New Trends in Hospital/Physician Integration

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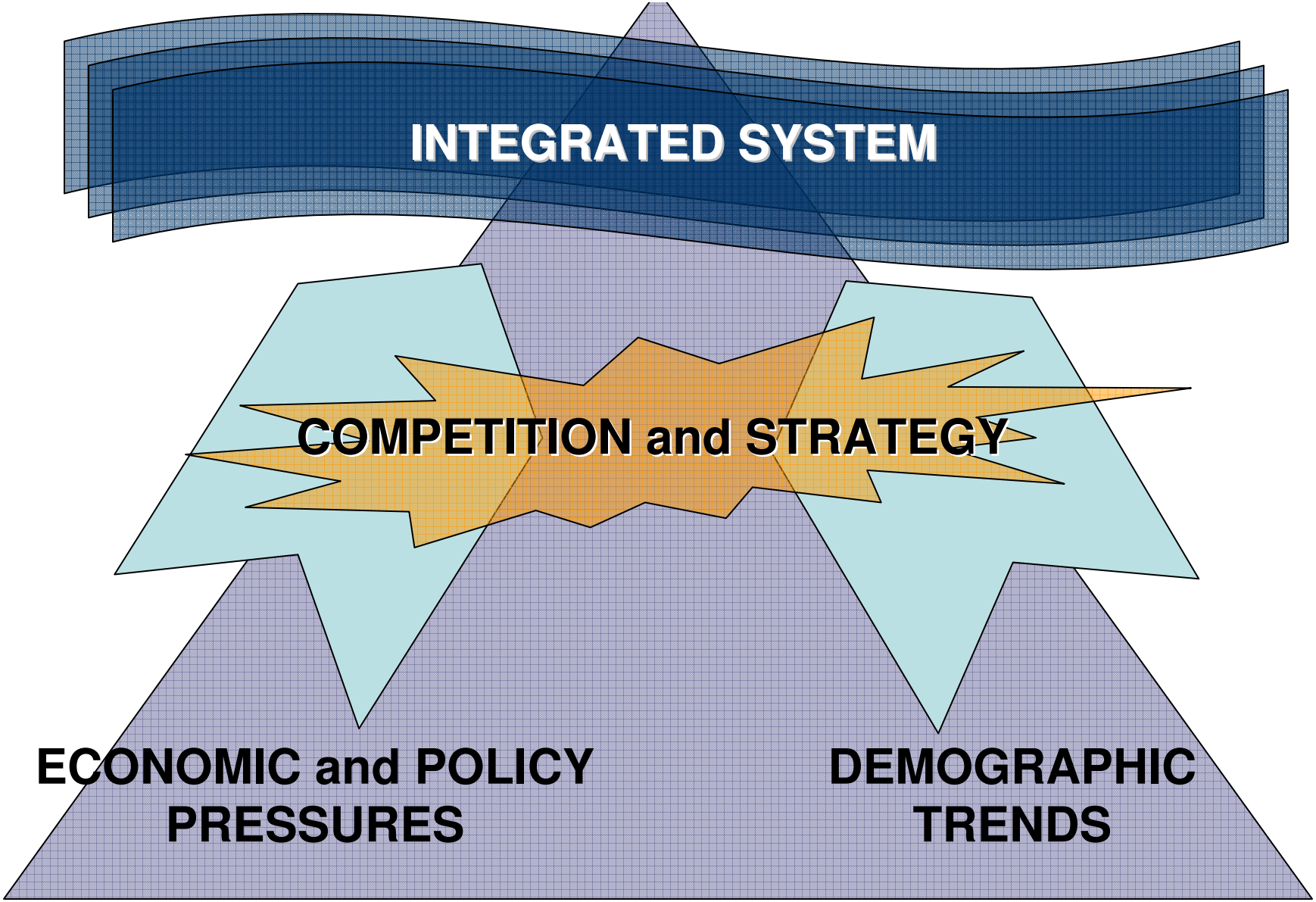
Agenda

- Drivers of Integration
- Qualities of Successful Integration
- New Trends in Integration – Various Structures

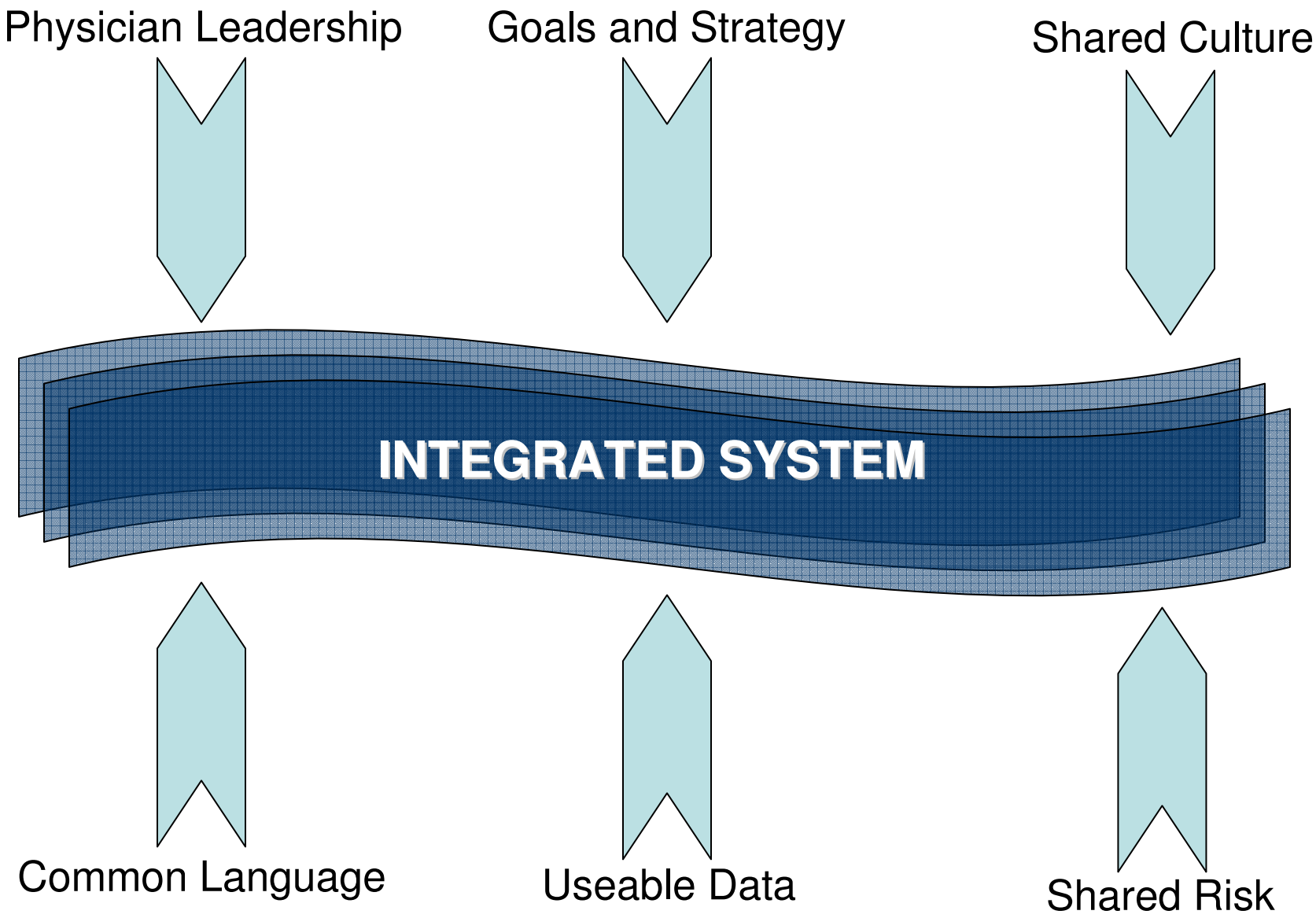


Drivers of Integration

Key Drivers of Integration / Consolidation

- Economics and Health Policy
  - Diminished ancillary profitability and growing practice expenses
  - Evolving reimbursement systems
  - Downward pressure on compensation
- Demographics
  - Physician supply challenges
  - Physician attitude toward independent practice – continued desire for some autonomy
  - Growing uninsured population and high deductible health insurance plans
- Competition and Strategy
  - Stabilize medical staff
  - Promote / ensure access
  - Transform care delivery

Qualities of Successful Integration



Qualities of Successful Integration

- Physician Leadership
  - Governance, management and clinical
  - Shared responsibility
- Clear Goals and Strategies
  - Well-defined objectives
- Shared Culture
  - Agreed upon responsibilities and behaviors

Breakthroughs: Aligning Hospitals and Physicians Toward Value. *HealthLeaders Media*, December 2009.

Qualities of Successful Integration

- Common Language
  - Physicians and administrators use same managerial lexicon
- Useable Data
  - Reliable data on which to create efficiencies and improve outcomes
- Shared Risk
  - Incentives for quality and outcomes
  - Engage in risk-based reimbursement

Breakthroughs: Aligning Hospitals and Physicians Toward Value. *HealthLeaders Media*, December 2009.

Integration…
More Considerations

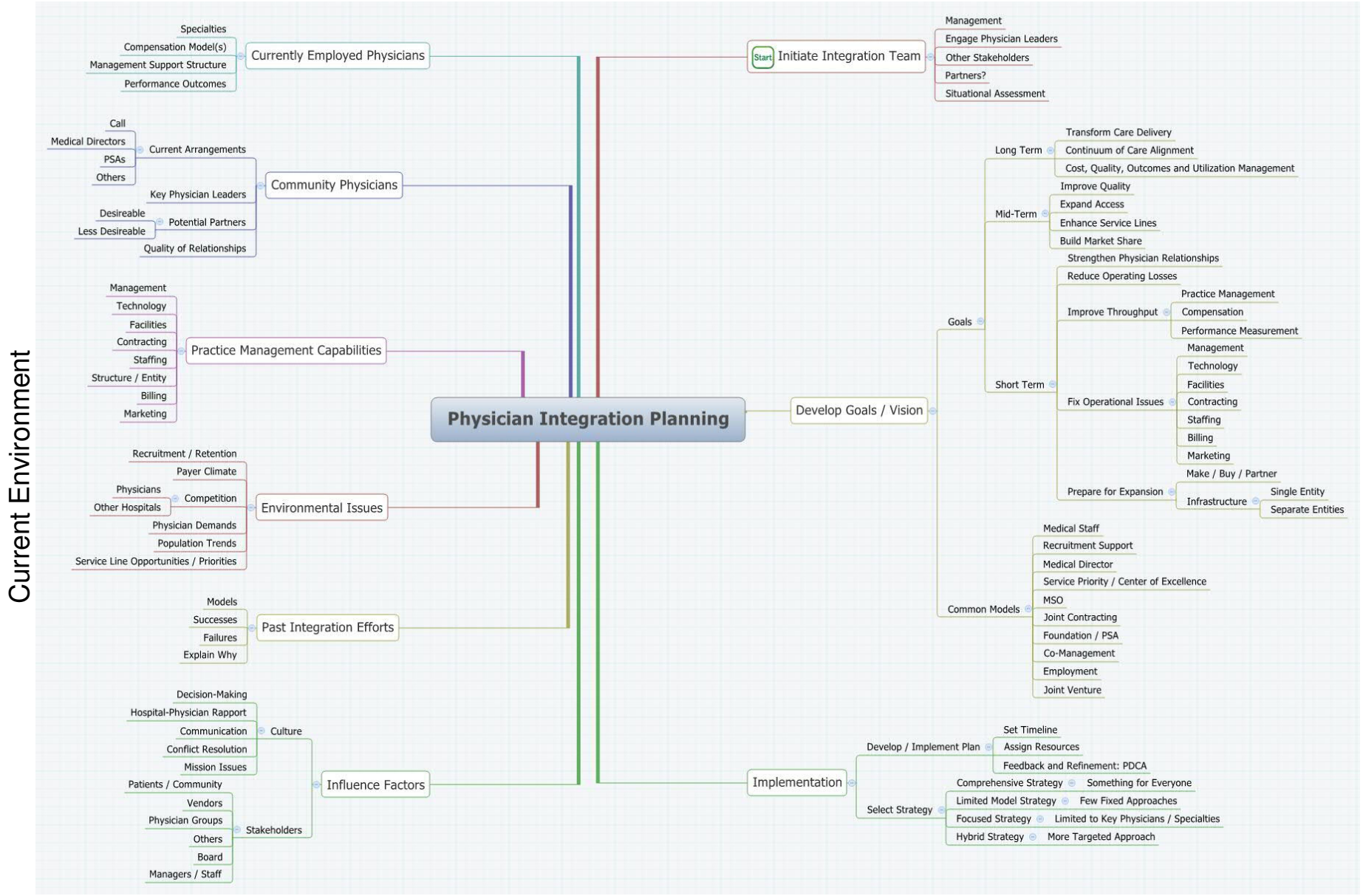
- Don't Commit the Sins of the Past
  - Overpay physicians
  - Ineffective compensation programs
  - Unrealistic (and unmonitored) performance expectations
  - Passive practice management
  - Poor health plan contracting
  - Exclude physicians from leadership
  - Select the wrong physicians as partners / employees

Integration…
More Considerations

- Do Create the Environment for Success
  - Establish the organization and expectations before taking on physician employment
  - Be selective / set priorities
  - Construct compensation programs that promote specific objectives
    - Be candid about physician retirement strategies
  - Share control and accountability with physicians
    - Engage physicians in devising your integration strategy

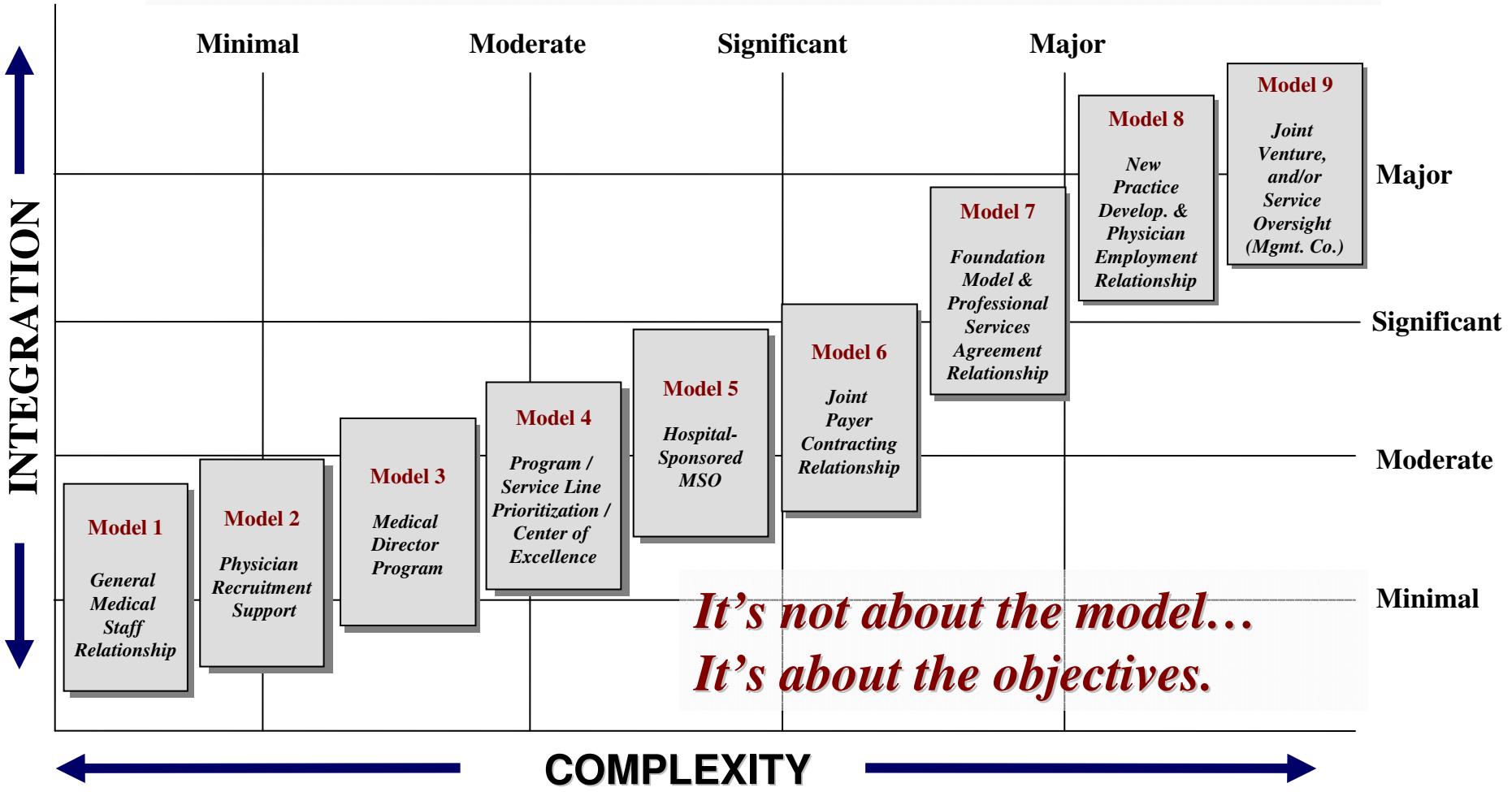
Pinnacle Integration Development Map

(April 2009)



Physician-Hospital Integration Continuum

Hospital Systems Continue to Re-Assess the Necessity of Utilizing a Broad Range of Affiliation Options with Physicians to Advance Their Shared Missions / Visions



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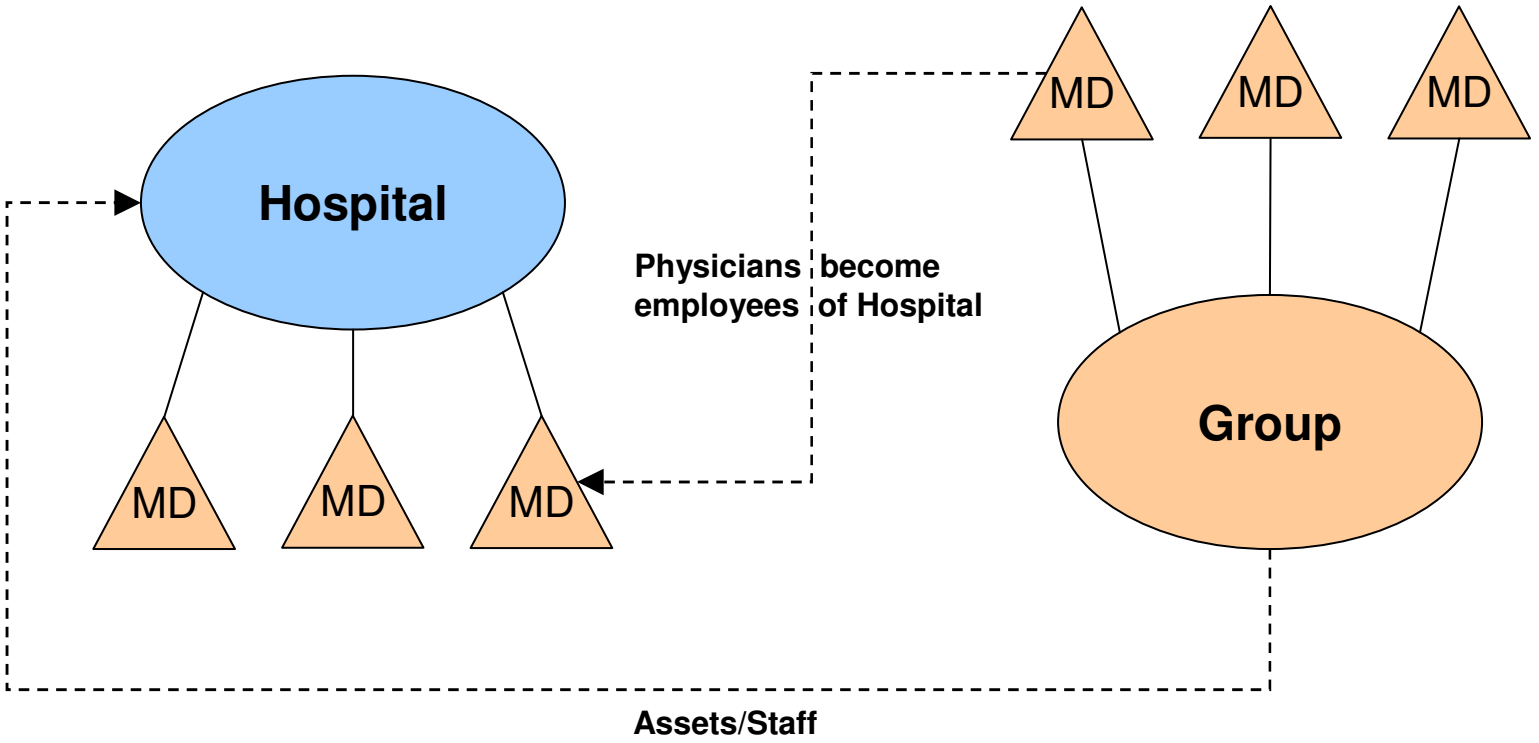
New Trends in Integration
- Various Structures -

- Employment
  - Traditional
  - Group Practice Subsidiary
  - Physician Integration Model
- Clinical Co-Management
- Recruitment / Seating Arrangements
- Management Services Arrangements
- PSA Models

"Employment" Options

- Traditional Employment Model: Purchase practice and directly employ physicians by hospital (ancillary services billed by hospital, possibly as provider based). Cannot give physicians credit for ancillaries.
- Group Practice Subsidiary Employment Model: Purchase practice and employ physicians through a subsidiary of hospital (ancillaries billed by hospital or by subsidiary that qualifies as a "group practice" in order to share ancillaries with physicians).
- Physician Integration Model: Employment of physicians through a group practice subsidiary, but instead of purchasing the practice, lease services (space, equipment, staff, etc.) from existing practice.
- Compensation Options: Prefer a physician compensation model that includes a productivity component (collections, RVUs) based on personally performed services.

Traditional Practice Acquisition and Employment Model



Traditional Practice Acquisition and Employment Model

- Structure:
  - Group sells hard assets to hospital at FMV
  - Physicians become employees of hospital
  - Staff become employees of hospital

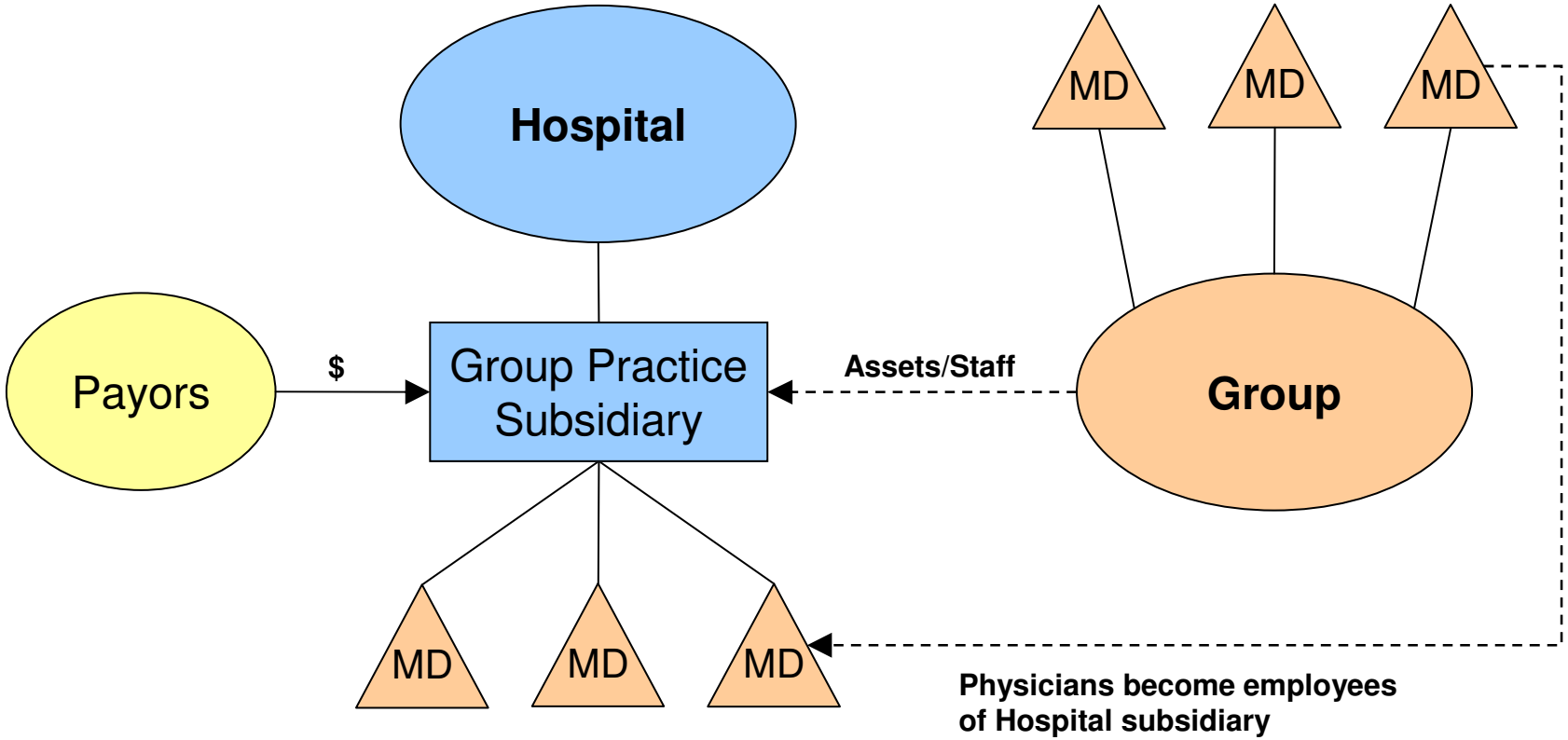
- Agreements:
  - Asset purchase agreement
  - Physician employment agreements
  - Lease / sublease for space
  - Lease / sublease of equipment

Traditional Practice Acquisition and Employment Model

- Advantages:
  - Highest level of integration with physicians

- Disadvantages:
  - Hospital has to come up with capital to buy practice
  - MDs nervous about selling & losing "control"
  - No physician sharing of ancillary revenues
  - Difficult to "unwind" if unhappy later
  - Hospitals have traditionally lost money on employed physicians

Group Practice Subsidiary Model



Group Practice Subsidiary Model

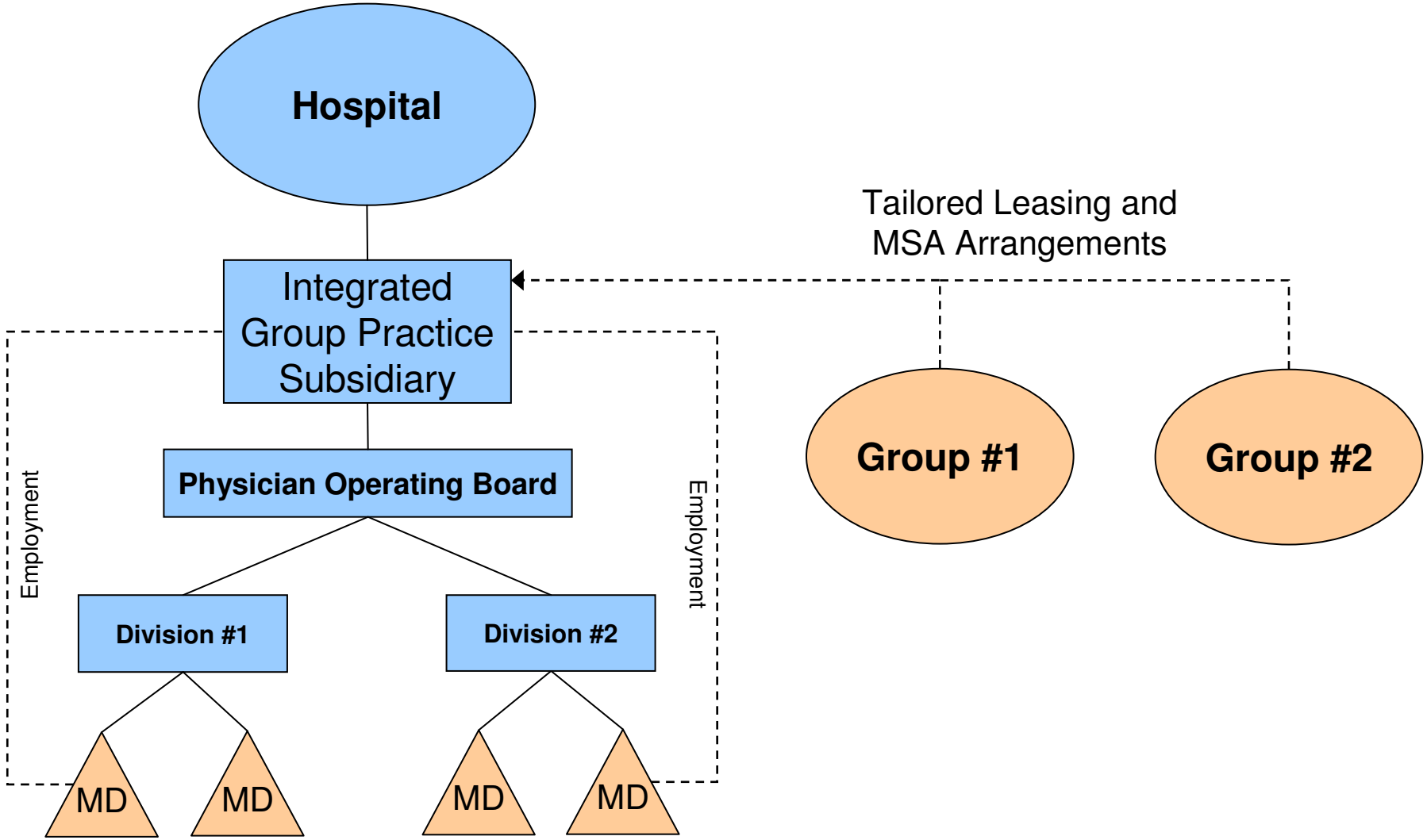
- Structure:
  - New entity that is a subsidiary of Hospital
  - Physicians become employed by new entity
  - Operations board is controlled by MDs
- Agreements:
  - Employment agreements between Hospital subsidiary and physicians
  - Asset purchase agreement
  - Organizational / governance documents for new entity including operational and governance policies

Group Practice Subsidiary Model

- Advantages:
  - Gives physicians ability to manage the Group Practice Subsidiary like their own private practice
  - Allows physicians to share in ancillary revenue

- Disadvantages:
  - Must meet "group practice" requirements under Stark which has many requirements
  - Hospital cannot subsidize subsidiary / physicians

Physician Integration Model



Physician Integration Model

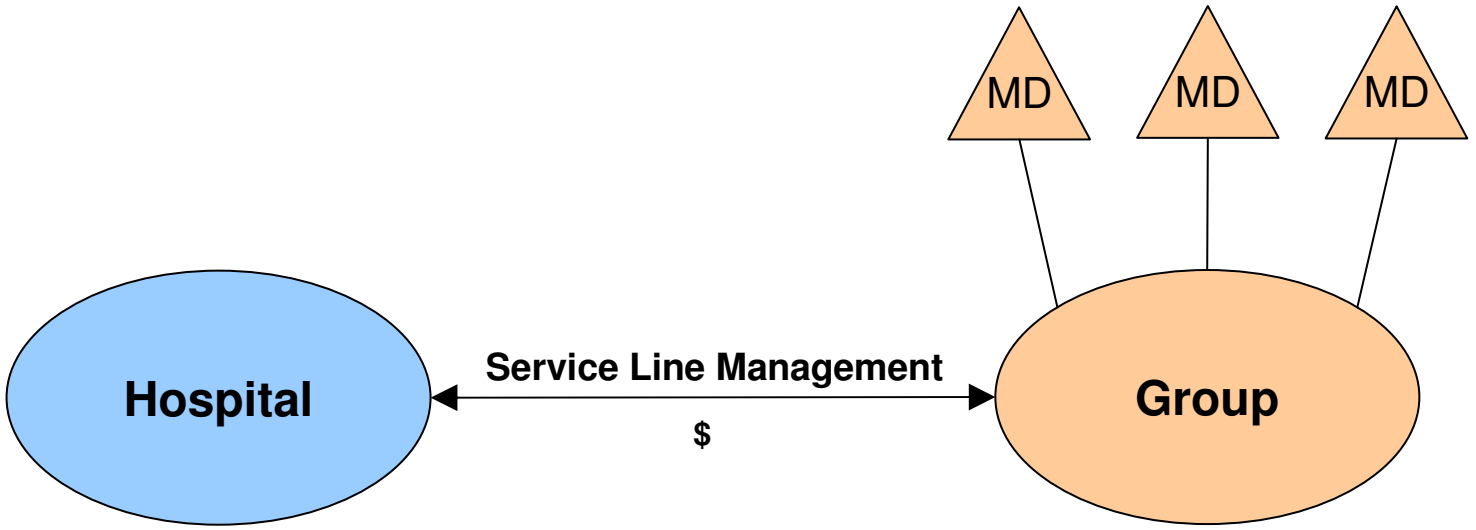
- Structure:
  - New entity (subsidiary of hospital?)
  - Physicians become employed by new entity
  - An operational board is set up
  - Divisions are established for various groups / specialties

- Agreements:
  - Employment agreements with MDs
  - MSA with practice
  - Leases with practice
  - Organizational / governance documents for new entity including operational and governance policies

Physician Integration Model

- Advantages:
  - Minimum capital outlay by hospital
  - Physicians have escape valve
  - Easier to implement than practice acquisition
- Disadvantages:
  - Complex structure to implement
  - Group / MDs lose payor contracts
  - Group has no A/R if physicians go back to private practice

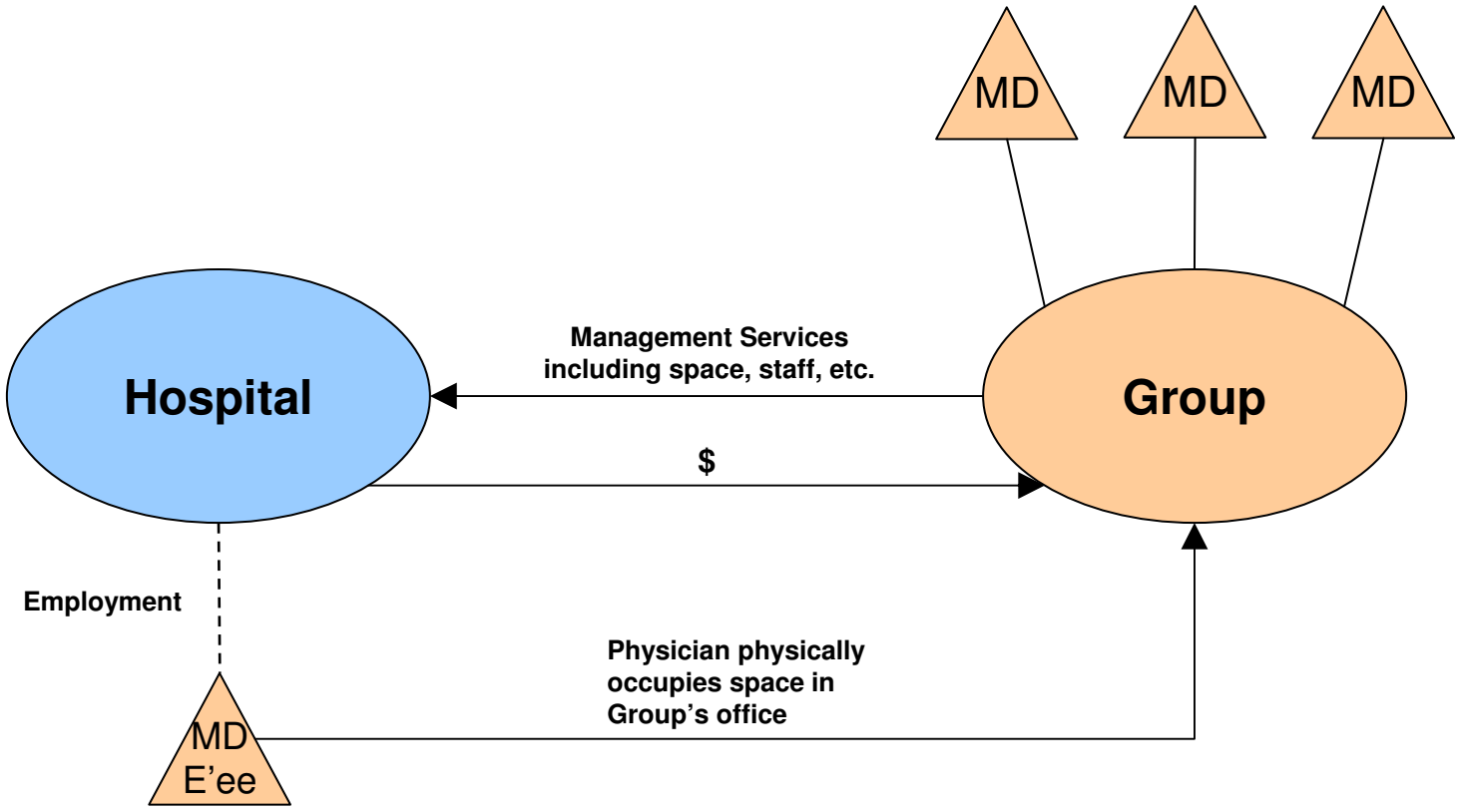
Clinical Co-Management Model



Clinical Co-Management Model

- Structure:
  - No new structure
  - Group provides comprehensive management services to Hospital for service line
- Agreements:
  - Management services agreement
- Advantages:
  - Simple way to integrate with Group and work toward common goals for service line
- Disadvantages:
  - Does not give entrepreneurial group the ability to share in the revenue stream of the technical services

Recruitment ("Seating") Model - Alternative to Traditional Recruitment



Recruitment ("Seating") Model – Alternative to Traditional Recruitment

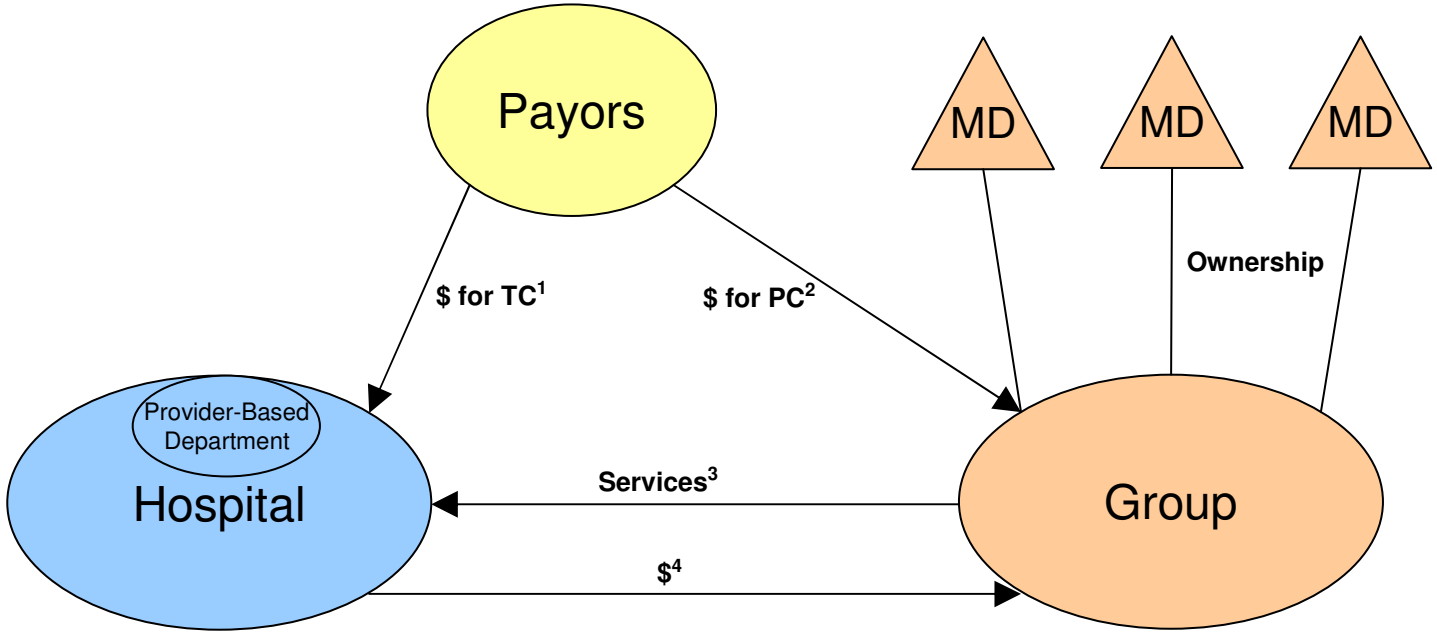
- Structure:
  - Hospital employs new recruit and collects for all professional services provided by recruited physician
  - Group provides management services, space, staff, etc. to Hospital for recruit in exchange for FMV compensation

- Agreements:
  - Employment Agreement between Hospital and recruited physician
  - Management Services Agreement between Hospital and Group

- Advantages:
  - Avoids cumbersome and restrictive recruitment rules (Income guarantee / incremental expense allocation provisions of recruitment exception are not applicable)

- Disadvantages:
  - Recent changes to the Stark laws have made equipment and space leases in an office-sharing arrangement more difficult

Management Services Agreements – The "New" Under Arrangements



1. Hospital bills for the non-professional services (facility or technical charge) at hospital rates
2. Physician Group bills for the professional services
3. Group provides a variety of services (i.e., equipment or staff; supplies; management services)
4. Hospital pays Group a FMV rate for each service

Management Services Arrangement Model

- Structure:
  - Very similar to a more traditional under arrangements model except that Group cannot perform the complete service (i.e., cannot provide turn-key cath lab services and sell to Hospital)
  - Group may provide management services, space, supplies, and either the equipment OR the technical staff (but not both)

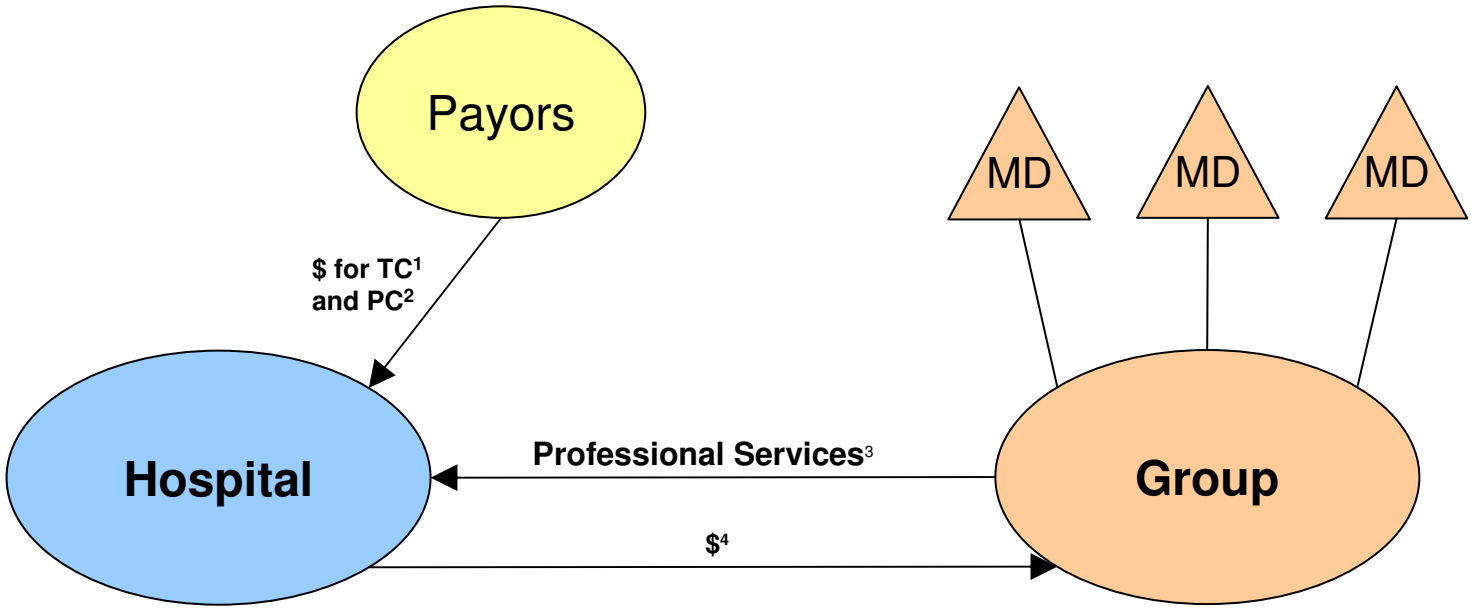
- Agreements:
  - Various leases (space, equipment, staff)
  - Management service agreement

Management Services Arrangement Model

- Advantages:
  - Option available for restructuring existing under arrangements deals without completely unwinding them
  - Continues to allow for integration with physicians

- Disadvantages:
  - Level of payments to Group through leases and management agreement is not likely going to be at the same level as what was paid for the entire service in a traditional under arrangements deal
  - Complex structure to implement and manage

PSA Model



1. Hospital bills for the non-professional services (facility or technical charge)
2. Group / MDs reassign right to bill for the professional services to Hospital
3. Group provides professional services to Hospital
4. Hospital pays Group an FMV fee for professional services

PSA Model

- Structure:
  - No new structure required
  - Group / MDs reassign PC to Hospital
- Agreements:
  - PSA for services (comp must be structured to meet exceptions/safe harbors & be FMV)
- Advantages:
  - Simple to implement because no new legal structure
- Disadvantages:
  - Does not necessarily provide level of integration opportunities hospital or physicians desire
  - Usually fairly short duration before needing to renegotiate

Questions?

A Former Federal Prosecutor's Views On Healthcare Enforcement Trends For 2010

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The take-aways for today

- The federal law enforcement community is still very committed to health care as a top priority
  - We'll talk about how we know this and what it means
- The Colorado U.S. Attorney's Office's healthcare efforts are led by a very capable Assistant United States Attorney
  - We'll talk about what this means for you
- There are a lot of things on your plate, and we'll talk about one prioritization approach for you to consider

How does the federal government signal it is still committed to health care enforcement activity?

The federal government is very clear about the signals that it sends:

- Prosecutions
- Investigation
- Civil settlements
- The resources that it requests and receives from Congress / the presentations that its representatives make

Prosecutions
(Go with what you are good at doing)

- Failure to provide service
- Failure to provide equipment
- Kickbacks
- Medically unnecessary

Investigations

- What would happen if Denver were chosen as the 8th location for a Medicare Fraud Strike Force (because they are adding up to 20)?
  - Their focus includes allegations of medically unnecessary procedures or never provided (rehab has been a big target)
  - Kickbacks, including recruiting schemes
- The Air Evac Investigation
  - False claims (medical supplies never bought)
- What is your best option for self-disclosure (and how will it play with the U.S. Attorney's Office for the District of Colorado)?

Civil Settlements
(the one promoted by DOJ)

- United States v. Mercy Medical Center - $2.79M for failure to provide, or failing to demonstrate if provided minimum number of hours of rehab therapy required under Medicare guidelines / self-disclosure / DOJ Civil Division / OIG
- United States ex rel. Steve Radojenovich v. Wheaton Community Hospital - $846,461 to settle allegations that hospital admission practices violated FCA because the hospital knowingly made claims for unreasonable and unnecessary admissions / Qui Tam by physician / DOJ Civil Division / USAO Minnesota / OIG

Settlements con't

- United States ex rel. Wendy Buterako v. Genesys Health System - $664,413 to settle a lawsuit that alleged that Genesys overbilled for evaluation and management services provided to cardiology patients / Qui Tam / DOJ Civil Division / USAO E.D. MI / OIG
- United States ex rel. v. Visiting Physicians Association - $9.5M to settle lawsuit where United States alleged that association violated FCA by submitting claims for unnecessary home visits and care plan oversight services, for unnecessary tests and procedures, and for more complex evaluation and management services than were actually provided / Qui Tam / DOJ Civil Division USAO for S.D. OH and E.D. MI

Settlements con't

- United States v. St. John Health System

- United States ex rel. Keshner v. Nursing Personnel Home Care, et al., $9.7M settlement of lawsuits alleging phony training certificates of home health aides and related billing for the aides' services / Qui Tam / Commercial Litigation Branch / USAO E.D.N.Y. / OIG / State of New York

Settlements con't

- United States ex rel. Tony Kite v. Our Lady of Lourdes Health Care Services, Inc. - $7.95M settlement of 2005 lawsuit alleging hospital fraudulently inflated its charges to obtain enhanced reimbursement for outlier payments when the cases were not extraordinarily costly or outlier payment should not have been made / Qui Tam / DOJ Civil Division / USAO D.N.J. / OIG and FBI
- United States v. Kerlan Jobe Orthopaedic Clinic - $3M settlement for allegations of kickback, including disproportionate high ownership interest in HealthSouth jointly owned ambulatory center. Follow-on to 2007 HealthSouth settlement.

Settlements con't

- Others
- United States ex rel. Fry v. Health Alliance of Greater Cincinnati (The Christ Hospital of Cincinnati)

Historical Settlements

Memorial Medical Center and Related Physician Groups

- $5.08M Stark and False Claims settlement in April 2008
- Lawsuit began as a whistle-blower claim by a physician that focused on:
  - Payments made by hospital to a non-profit subsidiary that employed ophthalmologists
  - Payments were for production, indigent care, and teaching activities
  - However, subsidiary group did not split compensation based on who performed indigent care and teaching, but instead used compensation to retain certain physicians
- Illustrates increased focus on hospital-employed physician relationships and "follows the money" to determine if compensation is for actual services rendered

Historical Settlements con't

Cardiologists' Settlement

- Ongoing investigation of several cardiologists and a New Jersey hospital's cardiology program – allegedly a $36M kickback scam
- Several cardiologists have already settled for multiple times their annual salary
- The investigation centers around:
  - Hospital's failing cardiology program
  - Hospital paid 18 cardiologists as "clinical assistant professors"
  - Cardiologists did not provide the level of academic services required under contract
  - Prosecutors alleged that the arrangements were a scheme to pay for referrals

Historical Settlements con't

Texas Settlement

- $1.9M Stark and False Claims settlement in 2008
- The issue:
  - Orthopedic group utilized space owned by hospital without paying rent
  - Physicians in group referred orthopedic patients, services, and items to hospital
- Hospital self-disclosed arrangement after conducting an internal compliance audit

Historical Settlements con't

HealthSouth and Physicians

- $14.9M Stark, Anti-kickback, and False Claims settlement in 2008
- Settlement involved both HealthSouth and the 2 affiliated physicians involved in the arrangement
- Allegation: Physicians received payments above FMV pursuant to sham medical director agreements
- OIG concerned about hidden financial arrangements between healthcare providers that influence where treatment is provided and what treatment is received

Historical Settlements con't

Lester E. Cox Medical Centers: The "New" Erlanger

- $60M Stark, anti-kickback, and False Claims settlement in July 2008
- DOJ compared Cox to Erlanger
- The investigation focused on:
  - Cost reporting violations
  - Inappropriate financial relationships between Cox and its contracted physicians (compensation formula and medical director relationships)
  - Flawed dialysis billing methodology
- DOJ says it is still investigating certain individuals from a criminal perspective

Historical Settlements con't

St. John Medical Center

- $13M settlement resulting from a voluntary self-disclosure to OIG
- Involved numerous physician agreements that did not comply with Stark and Anti-kickback Statutes:
  - Some not in writing
  - Question of whether services provided / documented
  - Fair market value issues
  - Contract term problems – too long

DOJ Health Care Resources and Presentations

- Holder speeches
- DOJ presentations

How Do I Prioritize Our Compliance Analysis?

- Gap Analysis

  Standards

  Minus performance

  Gap

  x

  Risk

- Chapter 8 definition of effective compliance program

Questions?

Medicare-Medicaid Program Integrity Update

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Summary

- Overview of the Medicare Recovery Audit Contractor (RAC) Program, Medicaid Integrity Contractor (MIC) Program and the transition to Zone Program Integrity Contractors (ZPIC) Program
- Experience from the RAC Demonstration Project - patterns of claim denials and experience with appeals of denials
- Implementation of the ZPIC and MIC programs
- Preparing for the reviews
- Appeal of Denials - The Medicare and Medicaid Appeals Processes
- Question / Answer

Reality

- Increased number of government contractors actively trying to identify Medicare and Medicaid overpayments and potential fraud or abuse in federal health programs
- Contracted are using sophisticated data mining programs to identify suspect claims
- Healthcare organizations need effective processes to facilitate proactive and reactive steps to prepare for and manage contractor inquiries and disputes

Pressure on Claims

- Growing number of entities reviewing healthcare provider reimbursement
- Not limited to inpatient and outpatient hospital reimbursement
- Weapons becoming more powerful
  - Enhanced False Claims Act and state false claims acts
  - DRA-required employee education designed to encourage whistle blowing

Low-Hanging Fruit

- Government agencies and prosecutors believe there is massive fraud and abuse in the system
  - CMS estimates $10.4 billion in improper Medicare payments
  - CMS estimates $18.6 billion in improper Medicaid payments
  - FBI projects fraud and abuse represents 3 to10 percent of total health spending
  - OIG reports $2.04 billion in investigative receivables and $1.22 billion in audit disallowances in FY 2006-2008

Contractor Landscape

- Medicare Administrative Contractors (MAC)
- Zone Program Integrity Contractors (ZPIC)
- Program Safety Contractors (PSC)
- Medicare Drug Integrity Contractors (MEDIC)
- Recovery Audit Contractors (RAC)
- Qualified Independent Contractors (QIC)
- Medicaid Integrity Contractors (MIC)
- Federal Medicaid Integrity Group (MIG) (which engages MICs)
- Office of Inspector General (OIG)
- State Medicaid agencies and Medicaid Fraud Control Units (MFCU)

CMS Recovery Audit Contractor Program

- Demonstration project authorized by Section 306 of Medicare Modernization Act of 2003
- RACs were tasked to identify and correct Medicare overpayments and underpayments
- RACs compensated on contingency fee basis (Region D = 9.49%)
- Demonstration project was designed to determine whether RACs were a cost-effective method to identify and correct overpayments by Medicare

CMS Recovery Audit Contractor Program con't

- Demonstration project started in California, New York and Florida and expanded in 2007 to South Carolina, Massachusetts and Arizona
- More than $1.0 billion dollars recovered, not counting operating costs and results of appeals
- CMS determined RACs were cost-effective as the demonstration project cost was $.20 for every $1.00 returned to the Medicare Trust Fund

Demonstration Project Expansion

- The Tax Relief and Health Care Act of 2006 made the RAC program permanent - required nationwide expansion by 2010
- CMS planned to expand to 19 states by October 2008, but bid protest by unsuccessful RAC bidders delayed implementation
- Bid protests were settled in early February 2009 and nationwide expansion is moving forward
- For most states, automated review began in late 2009 and complex review will begin in calendar year 2010
- New issues initially posted to RAC website in August 2009 and have dramatically increased in recent months

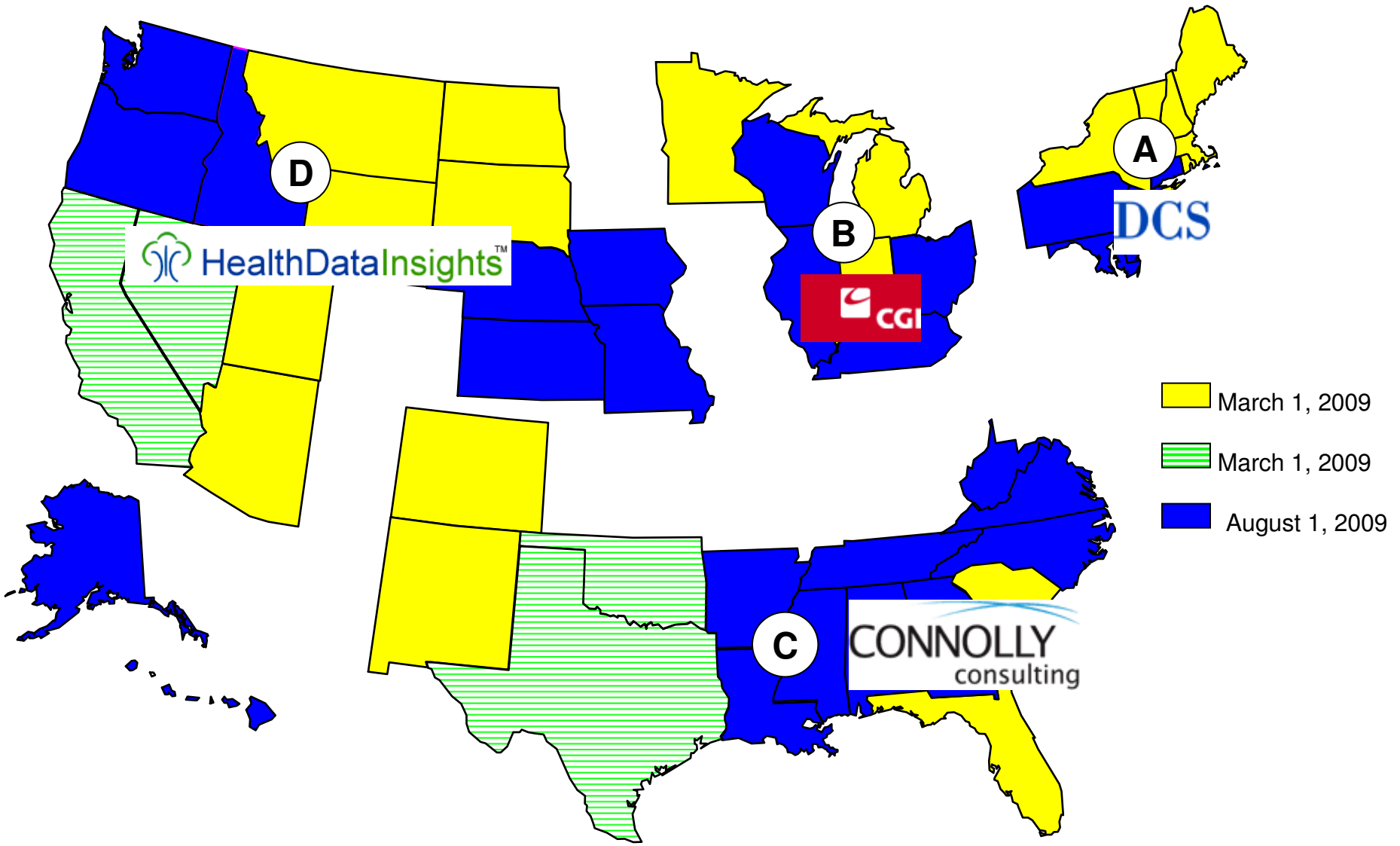
Permanent RAC Rollout

- CMS will give pre-approval to each coding and medical necessity review, and will approve language in the RAC medical record requests and demand letters
- New RAC audits will be screened by CMS "new issues review board"
- CMS pledges to "cap" the number of medical records requests per month per provider or supplier, based on NPI
- CMS hired a validation contractor to audit RAC audit accuracy rates
- CMS will require RACs to provide more detailed information in denial letters
- RACs required to have websites with detailed review status information

RACs – Just Who Are These Guys

- Diversified Collection Services Inc. (DCS) - Region A
- CGI Technologies and Solutions Inc. (CGI) - Region B
- **Connolly Consulting Associates Inc. ("Connolly") - Region C (includes Colorado)**
- HealthDataInsights (HDI) - Region D
- PRG-Schultz will subcontract with HDI, DCS and CGI in Regions A, B and D, and its responsibilities will include some claims review (home health claims in Region D)
- Viant Payment Systems, Inc. will subcontract with Connolly in Region C, conducting complex review of physician-administered J-codes and hospital inpatient claims

RAC Jurisdictions



RAC Methodology

- "Automated Review"- review of claims data where there is "certainty" that the claim includes an overpayment and does not include medical record review. RACs recently posted new automated reviews on their websites.
- "Complex Review"- review of medical and other records and is used in situations where there is "high probability" that the claim includes an overpayment. Medical necessity is an example of complex review.
- RACs do not randomly select claims for review but use proprietary software to determine claims likely to contain overpayments ("Targeted Reviews").

RAC Review Process

- RACs review claims on a post-payment process
- RACs do not review claims already reviewed by another contractor
- RACs use same Medicare policies as FIs, Carriers and MACs, including NCDs, LCDs and CMS Transmittals and Manuals. In complex reviews, RACs can apply an exception to the clinical reasonableness and necessary requirements described in an LCD to not deny a claim (see Transmittal 302, Sept. 11, 2009).
- RACs are required to employ a staff consisting of nurses, therapists and coders and a contract medical director

CMS Says Three Keys to RAC Program Success

- Minimize Provider Burden
- Ensure Accuracy
- Maximize Transparency

Minimize Provider Burden

- Limit “look-back” period to three years, no earlier than October 1, 2007 from date of initial payment
- RACs will accept imaged medical records on CD / DVD
- Limit the number of medical record requests (complex reviews)
  - For institutional providers, RACs set a limit “per campus” bases on maximum that can be requested every 45 days (see attached revised CMS communication)
  - Limits will be set at 1 percent of all Medicare claims submitted for the previous calendar year, divided into eight (45 day) periods
  - RACs may not make requests more frequently than 45 days
  - For physician groups, the number is based on the number of physicians in the group (range of 10 to 50 records per 45 days)

Ensure Accuracy

- Each RAC employs nurses, certified coders and a contract medical director
- CMS New Issues Review Board provides oversight over new audits
- RAC validation contractor provides annual accuracy scores for each RAC
- If RAC loses at any level of appeal, RAC must return contingency fee

Maximize Transparency

- New issues are posted to RAC web sites (Region C RAC has current approval for 15.2 percent of FY08 Medicare revenue)
- Vulnerabilities are posted to the web
- RAC claim status web interface (by 2010)
- Detailed review results letter after complex review

Sample Approved Complex Reviews for Region C

- MS-DRG 871: Septicemia w/mcc
- MS-DRG 329: Major small and large bowel procedures w/mcc
- MS-DRG 853: Infectious and Parasitic disease with OR procedure
- MS-DRG 207: Respiratory System Diagnosis
- MS-DRG 981: Extensive OR Procedure Unrelated to Principal Diagnosis
- MS-DRG 872: Septicemia w/o mcc
- MS-DRG 163: Major Chest Procedures w/mcc

Differences Between Demonstration and Permanent RAC Program

- Permanent RAC will expand to all provider and supplier types who bill Medicare Part A and B on a fee for service basis
- Permanent RAC will only be able to go back to claims paid beginning October 2007 and no more than three years past the date of initial payment

Differences Between Demonstration and Permanent RAC Program con't

- Registered nurses or therapists are required to make medical necessity determinations and certified coders are required for coding determinations
- RACs required to employ contract medical director to provide guidance regarding interpretation of Medicare policy
- If provider succeeds in appeal at any level, RAC must pay back contingency fee

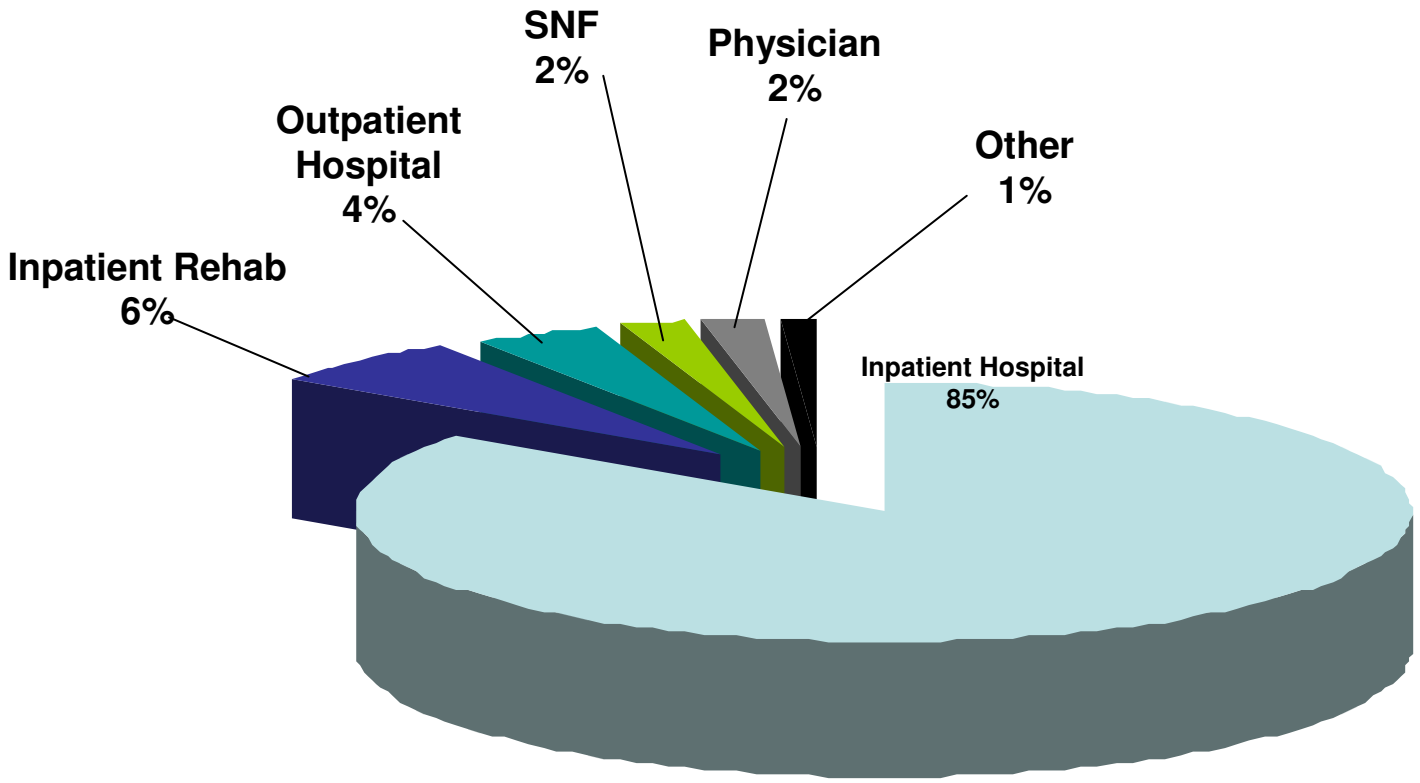
RAC "Standards" of Review

- InterQual, Milliman or other "screening criteria" used by Medicare QIOs are not Medicare policies. Both InterQual and Milliman have been provided to the RACs who have said they will attempt to match the screening criteria that is used by the claims processing contractor (be aware of RAC using screening criteria as sole basis for denial)
- National Coverage Determinations

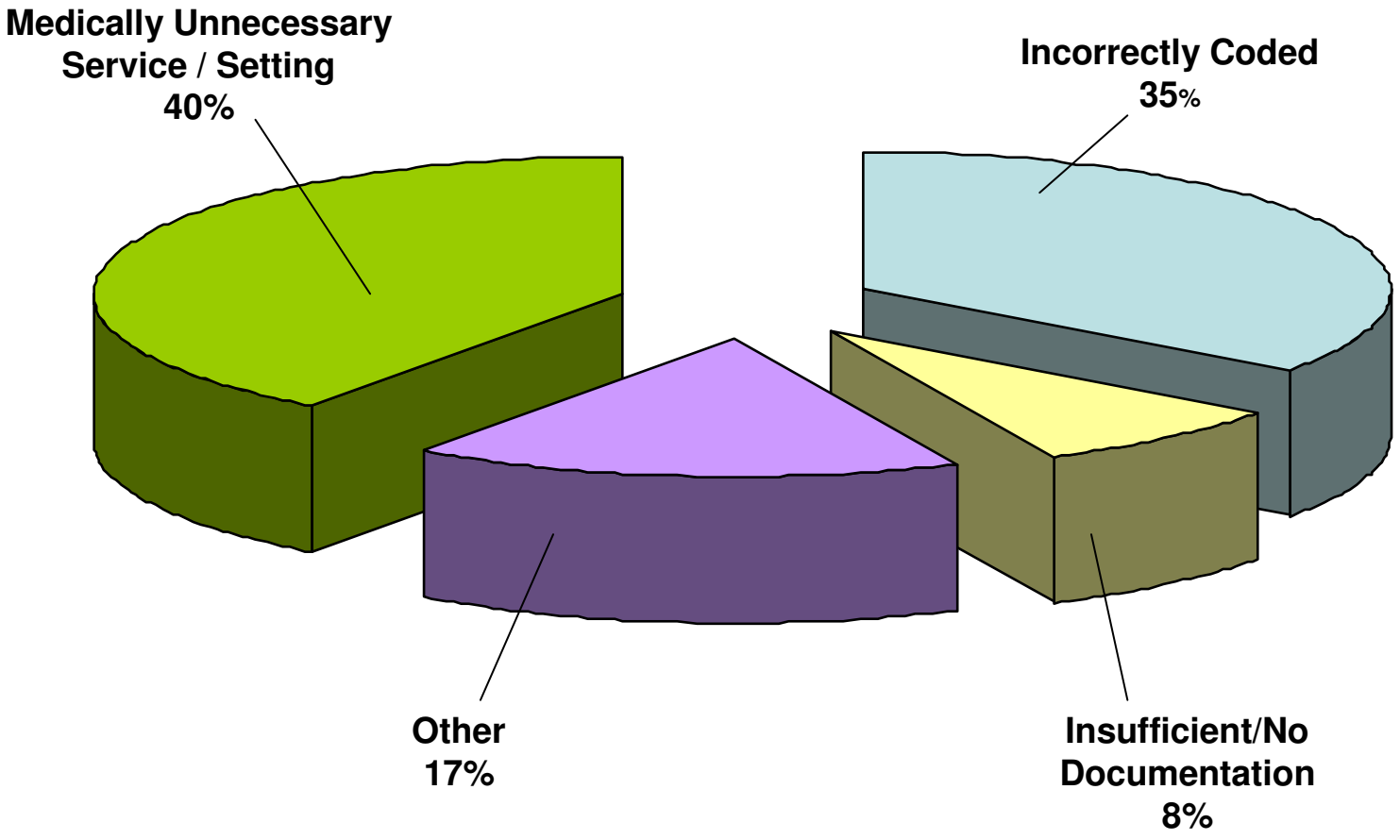
RAC "Standards" of Review con't

- Local Coverage Determinations. Transmittal 303 grants flexibility to RAC contract medical director to not use LCD to deny claim under "unique circumstances"
- Local medical review
- Medicare policies and publications

Overpayment by Provider Type Demonstration Project



Overpayment by Provider Error Type Demonstration Project



Focus Areas from the RAC Demonstration Project

- Inpatient admissions for procedures eligible to be performed in outpatient setting
- One-day stays that would qualify as observation (chest pain, non-acute CHF, back pain, gastroenteritis, elective defibrillator implantation)
- Three-day stays to qualify for skilled nursing facility care
- Treatment for heart failure and shock (setting)
- Services following joint replacement surgery
- Outpatient speech-language pathology
- Physical therapy, occupational therapy and speech-language pathology in SNF setting

Focus Areas from the RAC Demonstration Project con't

- Excisional Debridement documentation
- Respiratory system failure with ventilator support
- Medical Back Problems
- Non-extensive OR unrelated to principal diagnosis
- Respiratory infections and inflammations
- Sepsis
- Nutritional and metabolic disorders

Potential Focus Areas for New RACs

- Hospitals - Coding, including units of service, payments for diagnostic X-rays in ED setting, continued focus on patient classification, discharge disposition and medical necessity
- Physician Practices - E & M coding, duplicate claims, place of service errors, appropriateness of payments for colonoscopy services, high utilization of in-office diagnostic services, such as ultrasound
- Home Health - Part B therapy payments, accuracy of coding and claims for Medicare Home Health Resource Groups, physician referrals to home health (verify plan of care and referring physician identifier)
- SNF - medical necessity of therapy services, SNF consolidated billing, medical necessity of hospital stay to qualify for SNF coverage

Top RAC Recovered SNF Claims

- Medically unnecessary physical therapy, occupational therapy and speech language pathology services
- Other Part B claims (e.g., blood glucose)
- Part A claims
- Impact of consolidated billing

RAC Focus on Patient Classification

- Determination of patient status is reserved to the physician and should be based on the care the patient is expected to receive
- Physician should order an inpatient admission for a patient expected to need inpatient care for 24 hours or longer and treat other patients on outpatient basis
- RACs found that certain diagnoses and procedures (e.g., implantable cardiac defibrillators, chest pain admissions) do not support an inpatient admission and fall within the definition of outpatient observation

RAC Focus on Patient Classification con't

- Condition Code 44 - Physician can change admission order to outpatient observation prior to discharge and hospital can bill for observation
- CMS initially said that inpatient admissions denied by RACs will not be able to be re-billed as outpatient observation except for ancillary services (i.e., no APC payment). CMS has recently said it "may" delay reviews of short stay admissions until it can establish a process through rulemaking to allow for rebilling.
- Improper patient classification and claims submission can lead to False Claims Act liability ($26 million settlement involving St. Joseph's in Atlanta and recent settlements concerning kyphoplasty)

Observation Services

- Observation services involve the use of a bed and periodic monitoring by the hospital staff as reasonably necessary to evaluate the patient's condition or determine need for inpatient admission
- Observation services should not be billed for diagnostic or therapeutic procedures for which active monitoring is part of the procedure (colonoscopy, chemotherapy)
- Observation must be medically necessary (immediate risk of deterioration if not cared for in the hospital) and not for the convenience of the patient or physician
- In most cases, observation services are packaged services for which no additional payment is made
- Composite APC payment may be made when observation care is billed in conjunction with high level ED visit, critical care services or direct admission

One Hospital's Experience in RAC Demonstration Project

Complex Review

- 406 record requests
- Dates of service: 2004-2007
- 40 percent of requests were one-day stays
- 61 percent of the one-day stays related to cardiology
- 60 percent of denials related to medical necessity, 40 percent were DRG denials or related to coding

One Hospital's Experience con't

Automated Review

- 168 claims reviewed for discharge disposition
- Under permanent RAC, discharge disposition will become complex review (medical record review)
- Automated reviews focused on inpatient-only procedures, 72-hour rule, discharge disposition code assignments and units of service (transfusions, rehabilitation services and Neulasta infusions) (already approved for automated review in permanent RAC)

RAC Records Management

- Make sure entire record is submitted and review it before it is submitted (Is it legible, complete and do we think we can win on appeal?)
- See CMS Transmittal 47 (June 5, 2009) concerning requirements for complete medical records
- Number all pages, make sure they are legible and scan everything you are sending to the RAC
- Include NCDs, LCDs, coding guidance, letter from attending physician if applicable, etc.
- Sending records in electronic format is encouraged (encrypted CD, DVD)
- Send in manner where date of delivery can be confirmed
- Follow-up with RAC to confirm delivery

Preparing for RAC Audits

- Organize your team and assign responsibilities. Coordinator of RAC process should be detail-oriented
- Evaluate patterns of current denials by Medicare contractors, areas identified in the RAC demonstration project, the new issues posted to the RAC web sites and any “vulnerabilities” identified internally through audit and compliance activities
- Perform your own self-audits and consider voluntary repayment (such claims will be removed from RAC Data Warehouse) where appropriate
- Review OIG Work Plan and audit reports and CERT reports

Preparing for RAC Audits con't

- Determine who in the organization coordinates the process and is the contact person for the RAC
- Educate physicians about medical necessity and maintain a functioning UR Committee to review medical necessity of admissions, required as a Medicare CoP (42 CFR 482.30)
- Develop tracking tools - track record requests, date of RAC response, whether there was an overpayment, date of recoupment, deadline for redetermination request, other key dates in appeals process

RAC Communication

- Following automated review, provider will receive a demand letter
- For complex review, provider will receive a “results” letter
- Following results letter will be a demand letter
- From results letter to demand letter, provider has opportunity for “discussion” with the RAC to submit additional documentation, etc. in hopes of a different conclusion
- Discussion period does not change deadline for submitting appeal

Strategies for Defending Audits

- Advocate the merits, particularly where medical necessity is involved
- Get treating physician involved - he or she has examined the patient and is most familiar with patient's condition absent substantial evidence to the contrary and the physician's judgment should receive deference
- Waiver of liability - Payment may be made if provider or supplier did not know and could not have reasonably known payment would not be made. Generally applies to medical necessity and provider should support with carrier or FI communications
- Provider without fault - exercised reasonable care in billing and accepting payment, complied with pertinent regulations, disclosed material facts, etc.
- Challenges to reopening and use of statistical sampling

Provider Appeals of RAC Determinations

- Initially, CMS maintained that RAC determinations were rarely being overturned on appeal
- January 2009 report indicated 34 percent of appeals were decided in provider's favor
- Appeals data from demonstration project are not final, as appeals are still in the pipeline
- Costs of appeals are not allowable costs
- RAC appeals follow same appeal process as other Medicare appeals

Provider and Supplier Options Following RAC Denials

- Providers will note FI/MAC Remark Code N432 on Remittance Advice (adjustment based on recovery audit) (some current use of N469-Section 935 recoupment)
- Allow recoupment starting 41 days after RAC notice of denial and file appeal within 120 days
- Pay by check by day 30 and avoid interest
- File appeal prior to recoupment starting (within 30 days of notice of determination)
- Discussion period available to convince the RAC to modify its decision, but does not change deadlines for submitting appeal
- Section 935 of the Medicare Modernization Act modified CMS's recoupment remedies (applies to all appeals, not just RACs) (see 74 Federal Register 47458-47470)

Medicare Appeals/ Collection Process

- Step 1 - Request for Redetermination must be filed within 120 days of receipt of initial determination. However, if the provider or supplier wants to stop recoupment, redetermination request must be filed within 41 days of the date of the initial determination letter. In addition to CMS or FI form, prepare supporting letter on provider letterhead outlining medical evidence and legal authority supporting payment.
- Step 2 - Reconsideration by Qualified Independent Contractor (QIC). This appeal must be filed within 180 days of the receipt of the redetermination decision, but to stop recoupment, appeal must be filed in 60 days. When filing a reconsideration request, providers and suppliers must be careful to present all evidence and arguments why the redetermination is incorrect.

Medicare Appeals Process con't

- Step 3 - Administrative Law Judge (ALJ) - must be filed within 50 days following QIC decision. Amount in controversy requirement is $120. May be live, via video conference or telephone (most by telephone).
- Step 4 - Medicare Appeals Council (MAC) Review - MAC review request must be filed within 60 days following receipt of ALJ decision. MAC will limit review to the issues raised in the written request for review.

Medicare Appeals Process con't

- Step 5 - Federal District Court - Request must be filed within 60 days of receipt of MAC's decision. There is an amount in controversy requirement of $1,180.
- Interest accrues while appeal is pending. New rule provides that if overpayment determination is reversed on appeal above the QIC level of appeal, CMS is liable for interest for the entire period of the recoupment.

Appeals

RAC Denial (Initial Determination)

⇩

Redetermination

⇩

Qualified Independent Contractor (QIC)

⇩

Administrative Law Judge (ALJ)

⇩

Medicare Appeals Council (MAC)

⇩

Federal Court

Note: After redetermination level, can escalate to next level if reviewing entity fails to meet deadline to decide case.

RAC Takeaways

- Document, document, document, etc.
- Perform your own audits on identified risk areas and new issues identified by RACs
- Medical Necessity - Ensure consistent application of medical necessity criteria (need functioning UR Committee)
- Provide access to case management staff at all entry points to collaborate on admission status
- Educate physicians and staff regarding medical necessity documentation for inpatient admissions and / or determination of observation status
- Be prepared and don't wait until you receive your first medical record request
- Get to work on developing the necessary tracking tools

Region C RAC
Connolly Consulting

- Website: www.conollyhealthcare.com/RAC
- E-mail: RACinfo@connollyhealthcare.com
- Telephone: 1-866-360-2507
- CMS Contact: Amy Reese (amy.reese@cms.hhs.gov)

Region D RAC
HealthDataInsights

- Website: http://racinfo.healthdatainsights.com
- E-mail: racinfo@emailhdi.com
- Telephone: Part A 1-866-590-5598
  Part B 1-866-376-2319

- CMS Contact: Kathleen Wallace
  (kathleen.wallace@cms.hhs.gov)

RAC Resources

- Look for further communication from CMS and the RAC for your state as well as updates from provider associations
- Statement of Work for the Recovery Audit Contractor Program, available at www.cms.hhs.gov/RAC
- www.cms.hhs.gov/RAC- CMS site with FAQs, RAC updates and other information abut the RAC program. Questions can be submitted to RAC @cms.hhs.gov. This site also contains a link to the Statement of Work and contact information for each RAC
- RAC websites

Zone Program Integrity Program

- Program integrity activities are being transitioned to ZPIC (PSCs will go away)
- CMS organized ZPIC procurement to correspond to MAC jurisdictions (7 separate “zones”)
- ZPICs in each zone will perform benefit integrity functions for Medicare Part A, B, C, D, DME, Home Health and Hospice, and Medicare / Medicaid Matching Project
- Colorado, New Mexico, Texas and Oklahoma are located in zone 4 and the ZPIC contract was awarded to Health Integrity, LLC (see www.healthintegrity.org)
- Other Midwestern and Northwestern states are in zone 2, which is currently the subject of a bid protest

ZPIC Statement of Work Highlights

- Reactive and proactive identification of potential fraud through data analysis, evaluation of complaints, referrals from law enforcement and referrals from other contractors, including MACs
- Support for law enforcement during investigation and prosecution of healthcare fraud cases (medical review, data analysis, overpayment determination and expert testimony)
- Fraud, waste and abuse training for MAC and AC staff

ZPIC Implementation

- Combined oversight of all Medicare providers within a geographic “zone”
- CMS will award 7 umbrella contracts with each containing 2 task orders
- Task Order 1 is Part A, B, DME, and Home Health and Hospice
- Task Order 2 is the Medicare / Medicaid Matching Projects
- Future task orders will be awarded at CMS discretion

Medicaid Integrity Program

- Established by the Deficit Reduction Act of 2005 to increase federal government's role and responsibility in combating Medicaid fraud and abuse
- Requires CMS to contract with eligible entities to serve as Medicaid Integrity contractors (MICs) to review and audit Medicaid claims, to identify overpayments and to provide education on program integrity issues
- CMS also required to periodically publish its Comprehensive Medicaid Integrity Plan

Medicaid Provider Audit Program

- Three types of MICs:
  - Review MICs: Analyze claims data to identify aberrant claims and potential billing vulnerabilities and provide leads to Audit MICs. The Review MIC for Colorado and most Midwestern states is Advance Med.
  - Audit MICs: Conduct post-payment audits of all types of Medicaid providers and identify overpayments. The Audit MIC for Colorado and most Midwestern states is Health Management Solutions (HMS).
  - Education MICs: Work with Review MICs and Audit MICs to educate health care providers, state Medicaid officials and others about Medicaid integrity issues. The Education MIC is Strategic Health Solutions, LLC

The Medicaid Audit Process

- Identify potential audits through data analysis
- Coordinate potential audits with state Medicaid agencies and law enforcement
- Audit MIC receives audit assignment
- Audit MIC contacts provider, provides records request and schedules entrance conference
- Audit MIC performs audit
- Exit conference held and draft report prepared
- Review of draft report
- Draft report is finalized
- CMS issues report to state
- State issues report to provider and begins overpayment recovery

Comparing RAC and MIC Processes

- MICs not paid on contingent basis
- MICs identify but do not collect overpayments
- MICs more likely to use extrapolation to maximize take backs
- No limitation on number of MIC requests
- Sampling laws vary by state
- Different appeals process, which varies by state, with generally much shorter appeal timeframes

Applying and Attacking Extrapolation

- Dig out that statistics textbook
- Population size = 100, sample size = 10, error in 5 cases, 50 percent error rate for population
- Plan of attack on appeal - appeal whether the sample is representative and appeal individual claims in the sample
- The reversal of even one claim in the example would result in major difference in the outcome

Questions?

Maintaining FMV Perspective in Physician Contracting

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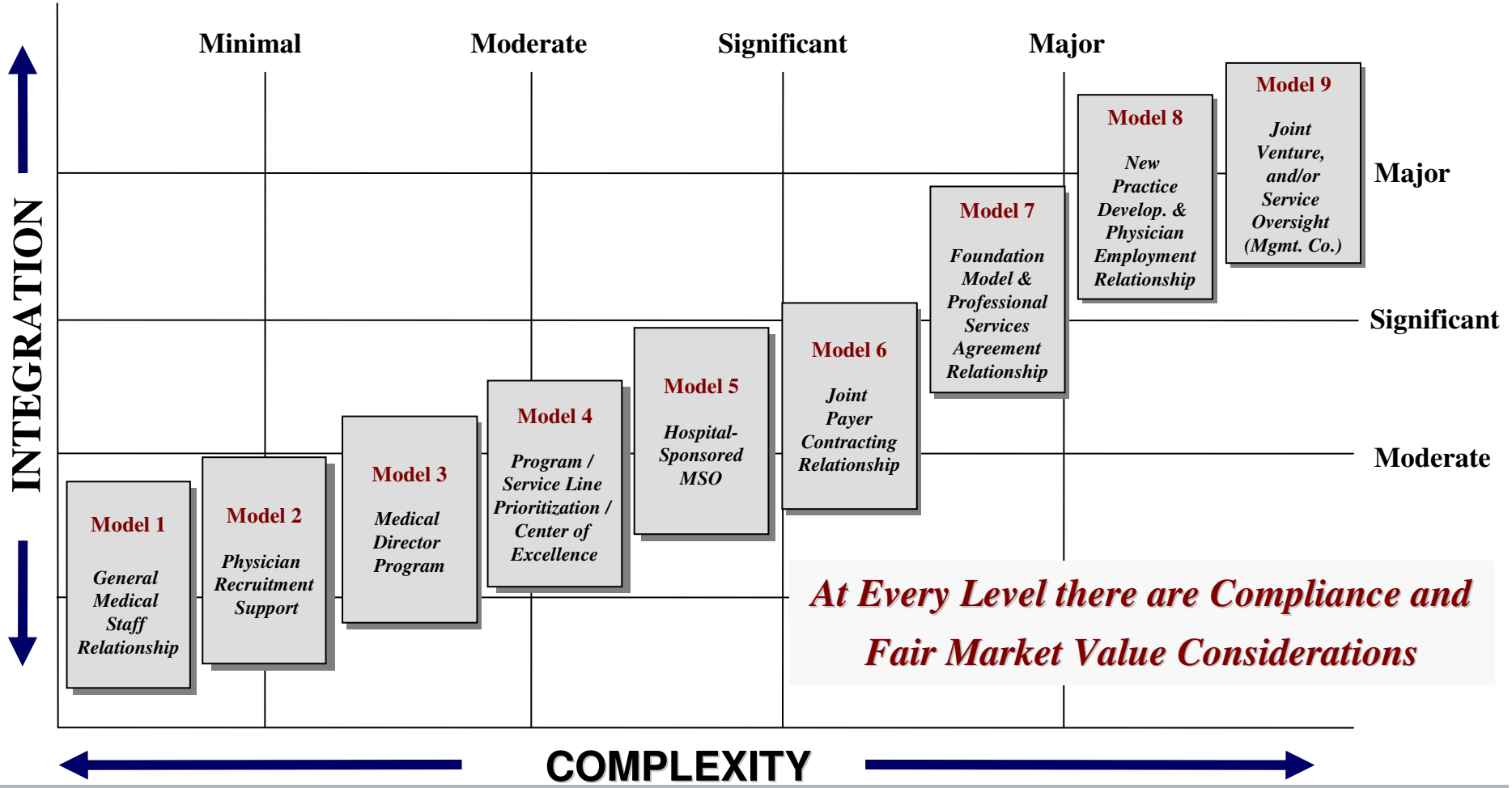
Integration – Round Two

Hospital Systems Continue to Re-Assess the Necessity of Utilizing a Broad Range of Affiliation Options with Physicians to Advance Their Shared Missions / Visions



At Every Level there are Compliance and Fair Market Value Considerations

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Trends Driving Integration and Creative Contracting

- Declining reimbursement
- Uncertainty in reimbursement
- Technology and administrative pressures
- Costs / risks of running a business
- Advantages in network relationships
- Positioning for changes in reimbursement (ACE, ACO, etc.)

Trends Driving Integration – How do you rate?

PAIN ASSESSMENT SCALES

Descriptions	0	2-3	4-5	6-7	8-9	10
Face						
Words	no pain feel "ok" does not hurt	mild pain hurts a little annoying nagging	moderate pain discomforting getting worse nauseating/numbing	distressing very strong miserable/gnawing agonizing	intense horrible vicious/crushing awful/dreadful	unbearable excruciating worst possible pain
SPANISH	no dolor me siento bien no me ducle	poco delor duele poco molestia inconfortable	dolor moderado inconfortable empeorando	perturbador muy fuerte miserable agonizante	intenso horrible vicioso muy doloroso	inaguantable demoledor el mas fuerte dolor posible
PORTUGUESE	não tenho dor sinto-me "ok" não magoa	dor branda magoa um pouco de maneira incómoda enervante	dor moderada desconforto ficar peor enjoativo/dormente	que aflige muito forte deprimente/roedor atroz	intensa horrivel má/trituradora terrivel/maçador	insoportavel excruciante peor dor possível
RUSSIAN	НЕТ БОЛЕЙ ЧУВСТВУЕТ СЕБЯ ХОРОШО	ЛЁГКАЯ БОЛЬ БОЛИТ НЕМНОЖКО НОЮЩАЯ БОЛЬ	СРЕДНЯЯ БОЛЬ УСИЛИВАЮЩАЯСЯ ТОШНОТА/ОНЕМЕНИЕ	МУЧИТЕЛЬНАЯ ОЧЕНЬ СИЛЬНАЯ ТЕРЗАЮЩАЯ БОЛЬ	СТРАШНАЯ УЖАСНАЯ СОКРУШАЮЩАЯ БОЛЬ	НЕВЫНОСИМАЯ, КОТОРУЮ НЕЛЬЗЯ ТЕРПЕТЬ БОЛЬ
VIETNAMESE	Không đau/nhức chút nào thấy bình thường không thấy đau/nhức	đau/nhức nhẹ đau/nhức chút xíu bực bội phiền phức	đau/nhức vừa khó chịu đau/nhức tăng lên buồn nôn/tê	đau/nhức dữ đau/nhức nhiều đau/nhức dữ dội đau điếng	đau/nhức nhối đau/nhức kinh khủng đau lặng đau/nhức ghê gớm	Hết chịu nổi đau/nhức dữ dội đau dữ dội
HAITIAN	pa gin doulè mwen byèn li pa fem mal	doulè tou piti fèm mal piti piti li bam picotman li aniye'm	doulè modéré mwen pa nèz li vin pi mal li fèm anvi vomi	man détrès doulè pi grav li mizérab mwen an agoni	li pi fò li térib lap tiye'm li krazém	mpa capab ankò li atròs doulè pidi
CHINESE	不痛 感觉"可以"	轻微痛疼. 苦恼, 不舒服	中度痛疼. 症状加重. 恶心/麻木.	重度痛疼. 强烈的. 折磨.	剧烈痛疼. 可怕的. 压倒性的痛.	不能忍受的痛 如施酷刑. 痛至极点.

PC 015 (Rev. 11/07)

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Why FMV Matters? – A Legal Perspective

All the Ways FMV Matters (Legal Issues)

- Stark
- Anti-Kickback
- Preservation of Tax-Exempt Status
- Intermediate Sanctions

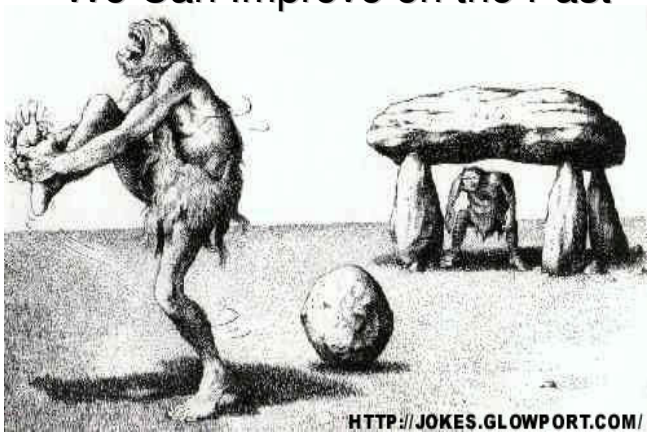
All the Ways FMV Matters (Cont.)

- New Form 990 Disclosures
- Antitrust
- Tax-exempt Bonds and Private Use
- Transparency in Corporate Governance

Contexts of FMV Applications

- Acquisition
- Employment and PSA
- Clinical v. administrative duties
- Call pay (normal or disproportionate)
- Recruitment / retention
- Space or equipment
- Research / Training / Quality
- Joint Ventures (ASC companies)

We Can Improve on the Past



Examples of the Physician Perspective

- Physicians (and unsophisticated counsel) can view Hospital's FMV legal concerns as a sword to drive down compensation
  - "Those bad things can't happen here!"

- Lifestyle priorities are tested when compensation diminishes due to FMV constraints
- "FMV" = what they hear other physicians make (or used to make)

Case Studies

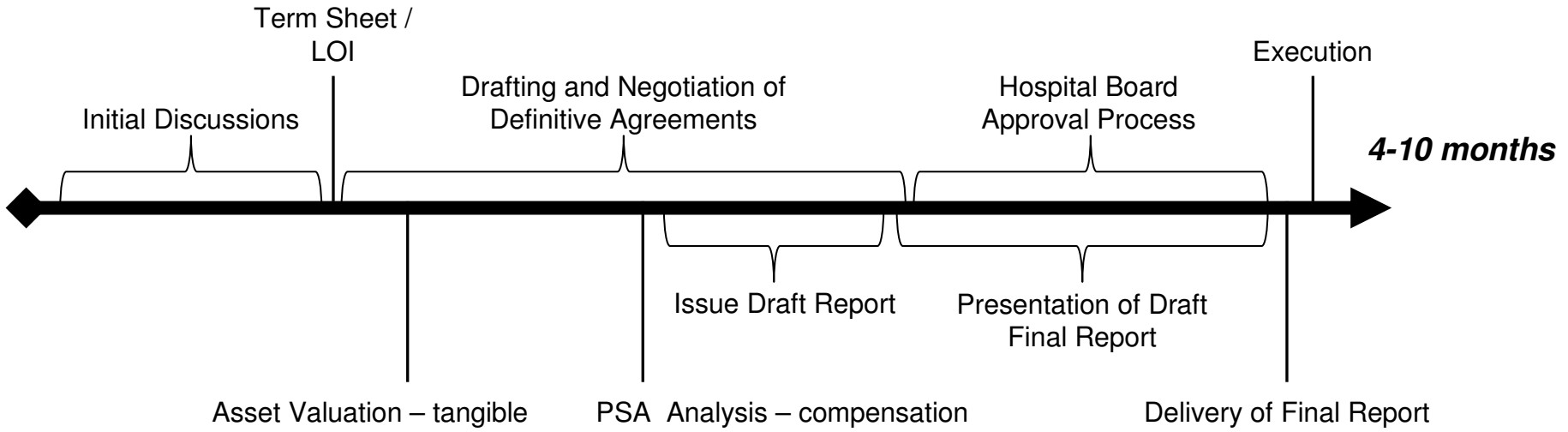
Examples of strategies and process to help put the odds in your favor

Case Study #1 – Specialist PSA

- Strategy by a large community-based hospital operating in a very competitive market
- Declining reimbursement by the group, strategic need by the hospital
- Physicians wanted to maintain some control in their PC due to concern over employment and benefit issues
- Why FMV required?
- Process – attorney / client privilege

Case Study #1 - Timeline

Legal Milestones



FMV Milestones

Case Study #1 – Data-Driven Process

- Background information on arrangement (duties and responsibilities)
- Rationales for proposed arrangement (hospital and physician perspective)
- Legal documents (e.g., draft agreements, LOI, existing / historical agreements)
- Practice information
    1) General (provider specialty composition, physician CVs, etc.)
    2) Financial (historical physician compensation, P&Ls, expense detail, etc.)
    3) Billing / collections data (CPT activity w/modifiers – calculate WRVUs, charges, collections, payor mix, etc.)
- Management and / or physician interviews

Case Study #1 – Data-Driven Process (Physician Compensation Element)

**** Please note the following figures are for illustrative purposes only. They are not representative of actual data and should not be used for FMV purposes ****

	Published Data Approach		Market Comparable Approach
Analysis Factors	***Annual Survey Data***	***$/WRVU Data***	
Units (FTE Physicians -or- WRVUs)	5 FTEs	10,000 WRVUs	5 FTEs
Survey Benchmark / Market Data[1]	$300k - $400k	Median $/WRVU (w/sensitivity)	$360k - $420k
Benchmark Compensation	**$1.5m - $2.0m**	**$1.7m - $2.2m**	**$1.8m - $2.1m**
Average FMV Indication	$1.6m - $2.1m		$1.8m - $2.1m

50/50 Blend of Approaches
$1.7m - $2.1m

1) Weighted to represent sub-specialty composition of group.

Case Study #1 – Data-Driven Process (Physician Benefit & Expense Element)

**** Please note the following figures are for illustrative purposes only. They are not representative of actual data and should not be used for FMV purposes ****

Per-FTE Expenses	**Low**	**High**
- Physician Benefits (retirement, FICA, health, etc.)[1]	$50,000	$65,000
- Legal / Outside Professional Fees[1]	$3,000	$5,000
- Office Lease (allocated portion)	$25,000	$30,000
- Utilities	$2,000	$2,000
- Professional Liability Expenses	$15,000	$15,000
- Misc. (Office expenses, parking, etc.)	$5,000	$3,000
Total Per-FTE	**$100,000**	**$120,000**
Total for Group (5 FTEs)	**$500,000**	**$600,000**

1) MGMA Cost Survey data applied due to unique, non-market representative expense structure -- are expenses within reason???

Case Study #1 – Data-Driven Process (Reconcile Phys. Comp. & Expenses)

**** Please note the following figures are for illustrative purposes only.*
*They are not representative of actual data and should not be used for FMV purposes ****

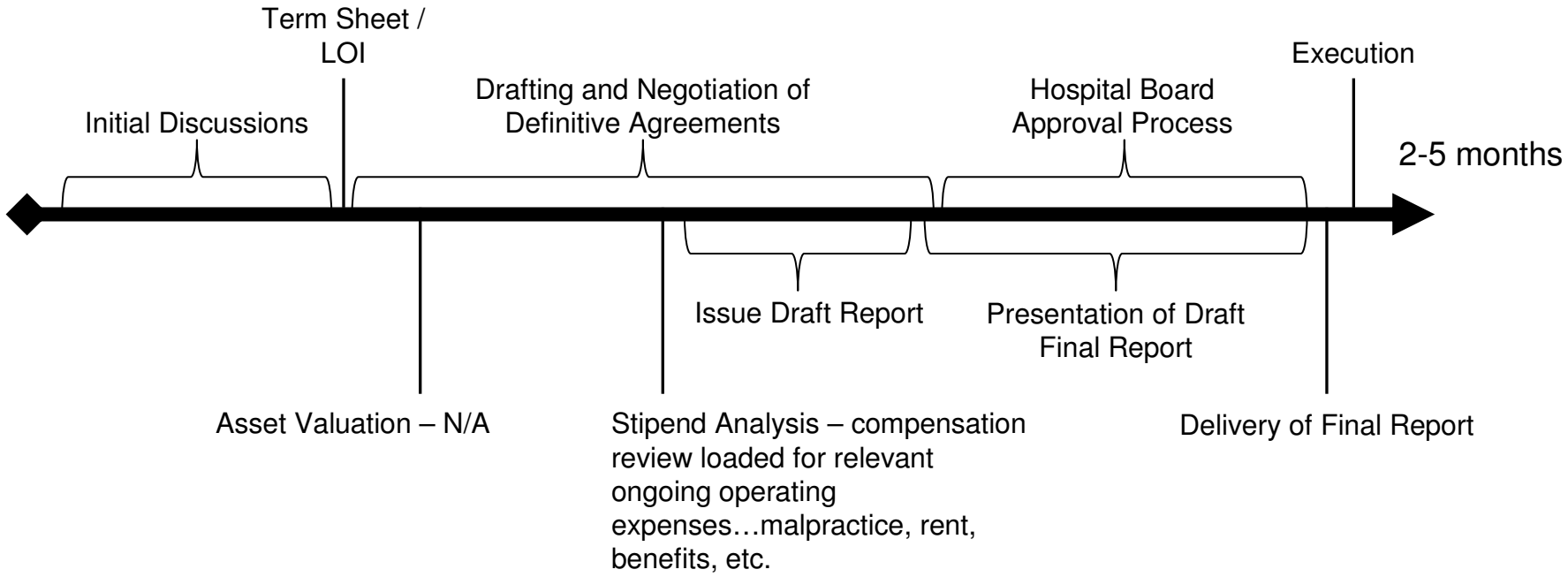
FINDINGS	Estimated FMV Range
Physician Compensation	$1.7m - $2.1m
Physician Benefits & Operating Expenses	$0.5m - $0.6m
Total Estimated FMV PSA Payment	**$2.2m - $2.7m**

Case Study #2 – HBP Analysis and Benchmarking

- Large community-based hospital needs to support hospital-based anesthesia practice with 10 physicians and 15 CRNAs
- Difficult payor market, competitive recruitment
- Differing Needs
- Why FMV required?
- Process – attorney / client privilege

Case Study #2 - Timeline

Legal Milestones



FMV Milestones

Case Study #2 – Data-Driven Process

- Contract Review
- Provider Compensation: 2008 and 2009 (physicians and CRNA's)
- Physician Productivity Data (Cases, ASA Units, RVUs, Collection and Charges): 2008 and 2009 (physicians and CRNA's)
- Service requirements
- Physician Group Income Statement with expense detail (2008 and 2009)
- Physician Group billing report (Net Collections, Days in A/R) (2008 and 2009)
- Description of staffing schedules, time-off, typical shifts, call rotations
- Medical Director job description

Case Study #2 – The Staffing Matrix

	Start	End	#hours	# Days	# Rooms	Anes Req	CRNAs Req	Anes Hrs	CRNA Hrs
			(a)	(b)		(c)	(d)	(a*b*c)	(a*b*d)
Main Hospital									
Weekdays (On-Site)	7:00:00	15:30:00	8.5	5.0	2.0	1.0	2.0	42.5	85.0
	15:30:00	17:30:00	2.0	5.0	2.0	1.0	2.0	10.0	20.0
	17:30:00	19:30:00	2.0	5.0	1.0	1.0	0.0	10.0	0.0
On-Call Coverage	19:30:00	23:30:00	4.0	5.0	1.0	1.0	0.0	20.0	0.0
	23:30:00	7:00:00	7.5	5.0	1.0	1.0	0.0	37.5	0.0
							Main Hospital Totals	120.0	105.0
Saturday									
On-Site	7:00:00	15:30:00	8.5	1.0	1.0	1.0	1.0	8.5	8.5
	15:30:00	18:00:00	2.5	1.0	1.0	1.0	0.0	2.5	0.0
On-Call Coverage	18:00:00	23:30:00	5.5	1.0	1.0	1.0	0.0	5.5	0.0
	23:30:00	7:00:00	7.5	1.0	1.0	1.0	0.0	7.5	0.0
							Saturday Totals	24.0	8.5
Sunday/Holiday									
On-Site	7:00:00	15:30:00	8.5	1.0	1.0	1.0	0.0	8.5	0.0
On-Call Coverage	15:30:00	23:30:00	8.0	1.0	1.0	1.0	0.0	8.0	0.0
	23:30:00	7:00:00	7.5	1.0	1.0	1.0	0.0	7.5	0.0
							Sunday Totals	24.0	0.0
Out of OR	7:00:00	15:30:00	8.5	5.0	0.0			0.0	0.0
OB	7:00:00	15:30:00	8.5	5.0	1.0	1.0	0.0	42.5	0.0
	15:30:00	7:00:00	15.5	5.0	2.0		1.0	0.0	77.5
Weekends/Hol	7:00:00	7:00:00	24.0	2.0	2.0		1.0	0.0	48.0
Administrative Duties	7:00:00	17:30:00	10.5	5.0	5.0	0.3		15.8	0.0
Pre Admin	8:30:00	18:30:00	10.0	5.0	2.0			0.0	0.0
								MD/DO	CRNA
							Hours Per Week	226.3	239.0
							Hours Per Year	11,765.0	12,428.0

PINNACLE

HUSCHBLACKWELL SANDERS LLP

Case Study #2 – Findings

**** Please note the following figures are for illustrative purposes only. They are not representative of actual data and should not be used for FMV purposes ****

	Staffed Hours-Based Approach			Productivity-Based Approach[1]	
Analysis Factors	***Anesthesiologists***	***CRNAs***		***Anesthesiologists***	***CRNAs***
Coverage Hrs. -or- Units	25,000 hrs.	40,000 hrs.		100,000 units	35,000 units
Per FTE Provider Benchmark[2]	2,010 hrs.	2,000 hrs.		13,000 units	3,000 units
Benchmark FTEs	**12 FTEs**	**20 FTEs**		**8 FTEs**	**12 FTEs**
	X	**X**		**X**	**X**
FMV Compensation[3]	$400k - $500k	$200k - $250k		$400k - $500k	$200k - $250k
	=	**=**		**=**	**=**
FMV Compensation	$4.8m - $6.0m	$4.0m - $5.0m		$3.2m - $4.0m	$2.4m - $3.0m
Total FMV Compensation	**$8.8m - $11.0m**			**$5.6m - $7.0m**	

50/50 Blend of Approaches

$7.2m - $9.0m

1) ASA units, WRVUs, TRVUS, etc.
2) Ex., median survey figure, etc.
3) Figure includes salary, benefits and expenses; and is a blend of published and market data sources

Closing – Avoid the Pitfalls

- Everyone can't be at the 75th Percentile" – what is the documentation to support higher levels?
- Be cautious of higher percentile $/WRVU survey data (high $/WRVU doesn't necessarily correlate to higher WRVU production)
- CMS's comment on prudent FMV determination, "Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating Fair Market Value." (STARK II, PHASE III, FR Vol. 72, No. 171)
- Cautious to repeat the sins of the past – "can't pay on the front end and the back end"
- Consistency matters
- Elements of an Effective FMV Program
  - Education – knowledge and training
  - Reliable Data
  - Analytical Tools
  - Corporate Standards – methods and payment terms
  - Transparency
  - Documentation
  - Oversight

Questions?

Medical Staff Landmines: Disruptive Physicians

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May 29, 2003

Dear Jane Doe,

I apologize for not getting back to you sooner regarding your earlier request that I provide documentation of anger therapy.

As you should recall, during our initial discussion in the physician's lounge, you were graciously flexible and not specific in regard to what the therapy should be, as long as some avenue was pursued. I must also remind you that the particular incident you vaguely alluded to still leaves me perplex, for I do not recall expressing any anger.

Nevertheless, to remain faithful, I saw the movie "Anger Management" on April 29th, starring Jack Nicholson and Adam Sandler. Enclosed is the stub to that movie.

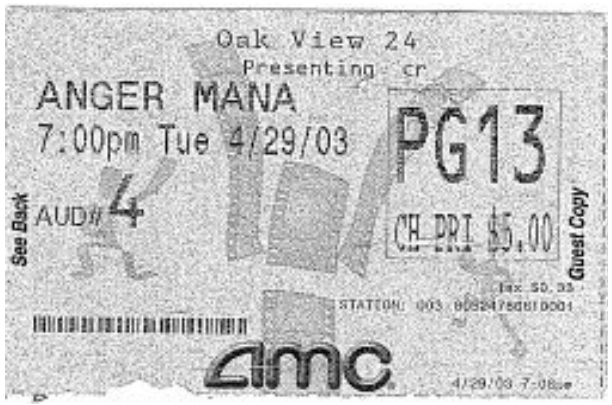
I hope that the ticket stub is satisfactory documentation.

Sincerely,

John Doe

John Q. Doe

JD



Introduction

- All healthcare facilities will deal with a disruptive physician and, therefore, must have policies and procedures in place to address the behavior. Further, The Joint Commission now requires hospitals to address disruptive behavior by physicians and other staff members.

- Healthcare facilities should not wait for the quality of care to be affected before taking action against a disruptive physician. To minimize liability, healthcare facilities must take proactive steps to address disruptive behavior.

Disruptive Behavior

- Disruptive v. Annoying: The line between annoying and disruptive is not always clear. Annoying behaviors may include the negative physician, the selfish physician, the immature physician, the whining physician, and the disorganized physician.
- Disruptive behavior is demonstrated when inappropriate conduct, whether in words or action, interferes with, or has the potential to interfere with, quality health care delivery. Disruptive behavior may, in rare circumstances, be demonstrated in a single egregious act (for example, a physical assault of a co-worker) but is more often composed of a pattern of behavior.

Examples of Disruptive Behavior

- Disruptive behavior may include:
  - profane, disrespectful, insulting, demeaning or abusive language;
  - shaming others for negative outcomes or passing severe judgment in front of patients, visitors or other staff;
  - inappropriate arguments with patients, family members, staff;
  - outbursts of anger;
  - jokes about race, ethnicity, religion, sexual orientation, age, physical appearance or socioeconomic or educational status;
  - refusal to comply with known and generally accepted practice standards; and
  - repeated failure to follow policies.

- The “White Knight” Physician

Hospitals Must Address Disruptive Behavior

- Patient Safety:
  - Disruptive behavior can cause stress, anxiety, frustration, and anger, which can impede communication and collaboration, which can result in avoidable medical errors, adverse events, and other compromises in quality care.
  - Disruptive physicians may disregard policies and protocols.
  - A hospital has the right and the duty to regulate the conduct of its medical staff and to maintain the quality of medical care its patients receive.

A Hospital's Duty as an Employer

- As an employer with control of the workplace, a hospital is prohibited under Title VII of the Civil Rights Act of 1964 from allowing its employees to engage in discrimination on the basis of sex, among other types of impermissible conduct.
- A hospital may be subject to vicarious liability for a non-employed physician's alleged harassment.
- Under 29 C.F.R. §1604.11(e), an Equal Employment Opportunity Commission regulation, employers may be liable for sexual harassment perpetrated by non-employees "in the workplace, where the employer . . . knows or should have known of the conduct, and fails to take immediate and appropriate corrective action."

CMS Conditions of Participation

- Hospitals (42 CFR 482.22)
  - The Governing Body shall ensure that criteria for selection are individual character, competence, training, experience and judgment.
  - The Governing Body shall ensure that the Medical Staff is accountable to the governing body for the quality of care provided to patients.

- Critical Access Hospitals (42 CFR 485.601)
  - The Governing Body assumes full legal responsibility for determining, implementing and monitoring policies governing a hospital's total operation.

The Joint Commission

- Effective January 1, 2009, for all accreditation programs, The Joint Commission implemented new Leadership standard (LD.03.01.01) that addresses disruptive and inappropriate behaviors in two of its elements of performance:
  - Element of Performance 4: “The hospital / organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.”
  - Element of Performance 5: “Leaders create and implement a process for managing disruptive and inappropriate behaviors.”

The Joint Commission "Sentinel Event Alert"

- On July 9, 2008, The Joint Commission issued a "Sentinel Event Alert" with a list of suggestions (not requirements) on how to address disruptive behavior. These suggestions include developing and implementing policies and procedures / processes appropriate for the organization that address:
  - "'Zero tolerance' for intimidating and / or disruptive behaviors, especially the most egregious instances of disruptive behavior such as assault and other criminal acts. Incorporate the zero tolerance policy into medical staff bylaws and employment agreements as well as administrative policies."
  - "Reducing fear of intimidation or retribution and protecting those who report or cooperating in an investigation in intimidating, disruptive and other unprofessional behavior. Non-retaliation clauses should be included in all policy statements that address disruptive behaviors."

The Joint Commission "Sentinel Event Alert" con't

- "Support surveillance with tiered, non-confrontation interventional strategies starting with informational 'cup of coffee' conversations directly addressing the problem and moving toward detailed action plan and progressive discipline, if patterns persist. These interventions should initially be non-adversarial in nature, with the focus on building trust, placing accountability on and rehabilitating the offending individual and protecting patient safety."

- "Document all attempts to address intimidation and disruptive behaviors"

American Medical Association

- American Medical Association Ethics Policy E-9.045(1):
  - "Personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively constitutes disruptive behavior. (This includes, but is not limited to, conduct that interferes with one's ability to work with other members of the health care team.) However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior."
  - "Each medical staff should develop and adopt bylaw provisions or policies for intervening in situations where a physician's behavior is identified as disruptive. The medical staff bylaw provisions or policies should contain procedural safeguards that protect due processes. Physicians exhibiting disruptive behavior should be referred to a medical staff wellness - or equivalent - committee."

Tools Needed to Address Disruptive Physicians

- Code of Conduct Policy:
  - The Joint Commission now requires that each hospital has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.

- Anti-Discrimination / Anti-Harassment Policies:
  - The policy should clearly convey that sexual harassment is against the law and that the hospital is enforcing a zero tolerance policy against sexual harassment in the workplace.

- Clear, Written Procedures for Handling Problems:
  - The procedures should provide framework and consistency for managing problems as they arise.
  - The procedures must provide hearing and due process rights as required by law and consistent with the Medical Staff Bylaws.
  - The procedures should set forth a road map that adheres to a philosophy of “progressive discipline”

Tools Needed to Address Disruptive Physicians con't

- Incident Reports:
  - Hospital employees and other physicians need a means to submit a complaint about disruptive physicians.
  - The incident report should ask for a statement of whether the behavior affected or involved a patient in any way, and, if so, information identifying the patient.
  - The incident report should start the inquiry process set forth in the code of conduct policy.
  - An incident report should be reviewed immediately to address the severity of the complaint.

- Educated Medical Staff Leadership:
  - Promotes prompt, fair and consistent handling of the situation.
  - Promotes meaningful peer review and corrective action.
  - Allows medical staff leadership to quickly recognize disruptive behavior.

Drafting a Code of Conduct Policy

- The policy should provide a basis for challenging inappropriate behavior.
  - The policy should provide the physicians with notice of the possible consequences of inappropriate behavior.
- The policy should map out a plan for addressing such behavior.
- The code of conduct policy must be consistent with other applicable instruments, including medical staff bylaws.

Drafting a Code of Conduct Policy con't

- Include an anti-retaliation clause.
- Give each member of the medical staff a copy of the policy, and have the individual sign and date an acknowledgement form indicating that he or she has received and understands it.
- Include a clause that states the code of conduct policy does not create new procedural rights / remedies.

Addressing Disruptive Behavior: Progressive Discipline

- Use a progressive discipline model.

- First Intervention:
  - Assess the complaint and behavior in a collegial manner with at least two Medical Staff leaders.
  - Interview the physician and discuss the incident in an informal setting.
  - Help the physician acknowledge the problem and remind them of the hospital's code of conduct policy.

Progressive Discipline con't

- Second Intervention:
  - If the initial intervention is ineffective, a more formal counseling session should take place.
  - The meeting should focus on the physician making a clear commitment to change the behavior.
  - There should be a discussion of consequences if the physician's conduct is not improved.

Progressive Discipline con't

- Third Intervention:
  - This is the last step before corrective action is taken.
  - The meeting should include a number of individuals from the Medical Staff Executive Committee.
  - A plan should be developed to monitor the physician's conduct. If appropriate, the physician should be referred to counseling or the well-being committee.
  - A final written warning should be delivered to the physician.

Progressive Discipline con't

- Taking Corrective Action
  - Fair hearing and due process procedures must be afforded. The hearing procedures should comply with the Medical Staff Bylaws and state and federal law.
  - Formal corrective action may include:
    - Continuing Medical Education
    - Participate in a Physician's Assistance Program
    - Counseling
    - Proctoring/Preceptoring
    - Voluntary Limitation of Privileges
    - Suspension
    - Revocation
  - Ensure Medical Staff Leadership follows the Peer Review Process as set forth in the policies and Medical Staff Bylaws.
  - Consider engaging counsel to guide Medical Staff leadership through the process.

Summary Suspension

- Suspension of privileges should be reserved for severe and well-documented misconduct.
- There will be times when patient safety is directly threatened by a physician's behavior. In such circumstances, the physician should be immediately removed from the situation. Examples where crisis intervention is required might include instances when:
  - the physician is so distressed or out of control that he or she poses a safety risk to other workers in the environment;
  - the physician threatens to physically harm him or herself or others;
  - the behavior appears to create unacceptable legal liability; and
  - the behavior poses an immediate threat to patient care.

Summary Suspension con't

- USE WITH CAUTION. There should be actual documentation or other reliable information that an immediate danger exists.
- Hospitals should have written procedures on how to document an immediate danger and to determine the reliability of information. These procedures must be consistent with the Medical Staff Bylaws.
- There should be an immediate review of suspension decision.
- The Health Care Quality Improvement Act specifically provides a summary suspension or restriction of privileges where "the failure to take such action may result in an imminent danger to the health of any individual" provided there is subsequent notice and hearing or other adequate procedures.

Document, Document, Document

- Document at all levels.
- Leaders must document both the concerns and the progressive steps taken to address those concerns.
  - Document the facts, not just opinions.
  - Document goals and plans of action.

Health Care Quality Improvement Act (HCQIA), 42 U.S.C § 11101

- Congress enacted the Health Care Quality Improvement Act (HCQIA) "to improve the quality of Medicare care by encouraging physicians to identify and discipline physicians who are incompetent **or who engage in unprofessional behavior.**"

- HCQIA allows those physicians on peer review committees to communicate in an open and honest environment.

HCQIA Immunity

- HCQIA provides immunity from monetary damages for a professional review body engaged in a "professional review action."
- A professional review action is "an action or recommendation of a professional review body which was taken or made in the conduct of a professional review activity, which is based on the competence **or professional conduct** of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients)…." (42 U.S.C. 11151 (9)).
- The statutory definition of "professional review body" does not require the committee to be formal, appointed or elected, and any committee of the medical staff qualifies as a professional review body when assisting the governing body in a professional review activity.
- Have medical staff, not administration, perform review function.

Requirements for Immunity for Professional Review Actions under HCQIA

- To qualify for immunity, the professional review action must be undertaken:
  - With a reasonable belief that the action was in the furtherance of quality health care;
  - Following a reasonable effort to obtain the facts;
  - After adequate notice and hearing procedures were afforded to the physician; and
  - With a reasonable belief that any adverse action was warranted by the facts.

Required Reporting under HCQIA

- HCQIA establishes the National Practitioners Data Bank (NPDB).
- Hospitals and other eligible health care entities **must** report professional review actions to the NPDB that adversely affect a physician's clinical privileges for a period of more than 30 days.
- Hospitals also report the acceptance of a physician's surrender or restriction of clinical privileges while under investigation for possible professional incompetence or improper professional conduct.

Failure to Report under HCQIA

- If HHS determines that a hospital or other health care entity has substantially failed to report information in accordance with the HCQIA, the name of the entity will be published in the *Federal Register*, and the entity will lose the immunity provided under HCQIA with respect to professional review activities for a period of 3 years.

Patients vs. Physicians

- Conflict between obligations that a medical facility owes to its patients and obligations it owes to physicians may arise in the context of:
  - Complying with state reporting requirements regarding physician conduct; and
  - Dealing with physician impairment that may be the cause of unprofessional conduct.

Colorado Medical Practice Act
Colo. Rev. Stat. § 12-36-101

- CMPA creates a statutory duty to report unprofessional conduct which includes:
  - Habitual intemperance or excessive use of any habit-forming drug or any controlled substance;
  - Physical or mental disability as to render the licensee unable to perform medical services with reasonable skill and with safety to the patient; and
  - Any act or omission which fails to meet generally accepted standards of medical practice.

Failure to Report Under CMPA

- Considered “unprofessional conduct.”
- Triggers an investigation by the Colorado State Board of Medical Examiners.
- May lead to discipline in the form of a letter of admonition, suspension for a definite or indefinite period, or revocation of license to practice.

Immunity under CMPA

- Immunity from civil and criminal liability for an individual who makes a complaint or report, or who participates in an investigation or proceeding under CMPA.
- But only if the individual acted in good faith.

Professional Review Committees
Colo. Rev. Stat. § 12-36.5-101

- Colorado provides for the use of professional review committees to assist the Colorado State Board of Medical Examiners.
- Professional review committees are, thus, considered an extension of the authority of the Colorado State Board of Medical Examiners.

Authority of Professional Review Committees

- Must operate pursuant to written bylaws, policies or procedures.

- May investigate or cause to be investigated:
  - Qualifications of a licensed physician;
  - The quality or appropriateness of patient care rendered by a licensed physician; and
  - The professional conduct of a licensed physician.

- Investigation must be subject to the written bylaws, policies or procedures of the medical facility.

Immunity under Colorado Law

- Immunity from suit in any civil or criminal action for:
  - A member of a professional review committee;
  - A witness before a professional review committee; and
  - Any person who files a complaint or otherwise participates in the professional review process.

- But only if the individual:
  - Made a reasonable effort to obtain the facts of the matter;
  - Acted in the reasonable belief that action was warranted by the facts; and
  - Acted in good faith.

The Impaired Physician

- The AMA defines an impaired physician as:
  - One who is unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or loss of motor skills, or excessive use or abuse of drugs, including alcohol.

Rights of the Impaired Physician

- Conflict arises where unprofessional conduct is the result of an impairment that brings physician within the purview of:
  - The Americans with Disabilities Act, 42 U.S.C. § 12101.
  - The Federal Rehabilitation Act, 29 U.S.C. § 701.

Americans with Disabilities Act (ADA)

- What is it?
  - Title I vs. Title III
- When and to whom does it apply?
  - Employers with required number of employees;
  - Employees who, despite disability, can perform the essential functions of the position at issue; and
    - Consideration given to employer's judgment.
    - Illegal drug users and alcoholics held to same qualification standards as other employees.

Disability under ADA is Defined Very Broadly

- Physical or mental impairment
  - Substantially limits "major life activity"
  - Without regard to mitigating measures
  - Disability that is episodic or in remission
- "Record of impairment"
- "Being regarded as"
- Does not include the current use of illegal drugs.

Prohibition Against Discrimination

- Medical facility that employs disabled physician is prohibited from:
  - Limiting or classifying the physician in a way that adversely affects opportunities or status; and
  - Not making reasonable accommodations.

Reasonable Accommodations under ADA

- "Reasonable accommodation" includes:
  - Job restructuring;
  - Part-time or modified work schedules; and
  - Reassignment to a vacant position.
- Employer not required to make reasonable accommodations if it would require significant difficulty or expense in light of:
  - Nature and cost of the accommodations; and
  - The financial resources of the employer.

Federal Rehabilitation Act (FRA)

- What is it?
- When and to whom does it apply?
  - Programs or activities receiving financial assistance from any federal department or agency; and
  - Individuals who, despite disability, can perform the essential functions of the position at issue.

Application of ADA to FRA

- In the employment context, ADA standards apply in determining violation of FRA.
- Applicable ADA definitions:
  - "Discrimination"
  - "Disability"
- In addition, an individual is not considered disabled if:
  - The current use of alcohol prevents the individual from performing the duties of the job in question; or
  - The individual's employment, by reason of current alcohol abuse, would constitute a direct threat to the property or safety of others.

The Independent Contractor v. Employee

- What is the distinction?
- Why does it matter?
  - *Fleming v. Yuma, Regional Medical Center*, 587 F.3d 938 (9th Cir. 2009).
  - *Wojewski v. Rapid City Regional Hospital, Inc.*, 450 F.3d 338 (8th Cir. 2006).
  - *Menkowitz v. Pottstown Memorial Medical Center*, 154 F.3d 113 (3rd Cir. 1998).

Dealing With the Impaired Physician

- Step 1: Identification
  - Look for:
    - High-risk conditions
    - Behavior changes
    - External signs of impairment
  - Provide a reporting mechanism for physicians and staff members.
- Step 2: Confrontation
  - Interview the physician in an informal setting.
  - Determine if a medical examination is necessary.
    - Be aware of ADA restrictions on medical examinations.

Dealing With the Impaired Physician con't

- Step 3: Accommodations
  - Determine what is reasonable, effective, and appropriate.
    - Know and take into account job functions.
    - Have the impaired physician involved in the process.
  - Determine if leave under the Family Medical Leave Act, 29 U.S.C. § 2601, is necessary.
  - Monitor the physician.

- Step 4: Reporting
  - If impairment triggers reporting requirements, engage the professional review committee to take appropriate action.
  - Meet reporting requirements under HCQIA and CMPA.

Liability for Failure to Act

- Malpractice claims
- Harassment claims
- Tort claims
  - Negligent Credentialing/Negligent Retention
  - Vicarious Liability
  - Third-Party Liability/Third-Party Reliance

To Sum It Up…

- Identify disruptive and unacceptable behavior.
- Have policies and procedures in place.
- Educate the Medical Staff and Hospital leadership to be aware of the policies.
- Follow the policies and procedures.

Questions?

Healthcare Quality Initiatives: The Next Big Thing

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Today's Goals

- Provide an overview of regulatory and enforcement efforts impacting acute and post-acute care
- Analyze impact of these efforts on certification, reimbursement and governance
- Discuss payment initiatives based on quality
- Offer strategies for compliance and achieving good survey outcomes

Today's Presentation

- Review recent history of quality initiatives
- Discuss quality as a condition for participation
- Analyze quality as a condition for payment
- Provide overview of government enforcement relating to quality issues
- Highlight governing body responsibilities related to quality assurance

Past as Prologue

- From “first do no harm” to “pay for performance,” quality concerns have always been present
- Initial (and quite possibly the most effective) quality control mechanisms included peer review and credentialing
- Threat of malpractice suits ostensibly has driven and still drives performance, but not necessarily quality
- With the advent of government payor systems came administrative standards for operations and, more recently, quality-based payment structures

To Err is Human

- IOM issues report in 1999
- Brings quality crisis to the fore
- Posits 44,000 to 98,000 deaths each year due to medication errors, inappropriate treatment, under treatment

Never Events

- NQF develops initial list in 2002 and updates in 2006
- Focuses on wrong limb, wrong medication, wrong patient
- CMS ceases payment for never events in 2008
- Commercial payors follow suit

The Quality Acronym Crescendo

- CMS Demonstration Projects and Regulations
  - 2003 MMA: Payment for reporting quality data
  - 2005 DRA: Reduced payment for hospital-acquired conditions
  - 2005 PSQIA: Establishes patient safety organizations
  - 2008 MIPPA: Value-based payment
  - 2009 ARRA: Funding for EHR adoption
  - 2010 OPPS: New supervision standards

New Payment Initiatives Based on Quality

- Senator Baucus' White Paper: *Call to Action & Health Reform 2009*
- Bundling programs under health reform legislation
- Accountable Care Organizations (ACOs)
- Medical Homes – a patient-centered primary care focused delivery model
- Shared savings model

New Payment Initiatives Based on Quality

- Bundling programs under health reform legislation
  - Moving from volume to value
  - Bundling payments for acute care and post-acute care provider services
  - Bundling for acute care and physicians' services
  - Bundling under health reform legislation

New Payment Initiatives Based on Quality

- Accountable Care Organizations (ACOs)
  - Can be an integrated delivery system
  - Physician-hospital organization (PHO)
  - Academic medical center
  - Hospital and multi-specialty groups
  - Hospital team with independent physician practice
- Uses incentives to providers to produce high quality care while containing growth in costs

New Payment Initiatives Based on Quality

- Medical Homes Model
  - Patient-centered primary care focused delivery model
  - Goal is to keep patients with chronic illnesses healthy enough to avoid hospital stays and preventable readmissions
  - Aims to reduce barriers and facilitate right care at right time
  - Uses nurses and physician-extenders for follow-up care
  - None of medical home services currently reimbursed by Medicare
  - Would require reform of physician payment systems to adequately compensate physicians for patient-centered services

Legal Barriers to Quality-Based Payment Reforms

- CMP law
- Anti-kickback laws
- Stark laws
- Lack of guidance by CMS and OIG

Steps to Take Now to Prepare for Quality-Based Payment Reforms

- Assess current operations and identify areas for improvement
- Develop programs or enhance existing programs to make targeted efforts to improve quality
- Analyze physician behaviors that result in quality improvement
- Facilitate conversations on quality
- Consider current technological capabilities

Quality Surveys

- New emphasis on survey compliance by CMS and Joint Commission
- Adverse survey actions
- Immediate jeopardy findings and “fast-track” decertification
- Collateral damage from adverse surveys

Achieving Good Survey Outcomes

- Managers / Supervisors on floor
- Implement audit procedures
  - Have nurses / physicians audit other nurses / physician's documentation
  - Use as learning tool
- Review physician and nursing documentation
  - To support services provided and billed
  - Services were necessary
- Train nurses on assessment skills

Achieving Good Survey Outcomes

- When errors occur, perform root cause analysis and document process
- Conduct satisfaction surveys
- Obtain input from direct care staff
- Reward quality care

Governing Body Challenges

- Fiduciary duty to institution
- Fiduciary duty for directors of non-profit organization
- Quality as a core fiduciary responsibility
- Ultimate responsibility for credentialing staff
- Accountable for poor quality outcomes resulting from willful failure to act or willful inattention

Governing Body Challenges

- IOM's Definition of Quality
  - Safe
  - Effective
  - Patient-centered
  - Timely
  - Efficient
- Director's obligation to quality of care
  - Decision-making function
  - Oversight function

Liability for Poor Quality

- Medically Unnecessary
  - When medically unnecessary services provided, patient is exposed to unnecessary risks to health
  - Government pays needless costs
- Failure of Care
  - Care is so deficient that it amounts to no care at all
- Can subject provider to exclusion or Corporate Integrity Agreement (CIA)
  - CIA may include specific responsibilities for the Board

Corporate Responsibility for Quality

- Legal compliance issues likely to arise in connection with efforts to implement change associated with quality of care and cost containment programs
- OIG provides guideposts for compliance measures
- Develop dashboards for compliance issues
- Move Quality from bottom of agenda to top

Governing Body Opportunities

- Specter of liability offers tool to implement and enforce quality measures within facility
- Statistics show that facilities with governing bodies actively involved in quality measures deliver better outcomes
- Better outcomes reap reputational and financial rewards

Questions?