County of Ventura
# AUDITOR-CONTROLLER
MEMORANDUM

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**To:** Johnson K. Gill, Director, Health Care Agency **Date:** August 20, 2018

**From:** Jeffery S. Burgh

**Subject:** **AUDIT OF CONTRACT COMPLIANCE FOR HEALTH CARE AGENCY PHYSICIAN COMPENSATION**

The audit has been completed of contract compliance for Health Care Agency (HCA) physician compensation. The audit was conducted by Moss Adams LLP, as commissioned by the Auditor-Controller. The audit report is attached for your reference.

The audit concluded that, overall, HCA physicians were paid in accordance with contract provisions. However, the audit resulted in recommendations for 15 findings in the following 5 areas: policies and procedures; supporting documentation; contract management; informal HCA practices; and other opportunities to implement best practices.

HCA management initiated corrective action to address the findings. Corrective action is planned to be completed by July 1, 2019.

We appreciate the cooperation and assistance extended by you and your staff during this audit.

Attachment

cc: Honorable Peter C. Foy, Chair, Board of Supervisors
Honorable Steve Bennett, Vice Chair, Board of Supervisors
Honorable Linda Parks, Board of Supervisors
Honorable Kelly Long, Board of Supervisors
Honorable John C. Zaragoza, Board of Supervisors
Michael Powers, County Executive Officer
Matt Sandoval, HCA Compliance Officer

# County of Ventura

Performance Audit of Contract Compliance for

Health Care Agency Physician Compensation

**August 20, 2018**

MOSSADAMS

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# Objective, Scope, and Methodology

Moss Adams conducted a performance audit of contract compliance for Health Care Agency (HCA) physician compensation for the County of Ventura (County). The objective of this performance audit was to determine whether the County's compensation to HCA physicians for fiscal years July 2013 – June 2014 and July 2014 – June 2015 was paid in accordance with contract provisions. During fiscal year 2013–2014, HCA paid approximately $53M to physicians on 248 contracts. During fiscal year 2014–2015, HCA paid approximately $55M to physicians on 218 contracts. In the course of the performance audit, we considered compliance with laws and regulations such as Stark Law (Stark), which is a set of United States federal laws that prohibit physician self-referral, specifically a referral by a physician of a Medicare or Medicaid patient to an entity providing designated health services if the physician (or an immediate family member) has a financial relationship with that entity; and the federal Anti-Kickback Statute (AKS), which is a criminal statute that prohibits the exchange (or offer to exchange) of anything of value in an effort to induce (or reward) the referral of federal health care program business. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The scope and methodology of our work included the following:

- Conducted a kick-off meeting with County of Ventura Auditor-Controller's Office (ACO) and HCA personnel to confirm the objectives of the performance audit, agree on the work plan, determine schedule for fieldwork, establish communication protocol, and address any questions posed by the project stakeholders.
- Worked with ACO to develop and implement a method to identify the universe of all payments to physicians/physician groups and match to the universe of all documented active physician/physician group agreements.
- Conducted an audit survey to identify the universe of physician contracts and types of compensation, and determine the specific performance audit scope. The universe of payments obtained from ACO consisted of a listing of individual invoices paid and the respective vendor names. Each invoice number included the type of compensation arrangement within the physician or group contract and the date incurred (e.g., DIR/JUL13 would represent Medical Director Fees for July 2013). These individual compensation arrangement amounts will be referred to as "compensation types" within this report.
- Selected samples for testing from both the universe of payments and listing of all contracts for fiscal years 2013–2014 and 2014–2015.
- Reviewed existing policies and procedures to determine the internal controls related to contracting with and paying physicians in California.
- Interviewed staff to determine the procedures and knowledge of the internal controls related to contracting and payment to physicians and if HCA practices were aligned to these controls.

- Selected a sample of 25 physician invoices, each from a different contract, to confirm that amounts:
  - Were mathematically accurate,
  - Were approved by an appropriate person with knowledge of the physician's work,
  - Had adequate supporting documentation for services,
  - Agreed with the scope of work in the contract, and
  - Agreed with the terms and conditions in the contact.
- Selected a separate sample of 10 physician contracts. Across the 10 contracts we selected a sample of 75 compensation types. We then tested the compensation types to the contract to confirm the following:
  - Physicians were compensated the proper amount in accordance with contract provisions.
  - Documentation supported that compensation requirements were met in accordance with contract provisions.
  - If claims were entered into the Ventura County Financial Management System (VCFMS) before compensation requirements were met, or if claims were based on prior year data or paid at the maximum amount because current year data was not available, then we validated the following:
    - HCA verified in a timely manner that compensation requirements were met, and the payments made were reconciled based on current year data [including review of production based incentive payments based on Work Relative Value Units (RVUs) or other measurement criteria for fiscal years 2013–2014 and 2014–2015].
    - HCA pursued in a timely manner any amounts due to the County because of overpayment (including review of production based incentive payments based on Work RVUs or other measurement criteria for fiscal years 2013–2014 and 2014–2015).
  - If any income guarantees and other advances were included, verified that there was an annual reconciliation, a reconciliation at contract termination, and a process to collect balances owed, if appropriate.

# Audit Results

## SUMMARY OF GOOD PRACTICES

- In the samples selected for testing, County compensation to HCA physicians was paid in accordance with contract provisions.
- The County has a contract approval policy which includes approval by the Board of Supervisors of the compensation maximum if over $100,000.
- Although the invoice approval process was not formally written in a policy, approval of each invoice was documented by the signature of the reviewer on the invoice.
- Although not formally documented, based on our discussions with HCA, a Fair Market Value (FMV) analysis of the physician contract is performed using Medical Group Management Association (MGMA) tables and other local market sources, as appropriate.
- Payment amounts were mathematically accurate.
- Overpayments due from physicians in the sample selected for testing were identified by HCA during their annual reconciliation process. These overpayments were recouped from the physicians over a varying number of months.
- HCA Accounts Payable (AP) and contracting staff were knowledgeable regarding processes and controls related to contracting and physician compensation arrangements. At least one member of the HCA contracting staff was knowledgeable regarding regulations related to contracting and physician compensation arrangements.
- ACO reviewed payment requests for accuracy with the supporting documentation and proper approval indicated on the VCFMS print out and signed invoices before payments were disbursed.

## SUMMARY OF FINDINGS

Our observations include recommendations in five general areas:

### Area 1: Policies and Procedures

- HCA does not have written policies or procedures related to physician contracts for compensation or administrative purposes.
- Formal written FMV analysis or opinion was not consistently performed, or documentation was not consistently retained and available for review. No policy or procedure was available to delineate the process for presenting FMV as support for each new or existing contract.
- For one of the contracts we tested, the physician was put on a payment plan to recoup an overpayment. This credit was repaid by the physician through seven quarterly payments to the County, which exceeded the industry standard of 90 days.

### Area 2: Supporting Documentation

- Contracts did not consistently list the type or amount of support required to be submitted by a physician or group in order to receive payment.
- Supporting documentation was lacking at the time the payment was made to physicians for base and director fee compensation types.
- On-call compensation arrangements were included in the same contract with other types of compensation arrangements. Having a separate contract would address specific requirements needed for on-call arrangements.
- HCA AP did not obtain and/or review support for payment of the documentation fee contract compensation type.

### Area 3: Contract Management

- HCA does not have a contract management software system to efficiently manage physician contracts.
- We noted one item within our sample where payment for a specific compensation type exceeded the maximum allowed for the year.
- During fiscal years 2013–2014 and fiscal year 2014–2015, HCA utilized the fiscal year 2012–2013 data to calculate the RVU payments throughout the year and then reconciled when the information became available. There was an instance in which the contract maximum was not considered when using the old data. The RVU payments were properly and timely reconciled when the actual data was available.

### Area 4: Informal HCA Practices

- We noted that providers were generally reimbursed at the annual maximum level allowed by the contract even if payment terms did not specifically address this. The sample payments we tested were appropriately reconciled at year-end.
- Blank monthly invoices are pre-signed by the physicians at the beginning of the fiscal year. When it is time to pay the physician each month, the signed invoices are manually completed by HCA AP with the month's compensation amounts. The invoices are often submitted without support for each type of payment such as timesheets or on-call details.

### Area 5: Other Opportunities to Implement Best Practices

- Some contracts within our sample were not signed timely, or were not consistently dated by both parties.
- HCA does not have a process for completing regular audits or monitoring of physician arrangements.

# Findings, Conclusions, and Recommendations

The following pages provide a detailed listing of the condition, criteria, cause and effect of our findings as well as our recommendations and HCA management's response to the findings.

| No. | Conditions/Observations | Criteria/Standard | Cause and Effect | Recommendation | Management Response |
|---|---|---|---|---|---|
| **AREA 1: POLICIES AND PROCEDURES.** HCA lacked written policies and procedures that could impact compliance with regulations. | | | | | |
| 1. | **Policies Related to Physician Contracts:** HCA does not have written policies or procedures related to physician contracts for compensation or administrative purposes. | Industry standard is to have formal written policies and procedures that are consistently followed. | Without documentation of policies, differences in processes may occur and the processes may not be consistent or in compliance with regulations as noted in Observations 1A and 1B below. | Develop and implement policies and procedures related to physician contracts for compensation and administrative purposes. Recommended policies include contract file requirements (FMV analysis, legal approval, etc.), timesheet requirements, leases with physicians, professional service agreements (PSAs), and call coverage agreements. | Currently HCA follows all County requirements for service contracts. This includes having all contracts with an annual value equal to or less than one hundred thousand dollars follow the General Services Agency (GSA) procurement process. This process requires all contracts to be reviewed and approved by GSA and Auditor Controllers Office (ACO). GSA obtains approval from County Counsel, either for each individual contract, or by using the County Counsel approved template. Any service contract over one hundred thousand dollars per year requires Board of Supervisors approval; therefore, these contracts, by way of the County process, are approved by the Ventura County Chief Executive Officer (CEO), County Counsel, ACO, and GSA when required. |

| No. | Conditions/Observations | Criteria/Standard | Cause and Effect | Recommendation | Management Response |
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| | | | | | HCA management agrees and acknowledges that documented policies and procedures will provide consistent guidance to HCA and will assist in ensuring contracts comply with regulations. Each contract is an individual document outlining the requirements based on the services provided. The services provided are unique based on the contracted physician's experience and education, as well as the needs of the County. As recommended HCA will set a goal to have the new policies and procedures fully implemented by July 1, 2019 for: contract file requirements, time reporting requirements, leases with physicians, professional service agreements, and call coverage agreements. |

| No. | Conditions/Observations | Criteria/Standard | Cause and Effect | Recommendation | Management Response |
|---|---|---|---|---|---|
| 1A. | **Fair Market Value (FMV):** Formal written FMV analysis or opinion was not consistently performed, or documentation was not consistently retained and available for review. | Stark[1], Anti-Kickback Statute (AKS)[2] – Each compensation arrangement to referral sources [physicians] will require fair market value or commercially reasonable compensation.[3]<br><br>Standard practice is to maintain support for FMV within the contract management system. Support may include salary surveys or FMV opinions.<br><br>If the specialties and/or region is not available within a survey, industry standard is to obtain an outside opinion for the specialty and update semiannually. | A policy or procedure was not available to indicate the process for presenting FMV as support for each new or existing contract. Without a formal policy, processes and analyses may vary and result in an increased exposure of financial penalties and fees for payments to physicians exceeding FMV. | Document and implement a formal written policy and procedure related to how to document FMV for each new and renewal contract. The policy should indicate a value per hour that is considered a safe harbor FMV and when a FMV opinion is not required. For all other contracts, the policy should indicate that a written valuation opinion is required. The FMV report should document the sources used and considerations of the FMV of the contract. All contracts should have documentation within the central contract repository. | HCA uses MGMA (Medical Group Management Association) data to determine the starting point for physician compensation. HCA policy is to set the physician compensation at 80% of the median income for the western region listed within MGMA. Although not documented, this was the process for HCA contracting. MGMA defines what type of compensation is covered within the base compensation. Beginning in 2016 HCA purchased the additional compensation books for medical directorship, on-call, and management. These tools assist HCA in negotiating FMV for the total compensation of the physicians.<br><br>HCA does agree that documenting the policy and procedures followed by HCA would help ensure consistency with the compensation negotiations of the physician contracts. HCA will set a goal to have the current policy, and new procedures and processes documented by July 1, 2019. |

[1] 42 CFR § 411.357(d) and (l)
[2] 42 CFR § 1001.952(d)
[3] 42 CFR § 411.351 Fair Market Value

| No. | Conditions/Observations | Criteria/Standard | Cause and Effect | Recommendation | Management Response |
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| 1B. | **RVU Payment:** We obtained the annual RVU reconciliations noting that, because current year data was not yet available from the new Electronic Health Records system, one physician was overpaid through monthly RVU payments by a total of $9,000 for the fiscal year. The physician was put on a payment plan to recoup this overpayment. This credit was repaid by the physician through seven quarterly payments due to the County with the final payment occurring in the 1st quarter of fiscal year 2016–2017. | Payment which exceeds the contract maximum due to services not rendered could be considered out of compliance with Stark and AKS. | HCA does not have a policy detailing the process for a recoupment, such as a payment period greater than 90 days. This could result in inconsistencies in applying the regulations to physicians. | Add terms to the contract that allow draws during the year for RVUs and true-up quarterly or annually, as deemed appropriate, in order to ensure the language of the contract is consistent with the actual payment process.<br><br>The RVU reconciliations should be completed quarterly with recoupment of the payment within 60 to 90 days. If the physician requires a lengthier period, there should be a written agreement to support the payment plan. The physician's draw would be reassessed and potentially reduced for future payments to align with the current productivity. | The correct RVU data was not available within the electronic health record system for the fiscal year 2013-2014 and data from fiscal year 2012-2013 was used to determine RVU bonus payments. When the correct data was available the RVU bonus amounts were reconciled and any overpayment was identified and payment plans were implemented. Most physicians who received an overpayment repaid the County immediately with a single payment delivered to HCA within 30 days. For physician utilizing the payment plan, the total amounts were repaid in quarterly payments to coincide with RVU bonus payments.<br><br>Several system changes were implemented during the contract review period performed by Moss Adams to address this issue. VCFMS does not allow for overpayments by compensation type. HCA does agree that a written policy and procedure detailing the process for recouping overpayments within a 90 day period may benefit the County should a similar situation arise in the future. HCA will set a goal to have the new policies and procedures fully implemented by July 1, 2019. |

| No. | Conditions/Observations | Criteria/Standard | Cause and Effect | Recommendation | Management Response |
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| **AREA 2: SUPPORTING DOCUMENTATION.** Physician contracts did not always require supporting documentation for certain compensation types (Observations under 2A), and HCA did not always obtain and review supporting documentation that was required by the physician contracts (Observation 2B). | | | | | |
| 2Ai. | **Contract Requirements for Supporting Documentation:** The contracts for 9 out of the 25 invoices tested did not clearly specify supporting documentation necessary to appropriately pay a physician or group for certain compensation types such as base pay, director fee and trauma fee. | Stark and AKS regulations require a written agreement with the services to be provided.[4] To demonstrate the validity of services rendered, industry standard is to outline the time and effort requirements with a requirement for tracking such information.<br><br>Detailed requirements for support in contracts and/or policy is an internal control to ensure payments are evidenced for the services within the contract prior to payment. | The contract does not specify what documentation is required prior to payment. Therefore, payment can potentially be completed for services that are not in compliance with the contract or regulations. | Contract terms should ideally include an appendix identifying all documentation required in order for the physician to get paid for each payment term in the contract. If the contract does not provide for the supporting document requirements, then management should establish a policy and procedure related to documentation requirements for all types of arrangements. The policy potentially would require sign off by each contracting party prior to contract execution. | Stark and AKS require a written agreement with the service to be provided. There is no requirement in the regulations to specify what documentation is required to support payment.<br><br>While the contracts may not state what supporting documentation is required before payment is made, HCA practice is to obtain written documentation for specific payment types. For example:<br><br>• Payments for on-call are based on the on-call scheduled published by HCA, there is no other documentation the physician could provide to support on-call because the physician may not be called during a particular shift.<br><br>• Payments for clinic times are based on clinic schedules published in the HCA electronic health record system. |

[4] 42 CFR § 411.357(d) and (l), and § 1001.952(d)

| No. | Conditions/Observations | Criteria/Standard | Cause and Effect | Recommendation | Management Response |
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| | | | | | • Payments for RVU bonuses are based on reports supplied by the HCA electronic health record system. These are provided to the physician or they can produce the report themselves.<br><br>The contracts as written, and approved by the County process, do not violate any regulation. Likewise, payments made for services provided as described in the contract would not violate any regulation.<br><br>However, HCA does agree policies and procedures related to documentation requirements for all compensation types would benefit the County. HCA will set a goal to have the new policies and procedures supporting the industry best practices related to documentation requirements for each compensation type fully implemented by July 1, 2019. |

| No. | Conditions/Observations | Criteria/Standard | Cause and Effect | Recommendation | Management Response |
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| 2Aii. | **Support for Base Compensation Payments:** Support is not provided to HCA AP for payment of base pay. | Stark regulations require a written agreement with the services to be provided consistent with FMV compensation.[5] To demonstrate the validity of services rendered, industry standard is to outline the time and effort requirements with a requirement for tracking changes from contract FMV compensation. | There is no stipulation in the contract to provide documentation that the physician is meeting the contract terms. HCA's process is to rely on physician management to notify HCA if the physician is not performing the services required by the contract. Without this supporting documentation, a physician could be paid after termination or without providing the services required by the contract. | Require supporting documentation to substantiate that the physician is meeting the requirements of the contract. A document with the draw schedule and a quarterly true-up should be developed and implemented. The document should have addendums or documentation to support or act as an audit trail when the draw must be reduced or increased due to the reconciliation. | Stark and AKS require a written agreement with the service to be provided; however, there is no requirement to specify what documentation is required to support payment. Therefore, the contracts as written, and approved by the County process, do not violate any regulation.<br><br>HCA physician management, hospital administration, and ambulatory care management provide documentation as to the services provided by each physician and determine if the base compensation requirement is being met. There are several different base compensation requirements. For example:<br><br>• The contract may state "medical services (are to be provided) 365 days per year, 7 days per week and 24 hours per day" |

[5] 42 CFR § 411.354(d)(4)

| No. | Conditions/Observations | Criteria/Standard | Cause and Effect | Recommendation | Management Response |
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| | | Industry practice for tracking changes to base compensation is to prepare monthly reconciliations and document adjustments to the base pay within the accounts payable approval system. Terminations are uploaded monthly to the AP system to ensure payment is not processed. Support is also required prior to payment which would establish an internal control to prevent payment for services not rendered. | | | • "To assure that adequate and appropriate physician coverage, in cooperation with other contracted providers, for all services is available, 24 hours per day, 7 days per week, each day of the year, through a system of primary and secondary call. Such services shall include, but not be limited to:"<br>• "Serving as hospitalist attending physicians who will cover the equivalent of four full-time hospitalist services fifty-two (52) weeks per year."<br>• "Assure adequate and appropriate physician, nurse practitioner, physician assistant and extra-resident coverage for the DEPARTMENT, through a regular call schedule, including CONTRACTOR as well as other needed members of the Medical Staff, such that needs for such professional services are met. Adequate and appropriate coverage means a minimum of fifty-seven (57) hours per day at Ventura County Medical Center, and twenty-seven (27) hours per day at Santa Paula Hospital." |

| No. | Conditions/Observations | Criteria/Standard | Cause and Effect | Recommendation | Management Response |
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| | | | | | • "CONTRACTOR will maintain, report and retain time records, in accordance with the requirements of federal and state laws, as specified by AGENCY. In particular, CONTRACTOR shall report on a quarterly basis the specific hours of service provided to AGENCY for selected two (2) week period during that month."<br><br>However, HCA management does agree supporting documentation to substantiate the physician is meeting the contract requirements is important. HCA will set a goal to have the new policies and procedures supporting the industry best practices for documentation required to support the services delivered fully implemented by July 1, 2019. |

| No. | Conditions/Observations | Criteria/Standard | Cause and Effect | Recommendation | Management Response |
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| 2Aiii. | **Support for Associate Director and Director Fee Payments:** For all seven (7) director fees invoices tested, support was not provided to HCA AP for payment. Within the 7 invoices, there was no support for the 8 director or associate director fee compensation types tested in the sample which totaled $17,500 in aggregate. | Stark regulations require a written agreement with the services to be provided.[6] To demonstrate the validity of services rendered, industry standard is to outline the time and effort requirements with a requirement for tracking such information. Payment for services not rendered could be considered not commercially reasonable and potentially a technical violation of Stark.<br><br>Industry standard is to establish an internal control where support is required prior to payment which would prevent payment for services not rendered. | There is no stipulation in the contract to provide documentation related to the physician meeting the contract terms. HCA's process is that AP will be advised by physician management if a physician is not meeting the terms of the contract. Without specific supporting documentation, a physician could be paid without providing the services required by the contract. | Require supporting documentation to substantiate the physician is meeting contract requirements. In order to comply with the AKS personal services and management contract safe harbor[7], medical director arrangements must be documented and industry standard is to submit time sheets as condition of payment. The timesheet should be authorized by an individual who monitors the medical director's performance. In addition, the timesheet should have detail to provide documentation of activity and how the activity relates to the medical director activity. | As stated above, Stark and AKS require a written agreement with the service to be provided. There is no requirement to specify what documentation is required to support payment. Therefore, the contracts as written, and approved by the County process, do not violate any regulation.<br><br>However, HCA does agree that the County could benefit from implementing industry best practices by requiring documentation supporting medical director payments. HCA will set a goal to have the new policies and procedures supporting the industry best practices for what should be received to support payment for medical directorship activities fully implemented by July 1, 2019. |

[6] 42 CFR § 411.357(d) and (l)

[7] 42 CFR § 1001.952 (d)

| No. | Conditions/Observations | Criteria/Standard | Cause and Effect | Recommendation | Management Response |
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| 2Aiv. | **Support for On-Call Arrangement Payments:** The on-call compensation arrangements were included in the same contract with other types of compensation arrangements. The on-call arrangement payment support has specific requirements which were not always present in the contract. | AKS – On-call coverage arrangements should clearly have mechanisms to ensure documentation is received to support payment for services rendered. In order to comply with the AKS personal services and management contract safe harbor[8], on-call arrangements must be documented and industry standard is to submit time sheets as condition of payment.<br><br>Industry standard is to provide separate agreements for administrative services such as on-call coverage or medical director services. | A lack of supporting documents related to services rendered prior to payment may cause the organization to be out of compliance. | Consider separating the on-call arrangements from other compensation in the same contract. The on-call contract should have specific guidelines that indicate the support required for payment for on-call arrangements.<br><br>Additionally, all supporting documentation required by the contract should be obtained from the physician and retained prior to payment. | Stark and AKS require a written agreement with the service to be provided, but there is no requirement for submitting timesheets. Therefore, the contracts as written, and approved by the County process, do not violate any regulation.<br><br>Payments for on-call are based on the physician being on-call and available immediately by phone for consultation, or to provide services in person when required. HCA publishes a monthly on-call schedule which is used to verify the physician's on-call services. There is no other documentation required from the physician to support on-call services because the physician may not be called during a particular shift. However, HCA is in the process of implementing an on-call system which will allow HCA to better manage the call schedule.<br><br>The new on-call system is planned to be implemented by October 1, 2018. |

[8] 42 CFR § 1001.952 (d)

| No. | Conditions/Observations | Criteria/Standard | Cause and Effect | Recommendation | Management Response |
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| 2B. | **Support for Documentation Fee Payments:** HCA AP did not obtain and/or review support for payment of the documentation fee compensation type. There was no support for the 3 documentation fee compensation types tested in the sample which totaled $5,250 in aggregate. The contract has certain requirements that need to be met in order for the physician to receive these payments. Such areas include support for review of medical charts and the related "documentation fee". | Requirements for support are included in the contract. In order to be in accordance with the executed contract, this support should be obtained in order for the payment to be made. | HCA process is to rely on physician management to notify HCA if the documentation fee requirements are not met. Without this documentation, a physician could be paid without providing the services required by the contract. | Require any incentive with a documentation requirement to have the required supporting documentation retained on a monthly or quarterly basis, whichever is more appropriate, by AP and be properly reviewed by the appropriate personnel in HCA.<br><br>In addition, such documentation should have appropriate approval by individuals who can accurately acknowledge the activity or work. For example, the medical director for a specialty has knowledge of the physician's activity. | Several system changes were implemented during the contract review period performed by Moss Adams to address this issue. In the past, HCA had a manual process to review physician's documentation (charts) to support this specific compensation type. Beginning in July 2013 with the implementation of the HCA electronic health record system, this is now an automated process. If a physician does not provide documentation in the system, the physician's privileges will be suspended until documentation is provided. The suspension list is published within HCA each Thursday by noon. To our knowledge, no contracted physician has had privileges suspended due to lack of documentation. This item has been addressed. However, HCA will set a goal to have the current policies and procedures supporting documentation verification fully implemented by July 1, 2019. |

| No. | Conditions/Observations | Criteria/Standard | Cause and Effect | Recommendation | Management Response |
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| **AREA 3: CONTRACT MANAGEMENT.** HCA overpaid certain compensation types, likely due to manual processes that may have been avoided by using contract management software. | | | | | |
| 3. | **Central Contract Management System:** HCA manually manages the physician contracts within Microsoft (MS) Excel and a network folder, and does not use a contract management software system. | Industry standard is to use a contract management software system for physician contracts. | Not having a central contract management software system with functionality to locate supporting documents for contracts creates risk during payment or external agency audits as noted in Observations 3A and 3B below. | Develop or procure a contract management software system. The system should function as a contract repository and should have a functionality that enables HCA to proactively monitor contract expirations to limit the exposure of operating under expired agreements. In addition, the system should allow HCA to store supporting documents such as legal approval, FMV, exclusion checks, extensions, holdovers, late signature approvals and other support. | In 2016 HCA began working with County IT to identify the requirements for a contract management system. It was discovered in late 2017, the most economical and timely option for HCA to obtain a contract management software system was for HCA to assume the license from another County Agency for the Contract Assistant Enterprise Edition. However, in 2018 GSA began to implement a new contract management system, which HCA will be able to use for managing all contracts. HCA will set a goal to have the physician contracts loaded into the contract management system by July 1, 2019. |

| No. | Conditions/Observations | Criteria/Standard | Cause and Effect | Recommendation | Management Response |
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| 3A. | **Contract Maximums:** For one (1) sample item of the 75 compensation types tested, payment to the physician group exceeded the maximum allowed for the year for the respective category, Hospital Rapid Care, by $4,615; however, there are robust detective controls in place and this overpayment was identified and recouped in the following fiscal year. Maximums at the whole contract level were not exceeded for any of the contracts tested. | Stark requires each arrangement to be set out in writing, be signed by the parties, and specify the services covered by the arrangement.[9] The aggregate dollar amount of the services covered by the arrangement should not exceed those that are reasonable or necessary (FMV).[10] A payment in excess of the maximum allowed may be at risk of exceeding FMV if amounts are not recouped in a reasonable amount of time. | The maximum amount varies by type of contract and is tracked by HCA in MS Excel. Manual processes such as tracking contract maximums in MS Excel could lead to erroneous payments. | Implement an automated process of tracking payments made to physicians to ensure that payments do not exceed the maximum allowed. The process should occur prior to each payment, be documented within the accounts payable files, and be a function of the central contract management system.<br><br>Regular monitoring of the payments to contracts should occur. The monitoring should be documented and variances should have corrective action plans developed. | As stated in the observation "there are robust detective controls in place" and "maximums at the whole contract level were not exceeded for any of the contracts tested" demonstrates that the physician payment process does work. The robust controls were further improved with the implementation of VCFMS, which now required payment controls at the compensation type.<br><br>The one incident, of the 75 compensation types tested, was related to the Hospital Rapid Care payment overage of $4,615 was related to the unforeseen expenses as a result of the February 24, 2015 Oxnard train accident where 30 people were injured. |

[9] 42 CFR § 411.357(d)(1)(i)

[10] 42 CFR § 411.357(d)(1)(v)

| No. | Conditions/Observations | Criteria/Standard | Cause and Effect | Recommendation | Management Response |
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| 3B. | **RVU True-Up:** During fiscal year 2013–2014 and fiscal year 2014–2015, due to the transition to the new Electronic Health Records system in July 2013, the fiscal year 2012–2013 data was used to calculate the RVU payments throughout the year and then reconciled when the information became available. We noted one (1) instance out of six (6) RVU true-ups tested in which the contract maximum was not considered when using the old data which resulted in an overpayment to the physician. The RVU payments were properly and timely reconciled when the actual data was available. This overpayment was recouped timely after the reconciliation was completed. | Best practice is to complete reconciliations quarterly in order to ensure compensation is estimated accurately. | Contract maximums and payments made throughout the year are tracked manually in MS Excel. Due to this manual process, payments over the contract limits can still be made to the physician if not identified through the manual process. | The contract maximum should have been followed to minimize the amounts of overpayments to physicians. Implement an automated process of tracking physician payments to minimize the risk that payments exceed the maximum allowed. | As stated in finding #1B, in the one contract identified as an issue, the payment was recouped and the County received the full repayment from the physician. VCFMS has eliminated the need to manually validate compensation type amounts. |

| No. | Conditions/Observations | Criteria/Standard | Cause and Effect | Recommendation | Management Response |
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| **AREA 4: INFORMAL HCA PRACTICES.** Certain informal HCA payment practices put HCA at risk of noncompliance with regulations. | | | | | |
| 4A. | **Reconciliation of Payments:** Physicians were generally reimbursed per month at the maximum level allowed by the contract even if payment terms did not specifically address this. The payment was appropriately reconciled at year-end. | Payment which exceeds the contract maximum due to services not rendered could be considered out of compliance with Stark and AKS. | The contract or HCA's informal policy allows for the maximum to be paid on a monthly basis and a year-end reconciliation. This could result in overpayments to physicians which could be difficult to recoup and appear to be out of compliance. | Pay physicians at maximum levels only when specified in the contract and productivity estimated is consistent. Additionally, paying only a percentage of the maximum prior to reconciliation should be considered. This approach would minimize overpayments to physicians that may be difficult to recover. | There was no finding identified where a physician was overpaid because the contract maximum level was paid on a monthly prorated basis. It is true that if payments were made in excess of the contract due to services not being rendered it could be considered out of compliance with Stark and AKS; however, none were identified in this audit.<br><br>Furthermore, VCFMS does not allow for overpayments for either a compensation type, or the contract total. Payments to the physicians at less than the contracted amount throughout the year and pay the balance at the end of the year would put an undue burden on the physicians and not have a significant benefit to the County. HCA will implement a policy to always pay at the maximum contract amount throughout the year, and then reconcile productivity regularly to prevent overpayments. |

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| 4B. | **Invoice Processing:** Per discussion with HCA personnel, blank monthly invoices are pre-signed by the physicians at the beginning of the fiscal year. When it is time to pay the physician each month, the signed invoices are completed by HCA AP with the month's compensation amounts. | Industry standard is to require submission of supporting documents within 90 days from the end of the month. No payment would be processed until the support is received. If the support is received later than 90 days, the physician must obtain approval for the late timesheet. Best practice is to allow a late time sheet only one time per year. | HCA has implemented this process due to the timing of the payments to the physicians after month-end. This process does not allow the physicians to review and approve the invoice prior to processing. | Implement a process for physicians to review and sign the invoices on a monthly basis after the services have been provided by the physician and the invoice has been completed by HCA AP. In order to implement this recommendation, management should consider a hybrid system until an on-line approval system can be implemented.<br><br>Invoices and support should be processed within 60 to 90 days of the service performed. Consider a policy requiring submission within 90 days. For those timesheets received later than 90 days, the approval should be escalated to the HCA Compliance Officer or legal. | Several system changes were implemented during the contract review period performed by Moss Adams to address this issue. Beginning with fiscal year 2015-2016 VCFMS allowed for electronic funds transfer (EFT) to County vendors. On October 16, 2015, HCA developed and distributed instructions to physicians on how to register for EFT payments. These payments began in January 2016. The EFT process allowed for immediate deposit of payments made to physicians for their services.<br><br>After the implementation of EFT, physicians were required to submit monthly invoices for their services, HCA no longer used the pre-sign invoices. Instructions were provided to the physicians on how, where, and when to submit the invoice and supporting documentation. This process has been fully implemented with each physician submitting monthly invoices for the services provided. |

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| | | | | In addition, consider an alternative to having a monthly invoice for the base payment. An alternative would be to process without an invoice with a confirmation from HCA that all physicians are eligible. Quarterly the RVU reconciliation would be provided to support the base pay. | |

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| **AREA 5: OTHER OPPORTUNITIES TO IMPLEMENT BEST PRACTICES.** We noted other opportunities for HCA to implement certain best practices. | | | | | |
| 5A. | **Contract Signatures:** For 35 contracts tested, one contract was not fully signed prior to the first payment to the physician, and 6 were not consistently dated by both parties. | Both Stark and AKS regulations require a signature by the parties on each contract.[11] Best practice is to sign and date the contracts prior to initiation of services. The signature and date represent the date of execution.<br><br>The failure to sign an independent contractor agreement prior to the effective date could create Stark and AKS problems. Stark contains a limited exception for a signature defect. Starting in 2016, Stark regulations allow an arrangement if a signature defect is cured within 90 days. The grace period is limited to once per physician every three years.[12] | Most contracts are renewed July 1st which results in a backlog of contracts to be signed. With a delay in contract signing, a physician may be paid under the contract without the contract being fully executed. | Although regulations allow for holdover periods and legal approval for late signature, there should be an audit trail to demonstrate the approval of the late signature. We recommend that all contracts be signed timely and prior to the first payment to the physician.<br><br>Establish a work flow to begin contract renewals a minimum of six months prior to renewal. Consider establishing staggered renewal dates. | There is no legal requirement in either Stark or AKS for a date to accompany a signature on a contract. And, in the one case where the physician did not sign the contract, the physician and the GSA buyer each signed a separate signature page of the contract.<br><br>Contracts over one hundred thousand dollars annually require Board of Supervisors approval. When a contract amendment is being presented to the Board of Supervisors every effort is made to have them approved before the amendment effective date, however, this is not always feasible. For example, the December 5, 2017 Board of Supervisors meeting was cancelled, delaying items from being approved and pushing all items on the agenda, some into January 2018. In other cases, the negotiations are finalized before the contract effective date, but not in time to be presented on the Board of Supervisors agenda. |

[11] 42 CFR § 411.357(d) and (l), and § 1001.952(d)

[12] 42 CFR § 411.353(g)

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| | | | | | In these cases, the amendment effective may begin before Board of Supervisors approval, but signatures are not obtained until after approval. This would create the situation where the signatures were not obtained prior to the contract amendment effective date. However, in these cases, the physician is paid according to the current contract, not the new amendment, until it is approved by the Board of Supervisors and fully executed. When a new contract is presented to the Board of Supervisors for approval, every effort is made to delay the effective date until after approval, so no physician is providing services who is not under contract with the County. However, services may begin before all signatures are obtained.<br><br>To streamline the process of obtaining signatures and executing contracts, HCA management recommends the County adopt the practice of signing contracts using an electronic signature software. Currently HCA is using DocuSign for internal documents. DocuSign reduces delays by getting signatures in minutes, not days. |

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| | | | | | It has the capability to execute contracts faster and ensure compliance with internal policies, signing levels and authority, and document retention. Furthermore, DocuSign ensures Sarbanes–Oxley Act of 2002 (SOX) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulatory compliance by storing signed documents and completed audit trail information secure and tamperproof, with retention policies set by the County. This system is affordable, industry accepted, and will assist HCA, and the County to be more efficient with its procurement practice. HCA management will request approval from the CEO, County Counsel, GSA, and ACO to use an electronic signature software for contracts and other documents requiring signatures. If approved, HCA will set a goal to begin using electronic signature software for all contracts by July 1, 2019. |

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| 5B. | **Audit and Monitoring of Physician Payments:** HCA does not complete regular audits or monitoring of physician arrangements. HCA does not have a consistent methodology to identify the universe of all payments made to physicians/physician groups. | Industry standard is to audit and monitor physician payments and to identify a mechanism to code physician payments to alert accounts payable and the approval work flow where additional scrutiny is required. | Without an audit or monitoring process, HCA is unable to ascertain whether the internal controls are operating effectively. HCA did not use a vendor identifier in VCFMS that is specific to physicians and physician groups. Payments could be made to physicians without contracts or adequate review. | Establish and perform a regular auditing and monitoring process of the physician contracts. At least quarterly, select samples based on a reasonable sampling methodology. Test procedures should be clearly delineated, and the related results should include comments on findings and recommendations for exceptions. Implement an identifier to mark "physician only" payments within the accounting system to aid with isolating and tracking physician related payments. The addition of the coding for physician only payments will allow an approval process to track risk areas such as maximums and request requirements such as a timesheet or on-call monthly document. | Several system changes were implemented during the contract review period performed by Moss Adams to address this issue. VCFMS requires payments to be setup by payment type for each contract. The controls within VCFMS do not allow ACO to process payment if no contract has been implemented or if the payment type requested does not match the data in VCFMS. The finding "Audit and Monitoring of Physician Payments" have been addressed with VCFMS beginning in 2015 and moving forward. HCA will document the policy and procedures for processing physician payments. HCA will conduct periodic audits to ensure the steps are being done according to the policy. |