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Developing your contracts and fair market value: Spidey sense for compliance officers, Part 1

by Drew Williamsen, MHA, CHC, CHPC

The first time I was asked to review a contract while working in compliance, I was mortified! I had never read a contract, nor did I know what I was even looking for. I'm sure I'm not the only one to have encountered this situation, but it wasn't a pleasant memory. I very well could have missed something that typically compliance is supposed to catch. Which, in hindsight, is a liability.

To get myself out of the situation of not knowing what I was doing, over the years, I attended as many webinars and conference sessions as I could that related to contracts and fair market value (FMV). It seems that every year, there is at least one session on FMV and/or contracts at the Health Care Compliance Association Compliance Institute.

As great as those sessions are (I have yet to walk away disappointed), one thing has escaped each presentation I've attended, and that is, as a compliance officer, how do I know what to look for? These conference and webinar presentations are often done by a lawyer, looking at it from a lawyer's perspective, which means it is very "legal." They tell me what safe harbor or exception may apply in various situations and how to ensure the safe harbor or exception standards are met. These sessions have always been a gold mine of information and "how to" regarding Anti-Kickback Statute (AKS) and Stark, but what about from the compliance officer's perspective —not from a legal standpoint? How does one know when something needs to go to legal for further analysis? That is what I want to discuss, is when you, a compliance officer, are sitting in a meeting and someone say something about a contract, how do you know if it needs a deeper dive or if it is fine to continue through to signature? Or, if you are reading a contract, how do you know what might stand out as an issue? To that end, I present how to develop your contracts and FMV "*Spidey sense*."

Baseline

To start developing your *Spidey sense*, you will need a solid foundation of the AKS and its associated safe harbors, as well as the Stark Law and its related exceptions. If you haven't read AKS and Stark, I highly recommend doing so, as they are crucial to building your *Spidey sense*. I want to point out that the False Claims Act, various state laws, and many other rules and regulations may also play a factor, so read up on those too!

Also, all those legal conference/institute sessions and webinars will certainly help create one's own *Spidey sense*. These sessions and webinars are invaluable; please take advantage of every opportunity!

By having a general knowledge of the laws that greatly affect healthcare compliance officers, you are increasing the baseline of your *Spidey sense*. The laws change from time to time and keeping up with the changes is critical to

being an effective compliance officer and enhancing one's *Spidey sense*. As I go through various areas of contracts, FMV, and more, please note it is always wise to consult multiple safe harbors and exceptions. I do not want to discount, or at a minimum, mention the need to always review each circumstance to the appropriate safe harbor or exception and to review it with the legal team. For the purposes of this article, that is the assumption for a best-practice process.

Contracting arrangements

There are many types of contracting arrangements, but I want to focus on five types of contract arrangements that one needs to be familiar with as a compliance officer. As I examine each type of contract, I will point out numerous possible concerns that often arise. These potential concerns are what you should be looking for as a compliance officer. When you encounter a similar issue, that is your *Spidey sense* or your gut telling you something isn't quite right or isn't as expected. The more exposure you have to these issues, the more your *Spidey sense* will grow! I also want to note that these items to be on the lookout for are not inclusive but are common issues that I have seen pop up.

Employment contracts

When reviewing employment contracts, there are several areas to make sure you have satisfactory answers either written in the contract or in supporting documentation:

- What percentage of full-time employees (FTE) is the provider? Meaning is the physician going to be a 1.0 FTE, or .08 FTE, or some other percentage? The reason for asking this question is simple; if the physician is less than or more than 1.0 FTE, the FMV needs to be adjusted accordingly. Would you pay a part-time employee a full-time wage?

- Are medical/dental and other benefits included in the compensation? While this may not be an obvious potential concern, is the organization consistent in who gets benefits and who does not? Do physicians get a better deal on the premium rates than nonphysician employees? Do some providers get benefits while others do not, and those who do not technically meet the organization's threshold for benefits? Ideally, the application of benefits to employed providers is consistent and available to all providers who meet the organization's eligibility for benefits. Perhaps a .5 FTE doesn't qualify, or maybe it was negotiated for one .5 FTE provider to get benefits, which would likely be outside the standard practice.

- Are there quality incentives, "citizenship" requirements, or work relative value unit ("wRVU") thresholds that may affect pay? Is it clearly written and defined? If the provider qualified for the full incentive pay, what percentile of FMV would they land? Looking ahead to maximum pay scenarios will help determine if the contract arrangement is doable.

- Is there consideration given with regard to student loan repayment, relocation, or any other payments to a physician? (Outside medical directorships and call coverage, which we will get to.)

- Is there language about referral expectations? Does the provider have to keep every referral in-house? Is there a referral threshold that, if they meet, they get some form of a bonus? Read between the lines; this kind of issue would likely be implied and not obvious.

- Is moonlighting allowed? Is it spelled out in the contract or referencing a policy that addresses moonlighting? For those entities that have resident physicians, this is even more applicable.

- How many other contracts exist with this same provider? Having numerous contracts isn't necessarily an issue, but it should not be ignored either. Is it possible for the physician to actually do everything that is in

the numerous contracts? We'll come back to this when we discuss the "medically impossible day" in Part 2 of this article.

Professional service arrangements (PSA)

With PSAs, you can ask the same questions you might ask with employment contracts; obviously, some questions may not always apply, but there are other questions to ensure an appropriate answer:

- Is the provider a sole provider or one of many? Some medium to small communities often may only have one physician of a particular specialty. If there is language that says "exclusive" or "sole provider," this could be problematic in the future. Meaning what if a new physician of the same specialty comes to town? This may run afoul of antitrust laws depending on the arrangements of the "exclusive" relationship. If there are multiple providers for a service line, do they have similar arrangements? Not that it is required to have similar arrangements, but the optics of possible inequality amongst providers can cause problems that have nothing to do with "compliance."
- Is the PSA to cover an entire service line? Meaning does this one contract cover 24-hours a day, 7-days a week, 365-days a year coverage? If so, is it reasonable that the number of providers can fulfill the coverage requirement? I bring this up because, in a past life, I dealt with an issue where there was a hospital that contracted with one physician for 24/7 coverage, including on-call duties for all but 15 calendar days per year. Again, more on the medically impossible day later.
- Is the PSA for a designated health service (DHS)? If so, we definitely want to ensure the Stark Law has been consulted and any conflicts of interest have been disclosed, if applicable.
- Same as with employment arrangements: is there language about referral expectations?

Medical directorships

Medical directorships are often a good way for physicians to augment their income, as they may only require a small number of hours per month. Organizations tend to have less desirable controls around medical directorship timecards and subsequent pay practices. I'm always excited when someone tells me of their organization's robust controls in the medical director space. A few questions to ask:

- How many hours are listed in the contract? Is it by week/month/year? Typically, anywhere from 10–40 hours per month is normal; anything higher, and the question becomes, "why?" Some may argue 40 hours per month is high, but it also depends on the duties of the directorship.
- What is the validation or verification method of the medical director's timecard? Is it audited? Too many times, organizations don't do anything to validate that the medical director is even doing their job as outlined in the contract.
- What is considered sufficient documentation of time? Going along with the last bullet point, does the medical director just write the number of hours down, or do they need to document what they did with the number of hours they wrote down? For example, did they review charts, attend department meetings, etc., or did they just write down 10 hours, sign and date it, and then turn it in on a scratch piece of paper?
- Is there a limitation your organization has on the number of medical directorships one individual physician may have? For instance, is it reasonable to have one individual physician be a medical director of seven separate nursing homes?

- Lastly, will the medical director be required to supervise any employees or providers as part of their duties? If so, this may be a reason to increase the pay rate. Also, is the medical director actually supervising?
- Audits and controls around payment to medical directors need to be part of the process if it isn't already.

On-call

Just as with the other types of contracts, many possible questions to ask overlap, but here are the ones specific to on-call:

- Is the pay rate based on per day/hour/shift/case? If it is based on a per-case basis, it doesn't necessarily mean it is considering the volume of the referral, but I would take a deeper dive and consult with legal. Perhaps there are so few "cases" that it becomes impractical to have someone on call for something that happens only several times per year.
- What is the response time expectation? Various specialties may have different response times, but is the response time reasonable? What happens if they don't respond? This question also includes time to be "onsite." Often, on-call contracts will have language that indicates how long the provider has until they physically must be "onsite." The only problem is, what if the provider lives 45 minutes away, but the contract says the provider has 30 minutes to be onsite?
- What is the "fill-in" expectation? Call schedules are often created months—even up to a year—in advance but if a provider is scheduled to be on-call but needs to go to a conference, family emergency, etc., what is the expectation of who fills the on-call slot? Is it up to the provider or the organization? What happens if there isn't a fill-in? What is the process for payment in the case of someone filling in? I have seen firsthand where the process was the original provider was paid for being on-call with the expectation that they then turn around and pay the person filling in—the one who actually took the call. Needless to say, those payments to the provider filling in never happened.
- Is there language in the contract that explains which party follows up with the patient should the need arise? Do they send the patient to their primary care physician, or does the on-call provider get the referral if it is a specialist? Who gets to bill the professional fee for the on-call visit, the on-call provider or the hospital? There may not be anything nefarious about this, but for clarity's sake, it should be spelled out. At a minimum, this can help alleviate potential double billing.

Service agreements

Service agreements could be anything from landscaping, environmental services to contracted IT solutions, contracted radiology/imaging staff, etc. Questions to consider:

- Is this a DHS? If so, consult Stark Law.
- Does a physician or family member have financial interest in the company? I've seen on many occasions where a physician or their close relative owns a company—such as a landscaping company—and there is no conflict of interest disclosed. Since it isn't for a billable health-related item, it may not run afoul of typical healthcare laws, but it certainly raises eyebrows! Does the organization have a nepotism policy? Does it get enforced?
- Lastly, is the service needed? Do you know what the contract is for? This is where you might often see "consulting" agreements for a consultant no one has ever heard of, met, or seen any of the consultant's work product—more on this in the "contracting arrangements red flags" section.

Space and equipment

The last type of contract we will review is most unlike every other category we've reviewed. When it comes to FMV for leasing or purchasing space, I recommend ensuring someone with real estate transaction experience is on the team or involved in the process.

- Does a physician or family member have financial interest in the building/space/equipment? If so, refer to Stark.
- Is the space/equipment necessary? Are there plans to use the space/equipment? Here is the reason these two questions should be asked: when you purchase a house, do you intend to do something with it, such as live in it or rent it out? Do you buy a house and then do nothing with it for three years? Is the organization buying/leasing a building in hopes that the current owner, who happens to be a physician, might send referrals? If there isn't a need or a reasonable explanation as to the plans for the space, it might throw up a red flag. Hospitals often buy houses and other buildings on the immediate lots surrounding the hospital so that one day, they can tear those structures down and expand, which is perfectly normal. If you will note, however, there is a plan in this case, albeit years down the road.
- Who is buying, and who is selling/leasing? See the previous bullet point. Also, communities often have someone who owns a high amount of office space, land, etc. Sometimes these individuals may prefer to sell/lease to specific organizations/individuals based on a "this for that" mentality. "This for that" could implicate the AKS. These types of individuals who purposefully sell/lease are very good at not putting particular language in writing, so be sure to understand the full scope of the transaction if a certain character is involved.
- Is 100% of the space being leased? If the plan is only to rent 50% of the space, is it spelled out in the arrangement as to the exact space, or is a floor plan provided that indicates what areas are being leased? How does the organization ensure that only the contracted space leased is used? What happens if more than the contracted amount of space is used? How does the usage of space get audited?
- Is the usage of supplies/overhead/equipment factored in?
- There are possibly many other questions and concerns that may arise with any given contract; this list was not meant to be inclusive but more of an "at a minimum" look for these types of issues.