Medical Director Agreements: Compensation Arrangements are Under the Microscope by HHS-OIG

(June 11, 2015): After a hiatus of almost a year, the Department of Health and Human Services, Office of Inspector General (HHS-OIG) has published a new ***"Fraud Alert"*** entitled ***"Fraud Alert: Physician Compensation Arrangements May Result in Significant Liability."*** As this alert makes crystal clear, physicians who serve as Medical Directors for home health agencies, hospices and other organizations must exercise care to ensure that the business relationship does not violate the federal Anti-Kickback Statute.

This article briefly discusses the potential criminal, civil and administrative liability you may suffer if your Medical Director arrangement does not fully comply with the law.

I. The Role of the Physician in the Care and Treatment of Home Health Patients:

In June 1995, HHS-OIG published its report, ***"The Physicians Role in Home Health Care."*** As set out in HHS-OIG's report, prior to 1995, Medicare covered home visits by a physician, but did not cover the services of physicians for managing the home health care of their patients. On December 8, 1994, the Health Care Financing Administration (HCFA), now known as the Centers for Medicare and Medicaid Services (CMS), published new regulations in the Federal Register which provided for separate payment to physicians for care plan oversight services.. As HHS-OIG's 1995 report further details, the agency had little data to rely on when assessing the full nature of physician involvement in home health care. Nevertheless, there were a number of

concerns (based on audits conducted and anecdotal evidence provided) that physicians were not appropriately involved in the planning and coordination of home health services.

II. HHS-OIG's Recent Fraud Alert on Physician Compensation Arrangements:

While the role of the physician in the care and treatment of beneficiaries referred for home health may have been unclear a decade ago, there is little doubt that HHS-OIG's view of this relationship has now crystallized.

Earlier this week, HHS-OIG published its latest Special Fraud Alert, entitled ***"Fraud Alert: Physician Compensation Arrangements May Result in Significant Liability."*** As this report reflects, HHS-OIG is very concerned that the relationships between physicians and home health agencies (or hospices) to whom they refer patients may violate the federal Anti-Kickback Statute. The federal Anti-Kickback Statute is a ***criminal*** statute, violations of which can result in fines of up to $25,000 and up to five years imprisonment. As you will recall, under the federal Anti-Kickback Statute (42 U.S.C. §1320a-7b(b)(1)(A):

> ***"Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind – in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a federal health care program."*** **(emphasis added).**

Unfortunately, HHS-OIG has good reason to be concerned. In recent years, a number of the so-called ***"Medical Director"*** relationships established between a referring physician and a home health agency have been shown to be sham agreements, the purpose of which has been to illegally compensate a physician for the number of referrals made to a given home health agency. As HHS-OIG's fraud alert discusses, it is essential that both parties entering into a compensation arrangement ensure that the arrangement fully complies with applicable laws and regulations. A key component to be considered is whether the physician's compensation is reflective of the "fair market value" of the bona fide services he or she is required to provide (and does, in fact, provide) under the agreement. While both CMS and HHS-OIG expressly recognize the importance of a physician's involvement in the plan of care and ongoing assessment of patients receiving home health care services, they are also very cognizant of the fact that some of these relationships have been little more than a disguised kickback. As HHS-OIG's alert reiterates:

> ***"if even one purpose of the arrangement is to compensate a physician for his or her past or future referrals of [f]ederal health care program business. [HHS-OIG] encourages physicians to carefully consider the terms and conditions of medical directorships and other compensation arrangements before entering into them."***

HHS-OIG's fraud alert further notes that the agency recently reached settlements with "12 individual physicians who entered into questionable medical directorship and office staff arrangements." Arrangements that take into account physician's volume or value of referrals, are not for a least a year, and are not based on a flat fee are particularly suspect.

III. Impact of the Patient Protection and Affordable Care Act:

Under the Patient Protection and Affordable Care Act (Affordable Care Act), Public Law 111-148, a number of important revisions to the federal Anti-Kickback Statute were enacted, one of which expanded a health care provider's potential liability for a Medicare or Medicaid-related kickback violation. As 42 U.S.C. § 1320(a)-7b(g) now provides:

> ***"(f) HEALTH CARE FRAUD.—***
>
> ***(1) KICKBACKS.—Section 1128B of the Social Security Act***
>
> ***(42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:***
>
> ***''(g) In addition to the penalties provided for in this section or section 1128A, a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31, United States Code.''.***

In other words, a violation of the federal Anti-Kickback Statute may now give rise to liability under the Civil False Claims Act. As you will recall,

As a result of this legislation, federal prosecutors (and possibly whistleblowers) could have also pursued this case under the civil False Claims Act. As you will recall, a violation of the False Claims Act can result in penalties of between $5,500 to $11,000, plus treble damages, ***per false claim***.

We are now seeing False Claims Act cases brought by both the government and by private parties (Relators / Whistleblowers) involving allegations of illegal kickbacks. This is especially the case in situations where the government for whatever reasons chooses to pursue this type of conduct civilly – whether or not the government chooses to also pursue a criminal cases varies from case-to-case, and often depends on the egregiousness of the conduct and the amount of the fraud. In any event, it is important for physicians and organizations to whom they make referrals keep in mind that violations of the Anti-Kickback Statute can lead to significant civil liability.

IV. Liability Under the Civil Monetary Penalties Law:

While violations of the federal Anti-Kickback Statute can lead to both criminal and civil liability, HHS-OIG's fraud alert also notes that physicians and other parties to an illegal compensation agreement are also subject to liability under the Civil Monetary Penalties (CMP) Law. The administrative sanctions that HHS-OIG may pursue under CMP laws can be nearly as severe as those that may be imposed under the civil False Claims Act.

V. Role of ZPIC Auditors in Identifying Fraudulent Compensation Agreements:

While most questionable Medical Directorships and other compensation arrangements are identified by other means, it is important to keep in mind that Zone Program Integrity Contractors (ZPICs) are actively involved in the identification and referral of potentially fraudulent provider conduct to both CMS and HHS-OIG. In fact, most ZPIC audit letters for information now include two separate "silos" (our word, not theirs) of requests. The first silo of information sought is generally concerned with specific claims information (e.g. copies of medical records, test results, billing records, physician notes, treatment and care plans, etc.). In contrast, the second silo of requests is almost exclusively focused on a health care provider's business-related records and business relationships. Typical requests falling into this category would include lists of current and former employees, receipts for supplies purchased, copies of any Medical Directorships, copies of marketing materials, copies of any equipment / space leases, employee salary information and copies of Accounts Payable records. When reviewing the materials produced in response to the second silo of questions, if it appears to a ZPIC that a health care provider is engaged in impropriety (such as paying a referring physician for the referral of patients), they will refer the matter to CMS and / or law enforcement for further investigation and action.

VI. What Should You Do?

Move carefully before entering into any Medical Directorship or compensation arrangement. Prior to executing any compensation agreement, both a physician and the organization to whom he or she may send referrals should have the agreement carefully reviewed by a qualified health lawyer so that any potential violations of the federal Anti-Kickback Statute can be fully addressed. Depending on the facts, the health lawyer may be able to structure the arrangement so that is fails within a Safe Harbor. To be clear, it isn't enough that an agreement appear to be legal on its face,

the ***actual conduct*** between the parties is what will ultimately be examined by law enforcement.

Robert W. Liles, JD, MS, MBA serves as Managing Partner at Liles Parker, Attorneys and Counselors at Law. Robert represents home health agencies of all sizes around the country in connection with a full range of ZPIC prepayment reviews, postpayment audits and suspension actions. He also handles home health False Claims Act cases. For a complimentary consultation, please call Robert at: 1 (800) 475-1906.