Next Generation Healthcare Internal Audit

Presented to: 2016 Compliance Institute

Objectives

• Gain an understanding of the Next Gen healthcare internal audit model and its foundational pillars.
• Explore the current state of healthcare internal audit and some of the traditional approaches to risk assessment and risk coverage.
• Identify the need for a comprehensive enterprise risk assessment that goes beyond the ordinary.
• Recognize the approaches to achieving a flexible resource/staffing model to enable specialized coverage of new and emerging complex audit areas.
• Understand the need to leverage robust technology and data analytics to enable more efficient and effective coverage of traditional audit areas, while also providing a platform to facilitate coverage of new industry risks.
Traditional Role of Internal Audit

- What is the role of Internal Audit?
- Traditional Approaches to Risk Assessment and Risk Coverage

Traditional Internal Audit Methodology

Approach
- Linear/tactical
- Financial control driven
- Resource intense
- Limited sample/transaction focused
- Reactive
- Cycle coverage
- Risk universe determined by existing skill set

Results
- Lacks clarity and depth
- Extraneous detail
- Limited risk coverage
- Absence of key takeaways
- Lacks trend and comparative data

Audit Plan Areas
- Cash controls
- Accounts payable
- Payroll
- Travel and entertainment
- Basic charge capture
- External audit assistance
Traditional Auditing in the New World

• Areas traditionally covered are still risks that are important to the organization
• Routine cyclical areas cannot be ignored
• Focus needs to be on using data analytics to address traditional areas more comprehensively

Emerging Risks in Healthcare
Transformation

- Current HC Audit Landscape and its Transformation

Four Foundational Pillars for NextGen IA

- Robust Risk Assessment
- Data Analytics
- Specialized Expertise / Flexible Staffing Model
- Risk Culture and Alignment with Organization
First Pillar: Robust & Comprehensive Risk Assessment

- Identify and Focus on What Matters Most
- Continuous Risk Monitoring

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Planning

- Analyze relevant data
- Determine who to interview and when
- Using Data Analytics to aid in having meaningful questions for interviews
  - Risk Assessment Dashboard
  - CMS Hospital Compare
  - E & M Testing (Hospital and Physician)
  - Length of Stay
  - Trial Balance Testing (compare begin/end bal % chg)
  - Simple Summaries for Payroll, AP, Supply Chain, Human Resources
  - K
- Obtain and review documents
  - Strategy/objectives
  - Budget/financials
  - Org Charts
  - Etc.

Risk Assessment Dashboard
E & M Analysis

PROVIDER LIST - Step 3

Before I say “Yes” I’d like to carry out a risk assessment
Performance

- Centralized, Decentralized or Hybrid Approach
- Interview Approach
  - Order
  - Who Performs/Attends (IT, Compliance, etc.)
  - Real Time Knowledge Sharing
- Addressing Specialty Areas
- Continuous Analysis

Performance Universe

- Finance
- Revenue Cycle
- Clinical
- Primary Ancillaries
- Non-acute
- Post-acute
- Information Technology
- Compliance
- Legal
- Quality
- Governance
Performance – Using Data Analytics

- Healthcare Compliance
  - One Day Stays, 30 Day Readmissions, Same Day Readmissions, Transfers in Lieu of Discharges, Credit Balances, Three Day Rule, 2 Midnight, Sterilization, MUEs, RACs
- Charge Captures (ED, Surgery, Cardiac Cath and Interventional Radiology)
- Patient Access Statistics
- Denials Dashboard
- Physician Contractual Payments
- CDM Updates
- Compare CDM Prices to Payor Contracts
- Segregation of Duties Testing
- Interface Testing

Performance Scoring and Documentation

- Impact – Scale of 1 to 5
  - Materiality
  - Strategic Impact
  - Operational Importance

- Management Concerns and Internal Audit Concerns: Factor added to above to weight it more or less heavily

- Likelihood – Scale of 1 to 5
  - Complexity – Human, Volume, Code Sets, Number of systems, etc.
  - Regulatory Impact (including recent changes)
  - Focus
  - Inherent Risk Level
  - Control Awareness (what is in place)
  - Last time audited/reviewed
  - Monitoring programs in place
  - Management Concerns and Internal Audit Concerns: Factor added to above to weight it more or less heavily
Example Risk Assessment Scoring

- Patient Falls – Hospital has implemented EBPs for Falls Preventions. Number of Falls with Injury has not decreased, instead, has increased by 5% compared to prior to EBP implementation. Total number of Falls however, has decreased by 15%. Management is concerned about the reason for increase in number of Falls with Injury.

<table>
<thead>
<tr>
<th>Audit Area</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Management/Audit Concern Multiplier</th>
<th>Total Score</th>
<th>Risk Ranking</th>
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<tbody>
<tr>
<td>Falls</td>
<td>3.0</td>
<td>2.0</td>
<td>5</td>
<td>(3.0<em>5) + (2.0</em>5) = 25/2 = 12.5</td>
<td>2</td>
</tr>
<tr>
<td>Physician Comp</td>
<td>5.0</td>
<td>4.0</td>
<td>3</td>
<td>(5.0<em>3) + (4.0</em>3) = 27/2 = 13.5</td>
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<tr>
<td>EMTALA</td>
<td>2.0</td>
<td>2.0</td>
<td>5</td>
<td>(2.0<em>5) + (2.0</em>5) = 20/2 = 10.0</td>
<td>3</td>
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</table>

Risk Assessment Exercise #1 - Lab

- Scenario: Lab just underwent a software conversion. Order sets in the Cerner system had to be re-linked to the new software. The Lab CPT codes and corresponding order sets were not reviewed to make sure they were the most current. Lab revenues have suddenly increased since the implementation. Specifically, there have been an increase related to orders “with differential.” Additionally, the pathology lab billing has seen an increase in revenue as well.
## Risk Assessment Exercise #2 - Restraints

- **Scenario:** Hospital is a 150 bed hospital. Approximately 50 of the beds are designated as a distinct part Psychiatric Unit. Acute beds have a higher incidence of use of restraints (total patients) than the Psych unit on a per-day basis. Management has expressed concerns about the volume of restraint supplies being utilized on the acute side, but not as much on psych unit. Management states that there is ZERO use of Chemical restraints in either section of the hospital. They aren’t too worried about it.

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## Risk Assessment Exercise #3 – Home Health

- **Scenario:** HHA census is really high. One to two physicians make up over 60% of all referrals to the HHA. Physicians had historically been non-responsive to signing documents required for billing, with delays of up to 6 months. Recently, documentation has been returned within 30 days, a significant improvement. Additionally, the HHA has lost 3 of 4 therapists and 1 of 3 PTAs. Revenue related to therapy services provided has maintained, with a slight increase in the last 2 months. Quality metrics indicate an increase in hospital readmissions, falls in the home, and wounds becoming worse.

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</table>
Risk Assessment Ranking Results

<table>
<thead>
<tr>
<th>Audit Area</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Total Score</th>
<th>Risk Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab</td>
<td>2.0</td>
<td>4.0</td>
<td>9.0</td>
<td>3</td>
</tr>
<tr>
<td>Restraints</td>
<td>3.5</td>
<td>2.0</td>
<td>11.00</td>
<td>2</td>
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<tr>
<td>Home Health</td>
<td>1.0</td>
<td>3.5</td>
<td>11.25</td>
<td>1</td>
</tr>
</tbody>
</table>

Reporting

- Creation of Proposed Audit Plan (Plan)
- Reporting Results
  - Management
  - Governance
- Reporting back out on items that couldn't make the Plan
- Deliverables beyond the Plan – how to make results meaningful to clients
- Delivery of any unique product to Management vs. Governance
- How continuous risk assessment is achieved and reported back to Management and Governance
- Risk Assessment Dashboard
- Continuous Monitoring Tools
Future State of Risk Assessment

- Continuous Risk Assessment
- Incorporating Other Data
  - Audit Issues
  - Financial Benefits
  - Other Risk Assessment Data
- Other Means of Getting Information
  - Surveys (Questionnaires)
  - Use of Data Analytics
    - Predictive Analytics
    - Big Data in Health Care
    - Clinical Data Analytics
Key Considerations

- Plan Early and Thoroughly
  - Approach
  - Data Analytics
  - Interviews – Scoring Methodology
  - Deliverable

- Lead the Interview

- Continuously Document Risks

Second Pillar: Data Analytics

- Data Driven
- Ability to sift through the noise and information overload
- Risk Intelligence
Traditional Financial Areas

- Accounts Payable
  - Duplicate Vendors
  - Lost Discounts
- Travel and Entertainment
  - Expenses in Excess of Allowed
  - Unapproved Vendors
- Payroll
  - Duplicate Employees:
    - Names
    - Addresses
    - SSNs
- Financial Reporting
  - Unusual Journal Entries

Strategic Risk Areas

- Charge Description Master
  - Medicare Compliance
  - Pricing and Reimbursement
  - CDM Completeness
- Charge Capture
  - Cath Lab
  - Emergency Department
  - Laboratory
  - Interventional Radiology
- Managed Care Contracts
  - Payments Different from Expected
  - Accounts without Payments
- Pharmacy 340B
  - Drugs Provided during Inpatient Stay
  - Drugs not ordered by Eligible Provider
  - New Drugs not purchased via the WAC account
  - Duplicate records in the 340B accumulated population
  - Outpatient Drug charges not included in the 340B accumulated population
Third Pillar: Specialized Expertise & Flexible Staffing

- Multi-Disciplinary Team
- Deep Skills & Specialization
- Dynamic Service Delivery Model
- Risk-Focused & Agile

Common Areas Requiring Specialization

- Coding
- Clinical
- Compliance
- Technology
- Data Analytics
- Physician Practice/Non-acute
- Post-Acute Care
Goals and Objectives

- To recognize the risks inherent to both the employed and non-employed provider arrangements
- To identify key stakeholders within the provider spectrum and how to provide them value specific to their areas of responsibility
- Gain knowledge of specific types of arrangements, their risks and mitigating controls
- Open forum review of three case studies (*) – discuss the risks and potential audit steps and reporting
  * Case studies and examples are hypothetical in nature for discussion purposes.

Specialized Area: Physician Arrangements

- If Physicians Are Receiving Payments From Your Organization
  - Contract
  - Fair Market Value
  - Verifying Payment is Consistent with Contract
Inherent Risks of Physician Arrangements

- Physician Self-Referral Law ("Stark Law")
- The Anti-Kickback Statute ("AKS")
- The Civil False Claims Act ("FCA")

The strict liability nature of the Stark Law makes review of employment agreements and employed practices important.

A violation of the Stark Law can lead to nonpayment of claims, civil monetary penalties, program exclusions and may create liability under the FCA.

Key Client Stakeholders

- Physician Leadership – Both Provider and Administration
- Legal Department
- Corporate Responsibility Officers
- Revenue Cycle Management
- Credentialing Personnel
- Internal Coding Department
Common Physician Arrangements

- Employment
- Administrative Services
- Professional Services
- Call Coverage
- Space Leases
- Co-Management
- Recruitment/Income Guarantees
- Relocation Bonus
- Loan Payment Forgiveness
- Time Shares
- Embedded
- MSO
- Reverse MSO
- Joint Ventures

Physician Employment

Risks
- Due diligence not performed in support of arrangement.
- Physician productivity has no pre-set expectations or limits.
- Administration does not include multi-disciplinary oversight.

Mitigating Controls
- Defined and implemented due diligence process.
- Tiered contracts, oversight, tied to FMV, “floor” and “ceiling.”
- On-going oversight from other departments such as Corporate Responsibility, Revenue Cycle/Coding.
Administrative Service Arrangements
(medical directorships, physician leadership positions, hospital committee work)

- Contract must be in writing - Verify contract is not expired
- Have documentation stating the need and purpose for the administrative services - Services must not exceed what is reasonable and necessary for a legitimate business purpose
- Make sure the list of services in the contract is detailed and confirmed by the responsible manager.
- Compensation must be set in advance (typically hourly), at fair market value, and not based on referrals
- Should be signed before services are rendered
- Must reference master contract database
- Perform independent agreement review of compensation to contract.
  - Use of attestation of a time worked log to document physician hours worked.
  - Time worked log should be detailed.

Clinical Professional Service Agreements (PSA)

- Independent contractors
- Physicians are compensated directly for services
- Independent third party valuation to support FMV compensation.
- Documenting performance through reports or time logs.
- Hospital bills and collects for services
- Monitor performance according to terms stated in the contract.
- Pay based on documented performance.
  - Paid either hourly, per shift or per procedure
- Reconcile payments to contract terms.
  - Contract covers all services
  - Cross references contract database
  - Aggregate of services documented as reasonable and necessary
  - Compensation set in advance, FMV, and not referral based
Call Coverage

Risks
- OIG Advisory Opinion No. 12-15 (October 2012) “call arrangements pose “considerable risk” of being disguised payments for referrals
- Overpayment or auto-maximizing to contract terms.

Mitigation
- Independent valuation supported per-diem payments as FMV and commercially reasonable.
- Payments set in advance each year and applied uniformly to all physicians within a particular specialty.
- Providers were required to care for the uninsured.
- Call agreements were offered to all physicians in specialty, not selectively to high referrers.
- Monitoring oversight and use of call time sheets.

Space Leases – Key Elements
- Obtain written appraisal of FMV rental from certified real estate appraiser.
  - Avoid broker or real estate agent “quick opinions”.
  - Net vs. gross lease rent should be in appraisal.
  - Should provide range for FMV rent.
  - Should use comparable properties.
  - Keep appraisal on file and update regularly.
- Minimum 1 year term.
- Rent only the space reasonable and necessary for tenant’s business purpose.
- Tenant must have exclusive use of space during rental period - If part-time, should identify the exact rental periods for anti-kickback safe harbor (e.g., every Monday and Wednesday 8 AM – 11 AM).
- Rent must be “set in advance” at “fair market value,” and commercially reasonable
- Tenant may pay for common areas (waiting room, elevator, hallway, etc.), but can’t exceed Tenant’s pro-rata share.
Space Lease Arrangement Red Flags

- Not in writing – “handshake” agreement.
- Lease not signed by provider.
- Lease has expired.
- Hospital leases space from a referring physician without documented need.
- Parties have failed to reevaluate and adjust rent over term of lease (i.e., rent has an adjustment every three years tied to Consumer Price Index).
- FMV not reviewed in the case of changed economic conditions/environment.
- Leased space is used to the benefit of another entity. *(If DHS, BIG FLAG)*
- Failure to timely pay rent and application of late payment fees.
- Physician uses time shared space for more than allotted time or not paying appropriate share of expenses.
- Actual space the physician leases doesn’t match square footage in lease.

Co-Management Agreements (CMA)

Defined as an agreement in which a provider (typically, a hospital) contracts with a physician group (cardiologists, orthopedics, surgeons) to manage a service line to achieve quality and operational outcomes. This is usually a dual fee structure: Guaranteed “Fixed Fee” for management and medical direction services and “Performance Based Fee” paid if defined criteria are met. Services may include Medical Direction, Strategic Planning, Staff Development, Credentialing, Medical Staff Committee, Policy and Protocol Review, Recommending Equipment, and Supply Standardization, among others.

- Goals are clearly defined and documented.
- Physician must perform substantial, real services.
- Time log to document services.
- Independent third party valuation to verify that the terms of the arrangement and compensation are FMV and commercially reasonable.
- Performance fee components based on national quality measures and internal data/reports.
- ROBUST monitoring infrastructure place: Third party utilization firm review performance measures, care appropriateness, impact on patients; Review of quality and cost savings measures.
- Multi-department review: Compliance Officer, Peers, Audit Committee, etc.
Recruitment/Income Guarantee Primary Elements

Typically defined as a health system providing financial support to recruit a physician to practice medicine in the hospital's geographic area either in solo practice or joining an established group.

- Can only recruit new physician (in practice < one year) or physician who is relocating his/her medical practice at least 25 miles from outside the hospital's geographic area to inside the hospital's geographic area.
- Can't recruit non-physician practitioners.
- If recruiting physician to join group practice, can only pay actual, additional incremental expenses for recruited physician not a pro-rata share of expenses (e.g., rent).
- Maximum payment period is 3 years, followed by forgiveness period.
- Requires considerable oversight to administer.

Compensation Arrangements Types – The Pancake Effect

<table>
<thead>
<tr>
<th>Patient Experience Bonus</th>
<th>Sign-on or Retention Bonus</th>
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</thead>
<tbody>
<tr>
<td>Productivity/Incentive Bonus</td>
<td>Medical Administrative Directorship</td>
</tr>
<tr>
<td>Co-management Agreement</td>
<td>Quality Bonus</td>
</tr>
<tr>
<td>Retention Bonus</td>
<td>Call Pay</td>
</tr>
<tr>
<td>Tail Insurance</td>
<td>Excess Private Benefits – Auto Allowance</td>
</tr>
<tr>
<td>Relocation Costs</td>
<td>Financial Performance</td>
</tr>
</tbody>
</table>

The key is to identify all the Providers compensation arrangements and their cumulative impact when compared to FMV value and commercial reasonableness valuations.
The Pancake Effect – Continued

Considerations:

- Hours worked per agreement and their cumulative effect (only 24 hours)
- Compensation – cumulative effect

Use benchmarking as a guide toward reasonableness:

- Compensation per wRVUs or total RVUs
- Compensation to professional collections
- Compensation to total collections
- Compensation per encounter

Employed Compensation Arrangement by Type Analysis

Quality Measures:

- Clearly and separately identified.
- Objective methodology - verifiable by credible medical evidence.
- Reasonably should consider patient population.

Productivity/Incentive:

- Should not consider the value or volume of referrals.
- Is it offered to all applicable providers? If not, why not?
- Is it assessed annually with new baseline data applied?
- Are target levels developed by national benchmarks?
- Payments should be set at FMV.
CASE STUDY #1

- A group of five cardiologists are employed by a non-profit 501(c) health system ("System") to perform hospital based surgical procedures and consultations, and pre and post-surgery office visits all within a System-owned and -operated practice ("Practice"). The System acquired the existing Practice and employed most of the operational staff.
  - Two of the five cardiologists have guaranteed compensation which exceeds the 90th percentile of their applicable MGMA specialty.
  - The Practice building is owned by the cardiologists and leased to the System.
  - The Practice's annual financial reporting results in a significant loss per cardiologist.
  - An independent fair market value and commercial reasonableness assessment ("FMV") was obtained prior to the transaction and supports the two cardiologists whose compensation exceeds the MGMA 90th percentile predicated upon full-time employment and corresponding worked Relative Value Unit ("w/RVU") production.
  - A section of the Practice building (carved out of the "Practice Lease") is used exclusively for the cardiologist's own research clinical trials business ("Research"), which Research is independent of the System. The Research business leases nursing and administrative staff from the System’s Practice.
  - The agreements do not include a “right to audit” clause or require the cardiologists to disclose their Research compensation and time commitment.

CASE STUDY #1 – Discussion Points

Risks

- In light of the Research, does the FMV of the cardiologist’s compensation support and represent their actual full-time performance?

- Are they fulfilling their employed contractual obligations?

- Are the leases for the building and employees within fair market value and commercial reasonableness standards? If not, then has the potential to violate Stark and Anti-Kickback laws, as well as result in prohibited benefit inurement.

- Are the Practice’s space, supplies, and staff dually utilized by both the Practice and Research during a patient office visit? This again risks prohibited benefit inurement.
CASE STUDY #1 – Discussion Points Continued

Audit / Analysis

- Confirm the leases are commercially reasonable and would be considered fair market, at “arms length”, if independently reviewed.
- On-site inspection of the supplies and space.
- Review patient charge patterns for office visits, with focus on no-charge encounter applicability.
- Analysis of the FMV to the compensation paid; ensure the FMV documentation is an “apples to apples” comparison to the actual arrangement in place.
- Review of providers schedule and performance metrics including w/RVU production.
- On-site discussion with Practice staff and providers regarding workflow and observation of interaction with Research.

CASE STUDY #1 Risk Identification

- In the first Case Study, the primary focus was on the compensation level and obtaining an independent fair market value assessment in support of it.
- Identifiable risks present with the space leases, employees and equipment in that Case Study could also be addressed and adequately quantified during the initial on-boarding.
- However, a key element of a “right to audit clause” to mitigate risk during the operation of the Practice was missing.
- Carving out a section of the building for the Research work is one important step toward compliance. Yet, the physical proximity of the Practice to the Research entity and the carryover of practice management and staff heighten the risk that the Research entity could receive a private benefit inurement.
- With no one assigned through a “right to audit” provision to monitor the Research relationship and its use of the staff and space going forward, that risk is difficult to curtail.
CASE STUDY #1  Regulatory Risk

- In its June 9, 2015 Fraud Alert, the HHS Office of Inspector General alleged that because a staffing arrangement with an affiliated health care entity relieved some of the physicians of a financial burden they otherwise would have incurred, the salaries paid under the staffing arrangement constituted improper remuneration to the physicians. This improper remuneration may represent an excess economic benefit under the IRS and Treasury regulations and thus pose a threat to the organization’s non-profit status. Further, based on the June 9, 2015 Fraud Alert, such improper remuneration has led to liability under the healthcare fraud and abuse laws.

1 OIG FRAUD ALERT “PHYSICIAN COMPENSATION ARRANGEMENTS MAY RESULT IN SIGNIFICANT LIABILITY” (JUNE 9, 2015); http://oig.hhs.gov/compliance/alerts/guidance/index.asp

CASE STUDY #2

- A not-for-profit health system ("System") employs 8 providers who receive base compensation on a draw basis, predicated solely on worked Relative Value Unit ("w/RVU") production ("Base Draw").
  - The initial amount of the Base Draw was calculated using anticipated annual w/RVU production and is paid in standard bi-weekly pay cycles.
  - The initial compensation level is supported with an independent fair market value and commercial reasonableness assessment ("FMV"). The FMV is based on a “floor” of anticipated w/RVU production.
  - The provider’s each have a five-year contract with terms stating the compensation level is to be evaluated on a quarterly basis and adjusted to reflect actual w/RVU production and align with the FMV.
  - Three years into the provider’s contract terms, it was discovered that since the contract’s effective date, the w/RVU production for four of the eight cardiologists was significantly below the anticipated w/RVU floor used in the original calculation.
  - Investigation reveals that the respective Base Draw for each of the four provider’s was not adjusted downward to reflect their actual w/RVU production level.
CASE STUDY #2 – Discussion Points

Risks
- Provider on-boarding perceived a low-risk with Base Draw and quarterly adjustment language. “Set it and forget it” mentality. Risk for violation of Stark and Anti-Kickback laws is higher than perceived.
- Practice lacked accountability and enforceable procedures where actual performance should have triggered an adjustment in compensation.

Audit / Analysis
- Re-calculation of compensation to contract terms and verification of operational oversight including any required adjustments.
- Reporting to Physician Leadership and engaged to address policy and procedure with stakeholders across the System spectrum of Legal, Compliance, Operations, Revenue Cycle, Human Resources and others as needed.

CASE STUDY #2 Risk Identification
- The System did not adjust their employed cardiologists’ Base Draw payments per the agreed-to contractual terms.
- This lack of adjustment creates potential Stark Law liability in several ways.
  - One, it undermines the fair market value of the payments made to the cardiologists. In a 100% productivity-based model, a physician’s w/RVUs will tie directly to the Base Draw and to any reconciliation of those Draw payments. By not reducing the Draw per the express contract language, the System is paying compensation different from, and ultimately greater than, the agreed-to terms.
  - The lack of adjustment risks pushing the effective $/w/RVU rate to unsupportable levels because there is no productivity to support the full Base Draw payment.
CASE STUDY #2 Regulatory Risk

- This also shows why a coding audit is important. The coding audit would help ferret out whether a provider’s wRVUs are taking into account only personally performed services or if the productivity numbers are inflated.
  - *Halifax, M.D. Fla., 2013 at 11* (November 18, 2013) (denying defendant’s motion for summary judgment)(noting that the government’s expert raised questions as to whether the neurosurgeons’ productivity numbers were improperly inflated by, e.g., billing under their name for non-physician provider work).

- If the Base Draw payments are no longer supported, then there is likely an overpayment and attempts must be made to recoup the overpayment. If the overpayment cannot be recouped for any reason, then self-disclosures under the Self-Referral Self-Disclosure Protocol may be necessary.

CASE STUDY #3

- A not-for-profit health system (“System”) enters into a professional services agreement (PSA) for primary care and urgent care clinical services at its three locations with an independent physician group (“Group”). The Group is paid on a flat per w/RVU rate for all provider types.

- The Group includes physicians, physician assistants and nurse practitioners.

- System operates the three practices, provides all non-clinical staff and performs all billing services.

- The set annual draw amount is paid monthly and reconciled annually to actual wRVUs.

- The System leases the space at its 3 locations from the Group and purchased its equipment.

- The System also reimburses the Group for professional liability insurance, medical benefits and continuing education for its physicians and mid-level providers (MLP).

- The System does not “bill incident to” for its MLP and therefore does not receive the full physician reimbursement rate from Medicare.
CASE STUDY #3 Continued

- This is a conversion of existing group practice and represents an independent contractor arrangement.
  - Instead of traditional employment, physicians were able to retain their own practice and the Group was compensated on a productivity basis (w/RVU) for its services. Group was also reimbursed for certain expense (medical and insurance).
  - PSA models as opposed to employment models create a more uncertain status under the Stark law and the anti-kickback statute. The anti-kickback statute does not apply to employment agreements, but does apply to PSAs.

CASE STUDY #3 – Risks

Risks

- Productivity rates above FMV
  - Was there an independent third party FMV assessment performed? Were the assumptions made clearly stated and broken out by specialty and service type?
  - When comparing to benchmarks, did the valuation take into account the additional expenses reimbursed for medical and insurance?

- Including MLP productivity in the w/RVU rates
  - Did the valuation include assumptions by specialty and service type?
  - Does the FMV assessment match the contract?
  - Was there a physician to physician extender ratio statement in the contract?

- Paying full-time benefits and insurance for part-time services
  - Were the terms clearly stated in the contract and were they considered in the valuation?
CASE STUDY #3 – Risks Continued

Risks

- Leasing space and purchase of equipment above FMV
  - Was there a separate analysis and valuation for the leasing of space and purchase of equipment?
  - Was the space and equipment necessary for business purposes (did they lease more space than they needed or unused equipment)?

- Space, equipment and supplies used by Group for other services
  - Did the group have other existing arrangements prior to the PSA?

CASE STUDY #3 – Audit Analysis

Audit / Analysis

- Comparison of FMV valuation to contract terms.
- Comparison of assumptions and contract terms to actual performance and practice operations.
- Re-calculation of compensation to contract terms and verification of operational oversight including any required adjustments.
- Reconcile additional expense reimbursement to contract terms.
- Confirm the space leases and the purchase of equipment are commercially reasonable and would be considered fair market, at “arms length”, if independently reviewed.
- Perform an on-site walkthrough and observation of practice operations including space and equipment used.
Fourth Pillar: Risk Culture

- Organization Culture
- Strategy Driven
- Ambassador of the “Tone at the Top”

Next Generation of Healthcare Internal Audit

**Approach**
- Strategy driven
- Continuous connection to C-suite, leaders, managers, stakeholders
- Data driven
- Multidisciplinary and flexible team
- Deep specialization
- Responsive and real-time
- Collaborative approach
- Risks covered through continuous monitoring and data analytics

**Audit Plan Areas**
- Traditional plan coverage
- Clinical protocols
- Cybersecurity
- Process redesign
- Quality/performance measures
- Third-party risk
- Flexible care delivery models
- Regulatory compliance

**Results**
- Continuous auditing dashboard
- Benchmarking against peers
- Multi-level deliverable
- Comprehensive risk analysis
- Robust governance and management education
Takeaways

- Our industry is changing at a rapid pace

- Internal audit must, in turn, adapt our historic methods of risk coverage to address emerging risks

- Specialized resources are necessary to provide deeper risk coverage

- Using data analytics is critical so that traditional risk areas covered by internal audit are addressed

THANK YOU
for your time today.
We appreciate the opportunity to share the CHAN Healthcare vision of the Next Generation Healthcare Internal Audit.

For more information, please contact:

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