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Meet

Mary Dunaway, Hospital Revenue Cycle Compliance Director, University of Arizona Health Network

PAGE 14

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Feature Focus:

Medicaid RACs: Tool of transparency or torment?

PAGE 44

How to respond to a regulatory investigation

PAGE 8

Documenting fair market value for physician contracting

By Penny Stroud

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The rising costs of physician service contracts and compliance documentation is affecting hospitals across the country. California hospitals spend in excess of 3% of all expenses on non-salary physician costs for a broad range of services that includes medical direction, emergency call coverage, leadership positions, administrative services, diagnostic test interpretations, and more. In addition to the cost of service contracts, the cost of fair market value (FMV) documentation for service contracting is rising as government oversight and enforcement efforts are increasing.

All health care providers are subject to the regulations that require FMV compliance and documentation. There are a number of approaches to consider for the review of physician contracts and documentation of compliance. The costs, associated risks, and benefits of each of these approaches varies considerably. This article will explore the growing number of tools that enable hospitals, health systems, and other providers to institute cost effective strategies for controlling the cost and burden of compliance while upgrading the level of documentation for physician contracts.

Trends in physician contracting and compliance costs

The cost of physician contracts for non-salaried, non-billable services is rising rapidly for health facilities. Physicians are demanding more and higher pay for call coverage; medical direction; attendance at meetings; leadership positions; and many other teaching, research, and administrative functions that they formerly provided without pay in exchange for medical staff privileges or visibility in a medical community.

Data submitted to the California Office of Statewide Health Planning and Development[1] show that since 2000, these costs have increased 14% per year for California hospitals, reaching more than $8 million per hospital annually (see graph 1). Trauma hospitals pay considerably more. Other types of providers, including nursing homes, dialysis centers, ambulatory surgery centers, and clinics experience similar demands for physician services. The growing burden of administrative compliance, quality and peer review activities, and evidence-based practice protocols has increased the need for physician involvement in administrative and leadership functions at most health care organizations.

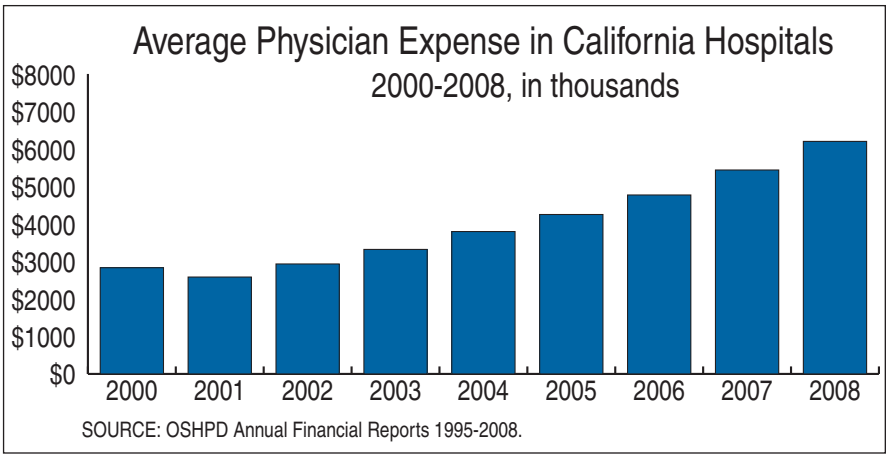
Another factor and trend impacting call compensation is the increasing number of uninsured patients who are treated in America's dwindling Emergency Rooms. One recent study[2] found that the number of hospital Emergency Departments (EDs) in urban areas fell 27% from 1990 to 2009, from 2,446 EDs to 1,779. Overall, about two-thirds of EDs are at safety net hospitals, which tend to have a worse payer mix. Many call payments begin when physicians ask for compensation for treating uninsured patients in the ED, and later expand into full-fledged per diem payments for call coverage.

Clinical integration initiatives, planning for health reform, electronic health records (EHR), and the development of Accountable Care Organizations also benefit from physician participation and leadership. Yet, decreased

reimbursement and the growing separation of many physicians' hospital and ambulatory practices have increased the challenge of engaging physicians to participate in these non-billable services. These trends, coupled with regulatory mandates, such as the Emergency Medical Treatment and Active Labor Act (EMTALA), are increasing the demand for services and the demand for payment by physician contractors.

Government regulations mandate that payments to physicians by a provider meet FMV. Compliance requires documentation of comparable rates for comparable services. Many providers seek an outside FMV opinion from an expert valuation consultant, often at a cost of $3,000 to $10,000 per opinion. An analysis conducted by MD Ranger to evaluate the FMV costs for outside opinions at a sample of 40 hospitals in California, found annual expenditures ranging from $5,000 to $100,000 per hospital, with a strong upward trend driven by heightened administrative and board requirements for objective documentation of FMV.[3]

Graph 1



As enforcement efforts raise the bar on compliance documentation, these costs are escalating at a time when most hospitals are working to reduce costs in anticipation of health reform. Strategies to control the cost of physician contracts and the cost of documentation can be a critical component of addressing budget challenges.

Compliance landscape

Regulations governing FMV payment for physician contracts include the Stark, anti-kickback, and private inurement rules. These laws were passed to deter health care providers from paying physicians for referrals, colluding on price, or otherwise manipulating physician relationships to disguise fraud and abuse.

There is growing evidence that government enforcement efforts to ensure FMV are intensifying. OIG reported in June 2011 that it expected to collect more than $3.4 billion from fraud investigations, including anti-kickback cases, in 2011. Between 2000 and 2010, almost 100 anti-kickback cases were settled with health care organizations, ranging from less than $100,000 to several million. Twenty new cases alone occurred in 2010 through May 2011, with settlements ranging between $50,000 and $7.3 million. At least five of these settlements included medical direction, administrative services, or call coverage components.[4]

Hospitals found guilty of non-compliance with FMV and documentation guidelines risk lawsuits, civil and monetary penalties, and even the loss of Medicare and Medicaid funding, as well as long and complicated settlement agreements.

What and when to document

In short, any negotiated agreements regarding physician compensation should always be documented, with proof of sources for FMV. The risk is just too high not to have documentation on file for all contracts.

The laws require documentation for any type of payment to physicians (or other providers) who are in a position to refer patients, including payments for:

- On-call coverage

Continued on page 70

- Medical direction
- Hospital-based services, such as emergency, radiology, anesthesiology, or hospitalists
- Leadership positions, such as chiefs of staff or other medical staff officers
- Ad hoc or ongoing committee or administrative services work
- Consulting for quality initiatives, peer review, and electronic health records
- Over-read and test interpretations

All of these physician payment arrangements are eligible for review in a Compliance audit, as would any other agreement to pay a physician or group who is in a position to refer patients to another provider.

Fair market value is generally considered to be the price at which a service would change hands between a willing buyer and willing seller on the open market at arm's length, when neither is under compulsion to complete the transaction. Because there is not an open market for most physician services, hospitals and valuators must find other ways to evaluate the FMV for arrangements.

In addition to the FMV standards, payments must also be "commercially reasonable." This term is a subjective test of a "standard of reasonableness" (i.e. what a reasonable entity would do in the specific circumstance, taking all factors into account, and judged by the standards of the applicable business community). For a health care entity, this means that the payment should reflect the business practice both for payment for the specific service, as well as for the amount of payment or time required to perform the service.

Examples of agreements that do not pass the commercial reasonableness standard could include payment for excessive hours for a medical direction or administrative services agreement, payment for call coverage to a specialty with limited or no demand in the Emergency Department, or payment for multiple medical directors for the same or very similar services.

Tools for documentation

So, what can a provider do to ensure an agreement is within FMV and is commercially reasonable? There are a few options for staying compliant. Some hospital administrators call colleagues at other health care organizations to ask about going rates. This method could help determine what other hospitals in a similar geography are paying, but it is unlikely to hold up to scrutiny, and at worst, could be construed as anti-competitive behavior. A more objective, systematic approach will provide more "cover" from government scrutiny.

Once it is determined that compensation is necessary for a physician contract, hospitals must document that the rate agreed upon is FMV. In many cases, high-quality market data—that with a robust sample—is acceptable as documentation of FMV. These market data also provide information that can be helpful in negotiating contracts and managing physicians' expectations.

National benchmark data for all or some of these services is published by several sources, including MD Ranger, Inc., Sullivan Cotter, Inc., and the Medical Group Management Association (MGMA). Non-salary physician service cost data is a new area, with more limited information sources compared to the availability of physician salary and compensation data.

Compensation benchmarking data is typically collected on an annual basis via survey to update information and benchmarks for on-call coverage, medical direction, hospital-based services, various contract non-payment terms, and certain diagnostic and testing services. Several of the surveys include hourly rates and hours required for various medical directorships. Hospitals using survey data and benchmarking databases for documentation are seeing a decrease in the need for FMV consultants, and sometimes

even a decrease in physician payments, as they bring the number of hours or hourly rates into line with industry benchmarks. Many valuation consultants recommend use of the 25th to 75th percentile range of published benchmarks to document FMV.

For unusual or very expensive situations, it may still be necessary or advisable to obtain an independent FMV opinion. Examples of such circumstances might include the need to justify a higher-than-market rate for hiring a nationally renowned physician for a specialty center, or implementation of an EHR system that requires exceptional participation of a physician champion.

Another instance could be when a physician is demanding higher than market rates for call coverage, because of limited supply in the community, but the hospital must provide coverage due to EMTALA. Hospitals needing a formal FMV opinion should engage a professional who:

- takes into account local, regional, and national market data;
- has the experience to evaluate the unique features of a particular service and organizational needs; and
- has experience employing the cost method of valuation to estimate costs of providing the service. In this method, the valuation experts calculates what it will cost the physician to provide the service relative to his/her expected income from other sources. However, be aware that payments for non-clinical services are not meant to replace lost income. OIG specifically cautions against taking into account the value of "lost opportunity" when formulating on-call or other physician arrangements.

Finally, an organization can seek a competitive bid for a service. This can be a costly and time-consuming process that could end with the lowest bid being much higher than anticipated. However, it may be necessary if payment demands exceed industry benchmarks or standards for commercial reasonableness.

Summary

The risk of failing to comply with FMV payments and documentation is increasing. However, new sources of published benchmark data and consistent use of standards and documentation can reduce the cost of compliance and the risk of overpayment.

1. California Office of Statewide Health Planning and Development. Available at http://mdranger.com/services-benefits.html
2. California Healthline: Number of Emergency Departments Decreasing in U.S., Study Concludes. http://www.californiahealthline.org/articles/2011/5/18/number-of-emergency-departments-decreasing-in-us-study-concludes.aspx (May 2011).
3. MD Ranger analysis (proprietary information)
4. Enforcement statistics available at http://oig.hhs.gov/newsroom/news-releases/2011/sar_release.asp