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Physician compensation arrangements: Robust reviews are a must

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Negotiating physician compensation arrangements has become more prevalent as an increasing number of physicians are employed by, or contract with, health systems, hospitals, and healthcare facilities to provide various services. Such arrangements are often complex, with multifaceted compensation, production, and quality-related elements, making them subject to hard-hitting regulatory scrutiny. Therefore, it is vital that hospital and health system executives implement robust contract management systems to assure the arrangements are negotiated in compliance with regulatory guidelines. Further, all involved parties should ensure that the supporting documentation adequately substantiates contract provisions for the defined arrangement.

The burden to make certain that physician arrangements are compliant with regulatory and legal considerations can be overwhelming. Violations of the Stark Law (Stark), Anti-Kickback Statute (AKS), or the False Claims Act (FCA) can not only be costly, but also embarrassing to a health system, its physicians, and its executives — potentially causing long-lasting reputational damage and distrust. In recent years, several hospitals have paid massive penalties, ranging from $25 million to $115 million, for excessive or improper physician compensation arrangements that exceeded fair market value (FMV) and may not have been commercially reasonable.[1]

For this reason, health system executives must recognize the need for conducting a thorough review of physician arrangements on a regular basis. Organizations will be in a stronger position if physician compensation arrangements are a fundamental component of their compliance work plans. Many potential compliance violations can be mitigated — or even prevented — by completing regular, detailed compensation arrangement reviews.

Physician compensation arrangement tracking may not be a top priority for some organizations, given limited resources and competing concerns. This is complicated by the fact that an organization's management of such arrangements may be decentralized or, in larger systems, perhaps maintained by external parties including legal counsel. However, comprehensive contract review and management is essential to ensure that the arrangements are current and meet organizational and regulatory requirements. Analyses of physician arrangements can reveal complicated party relationships, which could bring legal challenges. Furthermore, the executed contracts may often contain unintentionally vague language.

These issues can lead to uncertainty and a misunderstanding of the arrangement, inadvertently creating situations that otherwise could have been mitigated if thoroughly and proactively addressed. Physician compensation arrangements are often multifaceted — covering multiple services in a single arrangement, which can significantly impact FMV and commercial reasonableness. Commercial reasonableness is defined by the Stark Law as:

> An arrangement will be considered 'commercially reasonable' in the absence of

> referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential DHS [designated health services] referrals.[2]

Increased scrutiny

As the aggregate number of physician compensation agreements increases so, too, does regulatory oversight. Federal statutes, such as Stark, AKS, and FCA, directly affect physician employment or contracts for services, as do some state laws. Steep penalties can be imposed for noncompliance, particularly related to financial relationships with physicians.

Stark prohibits referrals for healthcare services amongst physicians and the entities with which they have financial relationships, unless the arrangement is structured to fit within a regulatory exception. Sanctions include repayment, fines, and exclusion from federal healthcare programs.

AKS prohibits the exchange of, or offer to exchange, anything of value that may influence the referral of federal healthcare program business. Criminal and civil penalties can be levied against any individual or entity that knowingly and willingly offers, pays, solicits, or receives any remuneration — including any kickback, bribe, or rebate — directly or indirectly, overtly or covertly, in cash or in kind, to any person to induce referrals, or to purchase, order, or lease an item.

FCA places liabilities on companies and individuals who attempt to defraud federal programs. It prohibits any person from knowingly presenting, or causing the presentation of, a fraudulent claim for payment to a federal healthcare program. The FCA has become an important, if not *the* most important, governmental tool for demanding healthcare providers' compliance with the requirements of federal healthcare program participation. Under the FCA, hospital or physician service payments that violate Stark or AKS are considered fraudulent. The FCA creates liability for any individual who knowingly uses or submits (or causes to be submitted) a false record, statement, or claim for payment to the government. Proof of intent to defraud is not required.

Steep penalties may also result from lack of compliance with various other certifications as the content identified within physician arrangements is central to completion of other critical governmental documentation. For example, certification requirements for Medicare cost reports must be taken into consideration. The misrepresentation or falsification of any information in a cost report may be punishable by criminal, civil, and administrative action, as well as a fine or imprisonment.

Specifically, the Medicare cost report includes facility costs associated with physician administrative time (Part A) and physician patient treatment time (Part B). The Centers for Medicare & Medicaid Services (CMS) expects that physician compensation agreements entered into by hospitals and health systems appropriately allocate the compensation between the administrative and professional components. Specifically, all physician time is defaulted to Part B, unless documentation shows the time qualifies for Part A. To report allocation of physician compensation, all compensation must be identified and quantified. Next, documentation must be reviewed to segregate Part A from Part B. Part A is reimbursable on the cost report and must be documented and verified with time studies, timely attestation signatures, and implementation of contracts.

Compliance with filings and the aforementioned laws has increasingly taken center stage as oversight agencies, such as the Department of Health and Human Services Office of Inspector General (OIG), have reinforced their goal to reduce healthcare fraud, waste, and abuse. Several dedicated entities have stepped up efforts to combat healthcare fraud, including the Medicare Fraud Strike Force, the FBI Healthcare Fraud Prevention Partnership,

the IRS Healthcare Fraud Criminal Investigation Unit, the OIG Health Care Fraud Prevention and Enforcement Action Team, and the USPS Office of Investigations Healthcare Provider Fraud Unit.

Such agencies are increasingly pursuing allegations against individual physicians and other providers, not only the hospitals and other organizations that employ them. These actions serve as reminders that physicians are increasingly held accountable for arrangements that may be in violation of multiple federal laws. As such, healthcare organizations that employ and/or contract with physicians must hold physicians accountable for regulatory compliance as part of the compensation arrangement to limit the organization's exposure to risk. The consequences of physician noncompliance can be severe.

Examples of these agencies' recent significant legal actions involving physician conduct are:

- July 2017: $1.3 billion in false billings to Medicare and Medicaid related to joint injections, opioid prescriptions, and drug screenings;[3]
- November 2017: $6.6 million in fraudulent claims to Medicare for nonemergency transports of dialysis patients;[4]
- January 2018: $2 million in restitution and four years in prison for a home health kickback and identity theft scheme;[5]
- February 2018: $63 million false billing for partial hospitalizations involving a community mental health center;[6] and
- March 2018: $30 million for pharmacy marketers who paid physicians to write prescriptions for expensive topical compounded medications.[7]

In addition, executives and members of boards of directors may potentially be held responsible for any organizational noncompliance.[8] The closer alignment of hospitals and physicians under new models of care delivery requires greater board oversight of compensation arrangements. The Department of Justice's focus on individual accountability leaves little doubt that efforts to assert individual accountability extends to officers and executives who "lead or participate" in activities perceived to be illegal conduct.