  - Payment without a contract or without valid time and effort supporting documentation.
- Contract never accurately represented the services or duties to be performed.
- Improper financial relationships – tied to referrals.
- Undisclosed conflicts of interest.
- Unable to substantiate efforts due to lack of documentation or inability to produce historical documentation.
- Contract never makes it completely through the hospital review process… (time-sensitive/forego the bureaucracy of the “suits”).

Physician Arrangements in the Headlines

Physician and cardiology group settle Stark violation case….

- A physician and cardiology group have agreed to pay $1 million in connection with their alleged improper compensation relationships with a regional hospital and medical center.
- Usually, it is the hospital that faces Stark and False Claims Act allegations; however, this case demonstrates exposure for physicians, as well.

Adventist – Largest Fraud Case With Physicians Referring to Hospitals

- Three former employees were whistleblowers, alleged scheme by Adventist Health System to pay doctors excessive compensation to lock in their patient referrals to Adventist-owned hospitals, clinics and other outpatient services in Florida, North Carolina, Tennessee and Texas.

- The US Justice Department announced 9/21/15 Adventist will pay a total of $118.7 million to the federal government and four states to settle a whistleblower (qui tam) lawsuit filed in December 2012.

- "We alleged Adventist's hospitals paid doctors outrageous sums and offered overly generous benefits and lax billing oversight as part of a corporate strategy to capture and control physician referrals for inpatient and outpatient services near its hospitals," the attorney said. "Federal law prohibits hospitals from paying doctors directly or indirectly for referrals so that doctors make recommendations for care based on what's best for the patient – not what's best for the doctor's bank account."

Columbus Regional Healthcare System

- Georgia system to pay up to $35 million in settlement with federal government.

- Stark law (self-referral) violations and billing the government for higher levels of services then actually provided in violation of the False Claims Act.

- CIA obligations.
Recent Settlements

$85 million – Halifax Hospital Medical Center

- Allegedly violated Stark Law by executing contracts giving incentive bonuses to employed physicians based on 15 percent of the hospital’s operating margin, thereby tying the bonus to the volume or value of referrals.

- Created a bonus pool for physicians that the more procedures they did, the more money that the hospital made, hence bonus paid.

- The government also alleged the hospital paid three of its neurosurgeons above fair market value.

- $120 million in legal fees and costs associated with the lawsuit.

- Five-year CIA with OIG.

More Physician Arrangements in the Headlines

“Tuomey Healthcare System – Judge orders health system to pay $237 million.”

- The issue: The hospital offered 10-year employment contracts to 19 specialists in exchange for performing all outpatient procedures at Tuomey Hospital or its other facilities, as it was concerned that referring physicians would shift outpatient procedures from its hospital to their own practices or an ambulatory surgery center.

- Compensation was based on net cash collections for outpatient procedures and productivity bonus that was found to be above fair market value.

- On May 8, a federal jury found that the hospital’s compensation agreements with 19 employed physicians ran afoul of the Stark Law, which turned the hospital’s claims for Medicare services by the 19 physicians into false claims.

- On September 30, a federal judge ordered Tuomey Healthcare System to pay more than $237 million for violating the False Claims Act and Stark Law.
Recent Settlement

Florida health system to pay $69.5 million over Stark, False Claims allegations

- A Florida taxing district that operates hospitals in Broward County will pay the government a record $69.5 million to settle allegations that it illegally paid nine doctors for referrals.

- A whistle-blower accused North Broward Hospital District of violating the Stark Law by paying employed doctors at levels beyond fair market value, based in part on their referrals to Broward Health hospitals and clinics.

- That, in turn, led to the submission of false claims to the government, in violation of the False Claims Act, the whistle-blower alleged.

- Whistleblower will receive $12 million.

Settlements continued…

Infirmary Health Systems, Inc. $24.5 million violation (July 14)

- Federal whistle-blower lawsuit that claimed its clinics routinely overpaid doctors to refer their radiology patients to hospitals.

- Whistleblower was a physician (2008) who received $4.4 million.

- Case centered upon incentives paid to physicians for referrals.

- Signed CIA –
  - Five-year commitment.
  - Legal IRO required.
  - Focus Arrangement obligations.
University of Medicine and Dentistry of New Jersey

- Five-year CIA.
- Focus Arrangements Training.
- Implementation of a Contract Management Database.
- Annual IRO Audits.

Whistleblowers Remain Active

Reports Made by Year

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“Qui Tam” Provisions

- “Qui tam” actions are brought under the False Claims Act by private individuals, called “relators” (aka whistleblowers) on behalf of the State or federal government.
- If the government joins a “qui tam” case:
  - Relator is entitled to a reward of 15-25 percent of what the government recovers.
- If the government declines to join and the whistleblower still proceeds against the defendant relator is entitled to a reward of 25-30 percent of the recovery.

Referrals

- Who is referring?
- What are the relationships among the entities?
- Who is the loser in the referral?
  - Could someone be upset?
- Show me the money!
- Referrals are a whistleblower’s best friend, so they are a big risk for providers.
Hospital-Physician and Focus Arrangements Current Environment

- Now more than ever, arrangements with nonhospital-employed physicians in a position to refer patients are under regulatory scrutiny (e.g., CMS and OIG).
- OIG Advisory Opinions.
- Being unaware of Stark Law revisions will not excuse physicians from liability.
  - Stark is a strict-liability statute.
  - Even the most innocent of intentions will be subject to penalties as if you meant to violate the law.
- Beyond hospitals: Physician Payment Sunshine Act.
  - Most physicians (94 percent) reported some type of relationship with the pharmaceutical industry, and most of these relationships involved receiving food in the workplace (83 percent) or receiving drug samples (78 percent)*.

Focus Arrangements
Focus Arrangements

You need to identify which of your contracts are Focus Arrangements. CIAs define “focus arrangements” as:

• Between entity and actual source of healthcare business or referrals to medical center and involves, directly or indirectly, the offer, payment or provision of anything of value;

• Between entity and any physician who makes a referral to medical center for designated health services; or

• Between entity and any physician (or a physician’s immediate family member) or medical practice that involves, directly or indirectly, the offer, payment or provision of anything of value in anticipation of that physician becoming an actual source of healthcare business or referrals (e.g., for purposes of recruitment).

Could These Types of Contracts Be Focus Arrangements in Any Organization?

• Accreditation services.
• Affiliation agreements.
• Ambulance service agreements.
• Billing and collection agreements.
• Biomed services agreements.
• Blood and plasma agreements.
• Chaplain services agreements.
• Clinical services agreements.
• Coding services agreements.
• Compliance services agreements.
• Software license with PHI agreements.
• Software or hardware maintenance or support with PHI agreements.
• Consignment agreements.
• Consulting services – clinical agreements.
• Contract labor agreements.
• Contract management agreements.
• CRNA services agreements.
• Document-shredding agreements.
• Durable medical equipment agreements.
• Equipment lease or rental – medical agreements.
• Equipment maintenance or support – medical agreements.
• Housekeeping services agreements.
• Interpreting services agreements.
• Laboratory services agreements.
• Laundry services agreements.
• Linen supply agreements.

• Lithotripsy services agreements.
• Management agreements.
• Massage therapy services agreements.
• Master services agreements.
• Medical director agreements.
• Medical records services agreements.
• Music therapy agreements.
• Nurse practitioner services agreements.
• Pharmacy services agreements.
• Physician assistant services agreements.
• Physician medical director agreements.
• Physician on-call agreements.
• Physician services agreements.
• Purchasing agreements.
• Quality improvement services agreements.
• Residency program agreements.
• Safe-child services agreements.
• Services – nutrition agreements.
• Telemedicine services agreements.
• Therapy services agreements.
• Transcription services agreements.
• Utility services agreements.
• Others.
Contracting Best Practices

Focus Arrangements

Best practices for focus arrangements

• In writing, signed by both parties.
• Maintained in a database or contract management system.
• No relationship to referrals.
  o Past, current or future ***
• Obtain documentation related to market valuation.
• Job descriptions.
  o Outline job duties and perform evaluation of performance.
• Position or activity business justification.
Compliance Best Practices

• Create and maintain a database of all existing and new or renewed physician arrangements and establish detailed procedures when arrangements are initiated.
  o Only one contract database should be maintained.
  o Database should implement the requirements recommended by the OIG in its CIAs.
  o The contract database should be reconciled with payments made or received under physician arrangements, at least quarterly (i.e., test of completeness and accuracy of the contract database).

• Keep business justification documentation and fair market value analysis and support.

• Develop policies and procedures.

Compliance Best Practices, Continued

• Implement or maintain a process that covers the initiation, development, review, approval and performance (i.e., contract the life cycle).
  o Needs assessment (business justification).
  o Fair market value documentation.
  o Legal review by an experienced counsel with expertise in the Anti-Kickback Statute and Stark Law.
  o Compliance checklist.
  o Contract templates.
  o Policy for internal review and approval by appropriate members of management and the governing body.
  o Payment and performance review and approvals (e.g., department-head review and approval and attestations).
  o Documentation of all internal controls, the purpose of which is to ensure that all new and existing or renewed arrangements do not violate the Anti-Kickback Statute and Stark Law.
  o In writing and signed by both parties.
How to Contract for Success

1. **Initiate**
   - Contract Requisition

2. **Negotiate**
   - Review and Approve

3. **Sign and Activate**
   - Monitor

4. **Compliance Best Practices**

   - If being paid for time related to activity, ensure that systems are in place to track, monitor and report time and effort.
     - Ensure checks and balances are in place.
   - Track nonmonetary compensation.
     - Annual Stark logs.
   - Conflicts of interest disclosure.
   - Keep documentation of your negotiations.
   - Proactively manage any complaints or concerns, and ensure corrective action promptly.
   - Track remuneration to and from all parties to the arrangements.
     - If the arrangement involves services, then track service and activity logs.
     - If the arrangement involves space or equipment, then monitor the use of leased space or equipment.
     - Regularly audit logs and reports to substantiate payments and terms of contract.
   - Require all parties to sign an agreement to abide by the organization’s Code of Conduct in connection with the arrangement.
Compliance Best Practices, Continued

- Compliance Oversight.
  - Have the Compliance Officer review the arrangements database, contract approval process and other arrangement procedures and supporting documentation.
  - Provide a report of the results of such review to the compliance or audit committee.
  - Implement effective responses, including investigation, corrective action and disclosure when suspected violations are discovered.
  - Flag expired arrangements and those pending expiration or due for renewal to avoid potential violations.

Audit of the Completeness of the Focus Arrangement Database

Objective
- Determine whether all transactions that potentially meet the definition of a Focus Arrangement are included in the database.

Goal
- Every payment should match contract terms and supporting documentation.
- Payments without a corresponding contract or documentation are flagged for additional investigation.
Audit for the Completeness of the Focus Arrangement Database, Continued

Planning

- Coordinate with legal counsel, compliance and key stakeholders.
- Consider the protection of attorney-client privilege.
- Obtain an understanding of the Stark Law and types of financial relationships.
- Audit priorities and plan of action.

Take Action

Identify  Investigate  Report

Implement Corrective Action
Compliance Is Pretty Basic

Seven Elements of the OIG Model Compliance Program:

1. Compliance Officer & Program Oversight
2. Policies & Procedures
3. Education
4. Audit
5. Corrective Actions to Identified Problems
6. Open Communication
7. Enforce Violations

If an organization is found guilty of state or federal laws, the government may offer a reduction in penalties if an effective compliance program is in place.
MediTract — Risk and Compliance Experts

Our mission is to minimize risk through better contract compliance solutions.

You don’t have to face compliance requirements alone.

Anti-Kickback • Conflict of interest • False Claims Act • HIPAA • OIG CIA • Stark Law • Sunshine Act • The Joint Commission Standards (LD)

We know healthcare.

Dara Quinn, MHA, CHC, CHPC, RHIA
Vice President, Compliance and Internal Audit &
Chief Compliance Officer
CarePoint Health

• In January 2014 Ms. Quinn assumed the role of Corporate Director, Compliance and Internal Audit for CarePoint Health
• Responsible for the development and implementation of the Corporate Compliance and Internal Audit Programs for the CarePoint Health system entities
• On June 1, 2014 she assumed the role of Vice President and Chief Compliance Officer, Compliance and Internal Audit for CarePoint Health Management Services Organization, where she oversees Compliance and Internal Audit and staff, system-wide.
BRET S. BISSEY
MBA, FACHE, CHC, CMPE
Senior vice president, Compliance Services

BACKGROUND

- Bret has more than 30 years of diversified healthcare management, operations and compliance experience, and presented at more than 100 regional and national industry conferences and meetings on numerous compliance topics.
- He joined MediTract in September 2013 as a senior executive.
- Bret is a fellow of the American College of Healthcare Executives.
- From 2010 to 2013, he was the Senior Vice President, Chief Ethics and Compliance Officer of the University of Medicine and Dentistry of New Jersey (UMDNJ). There he successfully re-engineered the nation’s largest sector compliance and ethics program under a rigorous Corporate Integrity Agreement (CIA) with the HHS OIG.
- Bret has taught undergraduate and graduate courses as an adjunct faculty member at College of St. Francis, Joliet, Illinois and Albright College, St. Francis De Sales, Center Valley, Pennsylvania.
- He is certified in the Health Care Compliance Association and the Medical Group Management Association. He is a past president (2001-2003) for Region 2 of the HCCA.
- Bret is the author of The Compliance Officer’s Handbook, which was published in 2006.

PROFESSIONAL & INDUSTRY EXPERIENCE

- At MediTract, Bret is responsible for thought management, enhancing product development, managing consulting engagements and providing compliance expertise to more than 1400 hospital and healthcare clients.
- At UMDNJ, the largest public sciences university in the country, Bret reported to the Chairman of the Audit Committee of the Board of Trustees and University President. There he managed 40 compliance, ethics and investigations professionals and an annual operating budget of $5.2 million.
- Bret improves compliance through the development and implementation of departmental and institutional processes and programs. He once developed a formal compliance process for a $1.7 billion international public company.
- Bret was responsible for the development and ongoing management of the Corporate Compliance Program, which resulted from the nation’s first Voluntary Disclosure Settlement (October, 1998) at a specialty hospital with more than 90 employed physicians. HCCA recognized the compliance program as a “Best Practice.”
- Bret uses his management leadership and direction to increase revenue. He once increased annual consulting revenue from $6 million to $11 million in one year. With his guidance, they signed contracts with many prestigious healthcare organizations and physician groups and gained recognition as one of the top 100 fastest-growing private companies in America as reported by Inc. Magazine (January 1998).

Q&A

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