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Enforcement, Regulatory Reimbursement Update, and Physician Arrangements

Healthcare Summit 2018:
Simplifying Healthcare

September 19, 2018

Ken Zeko
Ron Wolf

Agenda

- Physician Arrangement Concerns
- Regulatory/Policy History and Emerging Legal Framework
- The Impact of Enforcement Activities
- Data Analytics – The Playing Field Has Changed
- How Does Your Entity Look From the Outside?

After This Session, You'll Be Able To:

- Identify some emerging risks in the area of physician arrangements
- Explain the regulatory/policy history and evolving legal framework surrounding physician arrangements
- Understand the impact of enforcement activities
- Recognize the importance of data analytics in fraud detection/prevention

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Physician Arrangement Concerns

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Physician Arrangement Concerns

Inherent Risks of Physician Compensation Arrangements:

- Physician Self-Referral Law (“Stark Law”)
- The Anti-Kickback Statute (“AKS”)
- The Civil False Claims Act (“FCA”)
- June 9, 2015 OIG Fraud Alert – Physician Compensation Arrangements May Result in Significant Liability
- June 22, 2016 OIG Alert – Improper Arrangements and Conduct Involving HHAs and Physicians
- The strict liability nature of the Stark Law makes review of employment agreements and employed practices important.
- A violation of the Stark Law can lead to nonpayment of claims, civil monetary penalties, program exclusions and may create liability under the FCA.
- Hospitals need to document that physicians are furnishing “bona fide” services

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Physician Arrangement Concerns

Key stakeholders:

- Physician Leadership – Both Provider and Administration
- Legal Department
- Corporate Responsibility Officers
- Revenue Cycle Management
- Credentialing Personnel
- Internal Coding Department

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Physician Arrangement Concerns

Common Physician Arrangements:

- Employment
- Administrative Services
- Professional Services
- Call Coverage
- Space Leases
- Co-Management
- Recruitment / Income Guarantees
- Relocation Bonus
- Loan Payment Forgiveness
- Time Shares
- Embedded
- MSO
- Reverse MSO
- Joint Ventures

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Physician Arrangement Concerns

Administrative Service Contracts (Medical Directorships, Physician Leadership Positions, Hospital Committee Work):

- Contract must be in writing - Verify contract is not expired
- Have documentation stating the need and purpose for the administrative services - Services must not exceed what is reasonable and necessary for a legitimate business purpose
- Make sure the list of services in the contract is detailed and confirmed by the responsible manager.
- Compensation must be set in advance (typically hourly), at fair market value, and not based on referrals
- Should be signed before services are rendered
- Must reference master contract database
- Perform independent agreement review of compensation to contract.
  - Use of attestation of a time worked log to document physician hours worked.
  - Time worked log should be detailed.

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Physician Arrangement Concerns

Compensation Arrangements Types – The Pancake Effect:

- Patient Experience Bonus
- Productivity/Incentive Bonus
- Co-management Agreement
- Retention Bonus
- Tail Insurance
- Relocation Costs
- Sign-on or Retention Bonus
- Medical Administrative Directorship
- Quality Bonus
- Call Pay
- Excess Private Benefits – Auto Allowance
- Financial Performance

The key is to identify all the Providers compensation arrangements and their cumulative impact when compared to FMV value and commercial reasonableness valuations

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Physician Arrangement Concerns

The Pancake Effect (Continued):

Considerations:

- Hours worked per agreement and their cumulative effect (only 24 hours)
- Compensation – cumulative effect

Use benchmarking as a guide toward reasonableness:

- Compensation per wRVUs or total RVUs
- Compensation to professional collections
- Compensation to total collections
- Compensation per encounter
- http://doctors.healthgrove.com/

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Regulatory/Policy History, and Emerging Legal Framework

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Regulatory/Policy History and Emerging Legal Framework

Anti-Kickback Statute

42 USC §1320aa-7b(b)

- Criminal penalties for physicians and entities “who knowingly and willfully solicit or receive any remuneration” in exchanges for patient referrals from federal health care programs
- Remuneration includes anything of value, including excessive compensation for medical directorships or consultancies
- Potential consequences of violation include:
  - Jail terms of up to five years
  - Fines of up to $25,000 per violation
  - Expulsion from participation in federal health care programs
  - Penalties of up to $50,000 per kickback plus three times the amount of remuneration

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Regulatory/Policy History and Emerging Legal Framework

Physician Self-Referral Law (“Stark Law”)

42 USC §1395M

- Prohibits physicians who have a financial relationship, including compensation arrangements, with a health care entity from referring patients to that entity to receive “designated health services” billed to federal health care programs
- Mandates that all payments made to referring physicians be at **fair market** value for the services rendered.
- Potential consequences of violation include:
  - Denial of payments
  - Refund of payments
  - **A$15,000 per service civil penalty**
  - Civil assessments of up to **three times the amount claimed**

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Regulatory/Policy History and Emerging Legal Framework

False Claims Act (“FCA”)

31 USC §§3729-3733

- Prohibits submission of fraudulent claims for payment to federal health care programs
  - Claims that violate the Anti-Kickback Statute and/or the Stark Law may also render the claims fraudulent under FCA
- Civil penalties include fines of up to three times the program’s loss plus $21,563 per claim filed*

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Regulatory/Policy History and Emerging Legal Framework

OIG Fraud Alert – Physician Compensation Arrangements

- June 9, 2015 fraud alert issued regarding potential for medical directorships to violate the anti-kickback statute
- Medicare and Medicaid Patient Protection Act of 1987
- Compensation arrangements must reflect **fair market value for bona fide services that physicians actually provide**
- Looking at both sides (physicians and hospitals) of these arrangements for potential civil and criminal liability
- Supporting documentation, time studies and job descriptions, should reconcile to contract terms
- Automated time study systems can be mutually beneficial to all parties in ensuring regulatory compliance and mitigating risk

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Regulatory/Policy History and Emerging Legal Framework

DOJ – "Yates" Memorandum

- September 9, 2015 memo issued regarding individual accountability for corporate wrongdoing
- New emphasis to prosecute individual employees of corporations just like corporations themselves
  - Always could do this but DOJ is signaling a more aggressive approach
  - Directed at CEOs and other senior officers

http://www.justice.gov/dag/file/769036/download

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The Impact of Enforcement Activities

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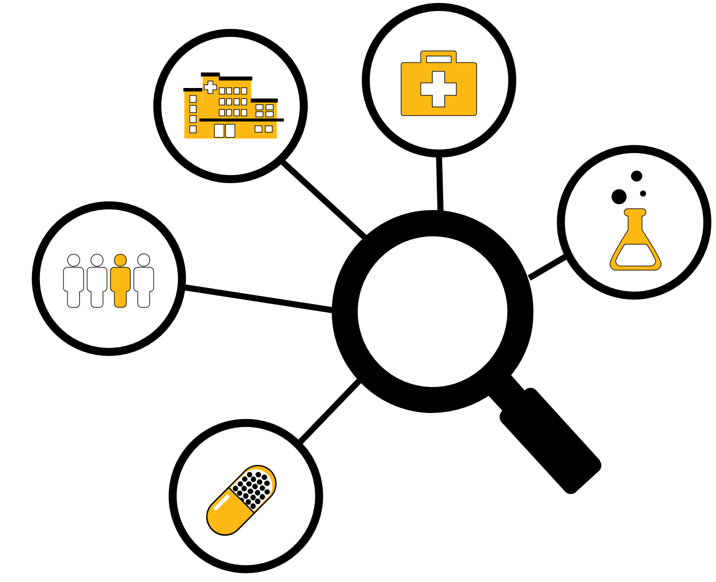
The Impact of Enforcement Activities

The following entities are being scrutinized:

- Labs/Toxicology Labs
- Specialty Pharmacies
- Workers Comp/DOL
- Pain Management



…beware of the following:

- Alleged Federal Carve Outs
- Conflicts of Interest and Gifts
- Uneducated sales reps willing to push the envelope for huge commissions
- Physicians' relationships with questionable entities
- Guilt by association

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The Impact of Enforcement Activities

Recent Case Examples

- Forest Park Medical Center – Dallas (December 1, 2016) - Uncle Sam indicts 21 individuals for massive conspiracy to pay and receive kickbacks and bribes totaling more than $40 million for patient referrals. Unique use of the Travel Act and Health Care Fraud Statute
- National Health Care Fraud Takedown (July 13, 2017) - The largest ever health care fraud enforcement action by the Medicare Fraud Strike Force, involving 412 charged defendants across 41 federal districts, including 115 doctors, nurses and other licensed medical professionals, for their alleged participation in health care fraud schemes involving approximately $1.3 billion in false billings

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The Impact of Enforcement Activities

Recent Case Examples

Missouri Hospitals Agree to Pay United States $34 Million to Settle Alleged False Claims Act Violations Arising from Improper Payments to Oncologists (May 18, 2017)

- "Two Southwest Missouri health care providers have agreed to pay the United States $34,000,000 to settle allegations that they violated the False Claims Act by engaging in improper financial relationships with referring physicians, the Justice Department announced today."
- "The settlement… resolved allegations that the Defendants submitted false claims to the Medicare Program for chemotherapy services rendered to patients referred by oncologists whose compensation was based in part on a formula that improperly took into account the value of their referrals of patients to the infusion center operated by the Defendants. Federal law restricts the financial relationships that hospitals and clinics may have with doctors who refer patients to them."

Https://www.justice.gov/opa/pr/missouri-hospitals-agree-pay-united-states-34-million-settle-alleged-false-claims-act

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The Impact of Enforcement Activities

Recent Case Examples

Dallas-Based Physician-Owned Hospital to Pay $7.5 Million to Settle Allegations of Paying Kickbacks to Physicians in Exchange for Surgical Referrals (December 1, 2017)

- “Pine Creek Medical Center LLC (“Pine Creek”), a physician-owned hospital serving the Dallas/Fort Worth area, has agreed to pay $7.5 million to resolve claims that it violated the False Claims Act by paying physicians kickbacks in the form of marketing services in exchange for surgical referrals, the Department of Justice announced today.”
- “The government alleged that, between 2009 and 2014, Pine Creek engaged in an illegal kickback scheme whereby the hospital would pay for marketing and/or advertising services on physicians’ behalf and, in return, the physicians would refer their patients, including Medicare and TRICARE beneficiaries, to Pine Creek.”

Https://www.justice.gov/opa/pr/missouri-hospitals-agree-pay-united-states-34-million-settle-alleged-false-claims-act

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The Impact of Enforcement Activities

Recent Case Examples

Los Angeles Hospital Agrees to Pay $42 Million to Settle Alleged False Claims Act Violations Arising from Improper Payments to Physicians (June 28, 2017)

- “Pacific Alliance Medical Center, an acute care hospital located in Los Angeles, California, agreed to pay $42 million to settle allegations that they violated the False Claims Act by engaging in improper financial relationships with referring physicians”
- “resolves allegations brought in a whistleblower lawsuit that the defendants submitted false claims to the Medicare and MediCal Programs for services rendered to patients referred by physicians with whom the defendants had improper financial relationships… (1) arrangements under which the defendants allegedly paid above-market rates to rent office space in physicians’ offices, and (2) marketing arrangements that allegedly provided undue benefit to physicians’ practices.”

Https://www.justice.gov/opa/pr/los-angeles-hospital-agrees-pay-42-million-settle-alleged-false-claims-act-violations-arising

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Data Analytics – The Playing Field Has Changed

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Data Analytics – The Playing Field Has Changed

Data analytics is nothing new in healthcare, but efficiencies have improved in last few years

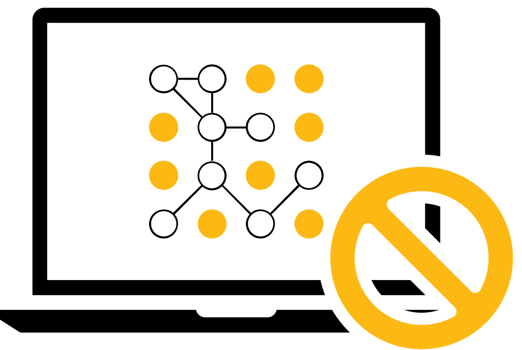
Twin Pillar Approach

CMS utilizes a Fraud Prevention System (“FPS”) using these strategies:

- Predictive Analytics
- Anomaly Detection Models
- Social Network Analysis
- Triangulating Information with Third-Party Data

Automated Provider Screening Program

- Identifies ineligible providers or suppliers before they are enrolled or revalidated by using enhanced screening procedures



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Data Analytics – The Playing Field Has Changed

Interviewed Current and Past Government Enforcement Individuals:

- Data analytics has changed the way they do their jobs
- Increased productivity
- Improved morale
- Increased collaboration
- Improved ability to find fraud, waste and abuse
- Combined with the Yates Memo – very powerful
- More than ever, Compliance is paramount

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Data Analytics – The Playing Field Has Changed

The Fraud Prevention System

- "Since June 2011, CMS uses the Fraud Prevention System (FPS) on all Medicare fee-for-service claims on a streaming, national basis. Similar to the fraud detection technology used by credit card companies, FPS applies predictive analytics to claims before making payments in order to identify aberrant and suspicious billing patterns. CMS uses leads generated by FPS to trigger actions that can be implemented swiftly."
- "Since 2011 the FPS identified savings (certified by HHS OIG) associated with these prevention and detection actions were $820 million... This resulted in more than a 10-to-1 return on investment for the first three years of implementation."

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-26.html

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Data Analytics – The Playing Field Has Changed

Healthcare Fraud Prevention Partnership

"The HFPP's purpose is to improve the detection and prevention of healthcare fraud by:

- Exchanging data and information between the public and private sectors.
- Leveraging various analytic tools against data sets provided by HFPP partners.
- Providing a forum for public and private leaders and subject matter experts to share successful anti-fraud practices and effective methodologies for detecting and preventing healthcare fraud."

https://hfpp.cms.gov/about/index.html

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Data Analytics – The Playing Field Has Changed

Medicare Provider Utilization and Payment Data

“The Physician and Other Supplier Public Use File (Physician and Other Supplier PUF) provides information on services and procedures provided to Medicare beneficiaries by physicians and other healthcare professionals. The Physician and Other Supplier PUF contains information on utilization, payment (allowed amount and Medicare payment), and submitted charges organized by National Provider Identifier (NPI), Healthcare Common Procedure Coding System (HCPCS) code, and place of service. This PUF is based on information from CMS administrative claims data for Medicare beneficiaries enrolled in the fee-for-service program. The data in the Physician and Other Supplier PUF covers calendar years 2012 through 2014 and contains 100% final-action physician/supplier Part B non-institutional line items for the Medicare fee-for-service population.”

https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicare-provider-charge-data/physician-and-other-supplier.html

Open Payments / Sunshine Act

“Open Payments is a federal program, required by the Affordable Care Act, that collects information about the payments drug and device companies make to physicians and teaching hospitals for things like travel, research, gifts, speaking fees, and meals. It also includes ownership interests that physicians or their immediate family members have in these companies.”

https://www.cms.gov/OpenPayments/

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Data Analytics – The Playing Field Has Changed

Integrated Data Repository

"The Integrated Data Repository (IDR) is a high-volume data warehouse integrating Parts A, B, C, D, and DME claims, beneficiary and provider data sources, along with ancillary data such as contract information, risk scores, and many others. Access to this robust integrated data supports much needed analytics across CMS."

https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/IDR/index.html

Medicare Program Integrity Manual Chapter 2 – Data Analysis

"This chapter specifies resources and procedures to the MACs, ZPICs, Recovery Auditors, and the [Supplemental Medical Review Contractor] SMRC. The contractors shall use these instructions to identify and verify potential errors to produce the greatest protection to the Medicare program. Contractors should objectively use analytical methodologies to evaluate potential errors…"

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Data Analytics – The Playing Field Has Changed

Department of Justice Health Care Fraud (HCF) Unit Creates Data Analytics Team – 2017

"As part of the HCF Unit's efforts to lead and coordinate a national approach to combating health care fraud, in 2017 the HCF Unit created and launched the Data Analytics Team. This team allows the HCF Unit to better assist prosecutors in effectively and efficiently identifying and prosecuting individuals and entities, and to learn about emerging health care fraud trends in the field. The Data Analytics Team also offers and provides U.S. Attorney's Offices with customized HCF data analytics training and ongoing case-specific investigation and prosecution assistance. The Data Analytics Team will continue to strengthen the HCF Unit's partnerships with U.S. Attorney's Offices across the country in combating health care fraud."

https://www.justice.gov/criminal-fraud/file/1026996/download

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Data Analytics – The Playing Field Has Changed

Attorney General Jeff Sessions in 2017:

"I am announcing a new data analytics program – the Opioid Fraud and Abuse Detection Unit.

This sort of data analytics team can tell us important information about prescription opioids—like which physicians are writing opioid prescriptions at a rate that far exceeds their peers; how many of a doctor's patients died within 60 days of an opioid prescription; the average age of the patients receiving these prescriptions; pharmacies that are dispensing disproportionately large amounts of opioids; and regional hot spots for opioid issues."

HHS, ESRI and ArcGIS:

Health and Human Services (HHS) uses Geographic Information System (GIS) analysis to identify opioid beneficiaries and outliers by using distance analysis and looking at the geographic distribution of opioid prescriptions.

Environmental Systems Research Institute (ESRI) is one of the biggest suppliers of GIS software in the world.

Click Here for Example: Opioid Fraud Example using GIS Technology by ESRI

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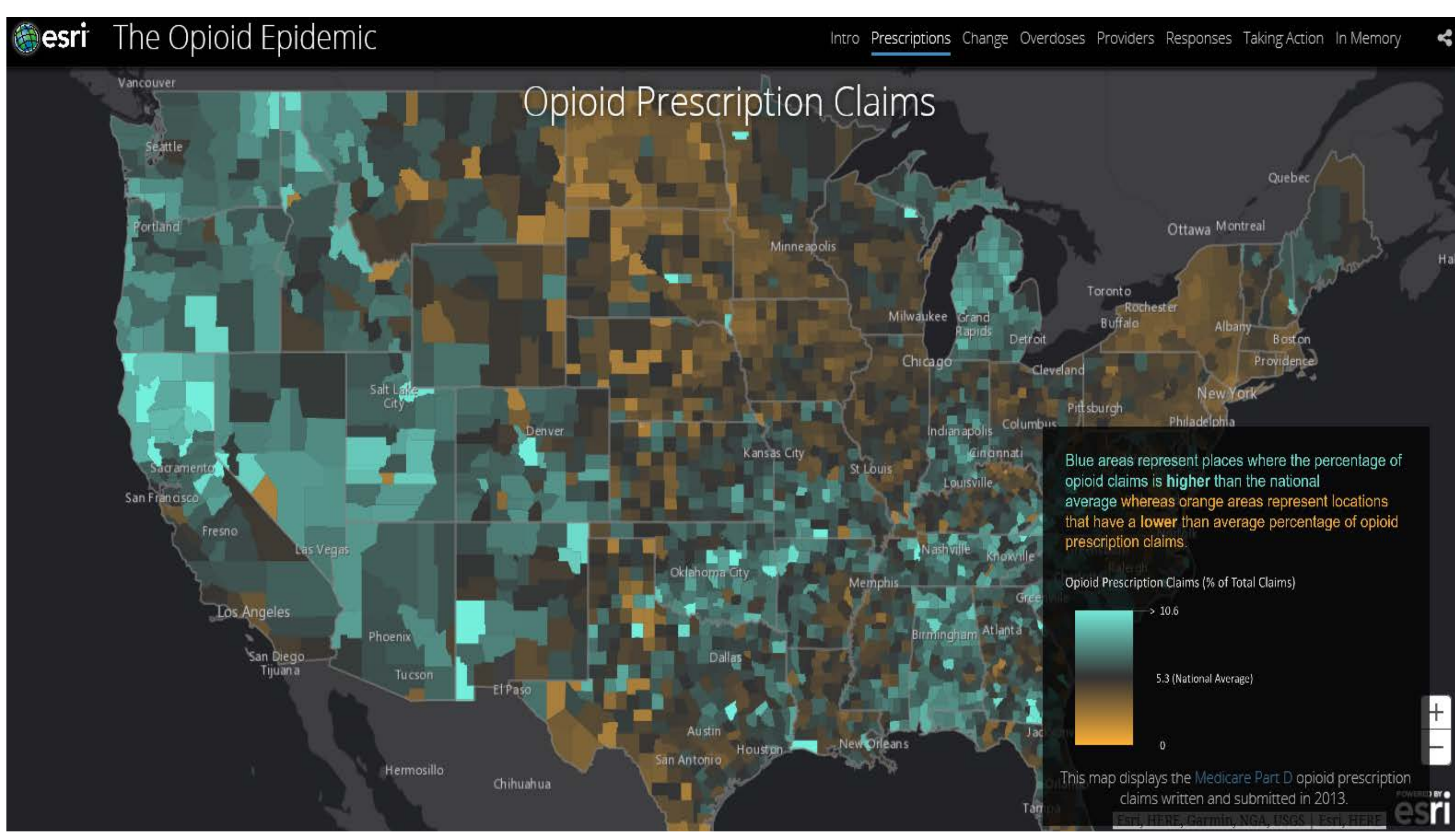
Data Analytics – The Playing Field Has Changed



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How Does Your Entity Look From the Outside?

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How Does Your Entity Look from the Outside?

Consider the following questions:

- What are your entity's most utilized codes?
- Who are your entity's highest paid providers?
- Who utilizes the highest and lowest E&M codes?
- Who is responsible for denials?
- Are you and your entity performing claims reviews?
- Is your entity being reimbursed for non-medically necessary services?
- Are you trending findings?
- Is your entity refunding money?
- Has your entity's compliance program been assessed?
- Who receives reimbursement from potential referral sources?
- Which physicians are receiving the most $ from industry?
- Does your entity do business with PODs?
- How does your entity assess FMV when acquiring physicians?
- Does your entity have a documented, strategic, compliant approach to physician compensation and acquisitions?
- Have you compared physician contract amounts to accounts payable?

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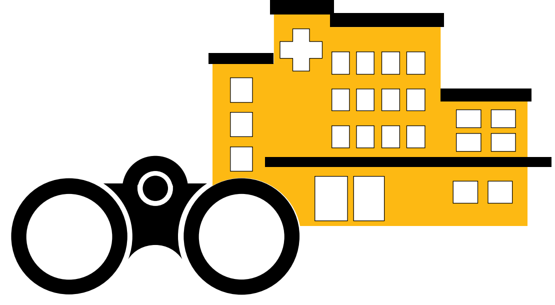
How Does Your Entity Look from the Outside?

Ultimately…

- Do you know what your organization’s compliance risk profile looks like?
- Do employees know their compliance responsibilities?
- Are they held accountable for them regardless of title?
- Are your entity’s compliance efforts satisfactory?
  - Could they attest that they are?
  - Could their board?
  - Could their executive leadership team?
  - Could operational management?



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Thank you

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