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THE COMPLIANCE GUIDE TO PHYSICIAN RELATIONSHIPS & COMPENSATION VALUATION

This Chapter . . .

Medical Directorship, Consulting and Administrative Services

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This Chapter:

Medical Directorship, Consulting and Administrative Services

The goal of this chapter is to provide our readers with a practical real-world guide to physician positions for administrative services, including medical directorships and consulting arrangements. We have included the following:

- **A conceptual overview** regarding the background for administrative arrangements in the healthcare industry;
- **An arrangement overview** detailing common themes in administrative arrangements;
- **A regulatory overview** outlining key compliance matters and concepts when considering administrative arrangements; and,
- **A step-by-step “best practices” guide** to developing, executing, and maintaining healthcare administrative positions.

I. Conceptual Overview

As the healthcare industry continues to evolve following the passage of the Patient Protection and Affordable Care Act (PPACA), an increased focus persists surrounding quality and efficiency in providing patient care. Thus – although physicians have served in administrative roles for many decades – it is worth revisiting the topic to review current pertinent factors related to these arrangements and associated compliance considerations.

Traditionally, physician administrative services have been provided as part of arrangements known as medical directorships. Typically, a medical director is a physician who provides oversight, guidance, management, planning, compliance support, and training related to a particular service area and/or service line. Given that the nature of the position is a leadership role, medical directors are generally physicians with a great deal of experience and/or expertise within a certain subject matter. In addition, in a post-PPACA world, rising scrutiny on protocols, procedures, and outcomes have placed arguably more importance on the planning and leadership aspects of physician services. Particularly, as said duties affect medical oversight, models of care, and quality metrics, some argue that these positions are more important now than ever.

II. Arrangement Overview

Medical directors are typically employed by hospitals for which they serve in an administrative capacity; however, such arrangements are also achieved through professional service agreements (PSAs). In the instance of employed medical directors, these positions are generally only a portion of a physician's total services provided. While the medical directors serve as leaders within the medical staff and often act as liaisons with hospital administrators and/or board, these providers generally continue to provide clinical patient care services as well. The proportion of this work is discussed in more detail with practical compliance tips later in this chapter.

Physicians can provide medical director services in numerous contexts and settings, including but not limited to:

- Hospitals;
- Post-acute care facilities;
- Centers of excellence;
- Pharmaceutical companies;
- Home health agencies;
- Dialysis centers; and,
- Long-term care companies;
- Large physician practices;
- Skilled nursing facilities.

While these types of administrative positions are most commonly referred to as “medical directorships”, similar services are also provided in the context of physician executive positions and roles for “key opinion leaders” and/or – depending on the duties of the position and experience of the subject physician as “thought leader” arrangements (e.g., at a center of excellence). Particularly as an increased focus on quality and efficiency continues, the role of physicians in nonclinical settings and services becomes arguably more important but also more complex.

III. Regulatory Overview

As is discussed in more detail in other chapter(s) within this Guide, the healthcare industry is one characterized by numerous regulations on both federal and state levels. Because of this fact, operating within the healthcare industry and navigating financial transactions involves a very complex environment and many considerations. Such considerations are particularly relevant to administrative positions held by physicians, not only given regulatory requirements, but also due to focus by the government on ensuring such arrangements are necessary, not duplicative, and advance defined objectives. Like most other physician services arrangements, the standards of fair market value and commercial reasonableness as defined by the Stark Law and the Anti-Kickback Statute (and similar provisions in the Internal Revenue Service rules) are key considerations. However, given increased governmental scrutiny on these types of arrangements – particularly surrounding the requirement that such positions are commercially reasonable – additional considerations can be clearly defined by reviewing arguments made by government experts in litigation surrounding medical director positions.

For instance, while one such litigation matter related to medical director arrangements reached a settlement, the arguments put forth by the government’s expert provides a certain amount of guidance regarding key factors that may indicate an arrangement is not in compliance with healthcare regulations.¹

Chief among the government’s arguments were that:

- The medical directors were paid for duties that were required under the medical staff bylaws;
- Numerous medical director positions were not necessary given the hospital’s low patient census;
- Coordinated protocols across hospital campuses were merited to reduce waste but were absent; and,
- Adequate oversight of the medical director positions was not provided.

¹Refer to *United States of America ex. rel., Darryl L. Kaczmarczyk, et al, v. SCCI Hospital Ventures, Inc. d/b/a SCCI Hospital Houston Central*, U.S. District Court, Southern District of Texas, Houston, Division No. H-99-1031, July 14, 2004.

In addition to guidance gleaned from governmental arguments in litigation, the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) released a Fraud Alert which offered some additional direction related to medical director positions.² That Fraud Alert focused on compensation paid to numerous physicians as part of medical director arrangements. The OIG reiterated that such arrangements must not only be paid at fair market value rates, but also must require legitimate services to be provided in return for such compensation. The Fraud Alert went on to highlight the fact that such arrangements should make sense in the absence of referrals and that the services which were contracted for must actually be provided. While medical director positions are required by law for some services and programs, recent focus on administrative positions by the government makes clear that even when there is a required and/or legitimate need for such services, such arrangements must be very carefully structured to ensure regulatory compliance.

In the next sections, we outline these factors as well as certain best practices for developing a medical director arrangement, the process for choosing an individual to provide said services, and additional regulatory and compliance considerations associated with such positions.

IV. Step-by-Step Best Practice Guide

Based on the matters outlined in the foregoing sections associated with (i) the concept of physician administrative positions, (ii) arrangement matters typical to these positions, and (iii) regulatory factors related to medical directorships, we have developed a “best practices” guide for planning, initiating, managing, and evaluating these arrangements. This “best practices” guide consists of five steps as follows:

- Step One: Developing the Position
- Step Two: Developing the Application
- Step Three: The Interview Process
- Step Four: Determining Agreement Terms
- Step Five: Agreement Execution and Beyond

This type of five-step process not only results in necessary due diligence and more effective position planning, but also helps to mitigate compliance risk. In the past, many hospitals and health systems did not use a uniform and pre-defined process related to their medical director positions which may have resulted in arrangements that lack arms-length negotiation. The goal of this section is to outline a process that we consider a “best practice” in establishing a medical directorship, appointing a medical director, and managing the arrangement.

Step One: Developing the Position

Physicians, particularly those with notable experience and who are well respected, are sometimes asked to serve in an administrative or consulting capacity as a medical director. Some such medical director positions are required by law as condition for a provider to offer a particular service to patients. Other medical directorships are developed to achieve pre-defined objectives. These objectives may relate to a certain program, service line, department, or patient population and may include examples such as improved efficiencies, planning, leadership, program development, oversight, or management.

²Refer to https://www.oig.hhs.gov/compliance/alerts/guidance/Fraud_Alert_Physician_Compensation_06092015.pdf.



Compliance Tip: A medical directorship should never be developed to capture the referrals of the director or the director's practice or to simply boost physician compensation.

Given the shift toward quality and efficiency across the healthcare industry, and in light of the numerous regulations governing such arrangements, hospitals and other entities engaging physicians to provide administrative services must begin the process by developing a list of duties and responsibilities that will define the objectives and function for a medical director position.

Example duties and responsibilities for many administrative arrangements include descriptions such as the following:

- Manage clinical peer review;
- Provide guidance and oversee the purchase and/or maintenance of clinical equipment or supplies;
- Oversee the quality and appropriateness of medical care;
- Serve as a liaison between the medical staff and hospital administration;
- Manage physician behavioral issues;
- Direct the activities provided by other physicians, including recruiting and credentialing;
- Conduct and/or attend meetings with the medical staff as well as hospital leadership, board of directors, etc.;
- Oversee utilization review, quality performance, protocol development and monitoring, staffing matters, and cost management;
- Manage the day-to-day activities of a group of physicians and/or a coverage rotation;
- Oversee, develop and/or manage a budget related to a particular service line or group of physicians;
- Provide support and/or manage patient satisfaction as well as community relations;
- Oversee documentation and care protocol development and tracking;
- Develop policies and procedures, including performance guidelines and clinical expectations;
- Direct strategic activities and coordinate with hospital leadership;
- Manage physician education and training activities;
- Provide community outreach;
- Offer compliance support;
- Address provider supply and demand matters; and,
- Direct any emergent clinical, provider, or service line issues.

As the healthcare industry continues to evolve and change, certain duties and responsibilities may emerge as more important while others decrease or are eliminated completely. However, given current trends in the industry, it is likely that certain responsibilities will remain on the rise, including:

- Quality of care;
- Cost containment;
- Strategic initiatives;
- Physician training and development;
- Development of performance guidelines; and,
- Peer review management.

As a result, coordination of care and other similar medico-administrative services will likely continue and/or increase to achieve these objectives. At those times when a hospital develops a new service line or otherwise recognizes the need for a medical director, hospital leadership should document the need for the medical director position. Moreover, clear delineation of duties will help in setting and communicating expectations with physicians. The following form serves as a useful example of the type of documentation that should take place on the front end of creating a medical director position.

MEDICAL DIRECTOR PLANNING WORKSHEET			
Department:			
Reporting Director:			
Proposed Hours per Month:			
Number of Physicians Participating in Program:			
	Yes	No	Reasoning
Is the directorship required by law?			State law:
Is there another medical director that can perform the services and/or does the position unnecessarily duplicate another existing position?			If yes, why are the services not combined and/or why are "additional" services needed?

Compliance Tip: The planning phase of a medical director position is critical for ensuring compliance with the "commercial reasonableness" requirement under the Stark Law and the Anti-Kickback Statute.

Key considerations related to commercial reasonableness at this phase³ of the medical director position include the following:

- Whether the arrangement is necessary in addition to the resources already available to the hospital (e.g., other physicians providing services at the hospital, duties required of the medical staff, and protocols at affiliated facilities);
- Whether the arrangement has a defined and specific purpose;
- Whether the arrangement will further the goals of the hospital (e.g., business, clinical, or community); and,
- Whether the arrangement has a particular objective (e.g., profit contribution or services development).

These types of factors are aimed to ultimately ensure the necessity of the position, particularly as it relates to legitimate business and/or community objectives. By appropriately planning for the position and evaluating these matters on the front end, hospitals and health systems set out with an advantage in mitigating compliance risk.

³It is important to note that while these considerations are particularly relevant to the planning phase, they should also be continuously monitored and assessed throughout the term of an arrangement.



Step Two: Developing the Application

Following the development and planning for the medical directorship in Step One, organizations should next turn to paying particular attention to developing the application for said position.

Compliance Tip: There are at least two critical factors in developing the application: (i) the services required (refer to Step One) and (ii) the required qualifications to perform the services.

As previously outlined, while medical director positions have existed in the healthcare industry for many years, they have recently come under governmental scrutiny in matters related to compliance, including fair market value, commercial reasonableness, necessity, and other matters. Therefore, the planning side of the position is critically important – including both the position and the application.

In general, the person best qualified to provide medical director services will be the physician that is the most respected on the medical staff for a particular specialty or service line. A physician that is most respected by his or her peers will also, generally, have a very large patient base that could be referred to the hospital. To help negate the appearance of any impropriety, the medical director position should be advertised and the physicians qualified for the position should apply as appropriate.

The following is a sample application for reference purposes:

Medical Director Application	
Name:	
Department:	
Program:	
Specific Qualifications:	
Available Hours per Month to Provide Services:	
*CV Attached	

While the above application provides a general template for consideration, additional detail should be paid to certain key factors.⁴

⁴As mentioned at the outset of this section, at least two critical matters should remain at the forefront in planning, managing, and reviewing medical director positions: (i) the services required and (ii) the required qualifications to perform the services. The former, the services required, are predominantly considered in Step One related to developing the position. The latter, the required qualifications, should be a key focus area in Step Two associated with developing the application.



Because of the nature of certain duties (e.g., equipment selection, physician communications, service line management), it is often required – and appropriate – to have a sub-specialty physician provide the services. For instance, a hospital renowned for cardiac surgery would likely require a specialized cardiac physician to manage the service line and its physicians. In that instance, a family practice physician would likely not have the expertise or experience to provide these services.

Compliance Tip: With regard to these types of specialized positions, all relevant facts should be documented including specific duties, outcome metrics, and expertise (i.e., specialty or sub-specialty) required.

Certain specialties commonly require medical director duties, particularly at high-volume or high-acuity facilities, or at facilities with center(s) of excellence. For example, the following specialties often involve administrative services:

- Obstetrics;
- Orthopedic surgery;
- Trauma surgery;
- Neurosciences; and,
- Cardiac services (including open heart).

While this list is not exhaustive, it aims to provide a reference point for those positions that may indeed require a more specialized provider. If, however, the duties can be performed by a physician within a less expensive specialty (or a non-physician in the case of certain clerical and administrative duties), a lesser amount should be paid in order to comply with regulatory requirements.⁵

For instance, certain duties as previously described likely require the expertise of a specialist, including:

- Equipment selection and management;
- Physician mentoring and communications; and,
- Quality improvement, efficiency initiatives, and peer review.

However, certain responsibilities may be able to be performed by a non-specialty physician – or in some instances – even a mid-level provider, including:

- Coverage schedules;
- Operational matters;
- Clerical duties; and,
- Administrative reporting duties.

⁵As discussed in more detail later in this chapter (and other chapters within this Guide), the required specialty of the physician can influence the fair market value of compensation for services provided.



In those instances – in which the duties can be performed by a physician within a less expensive specialty (such as neurosurgery as compared with family practice or a mid-level provider) – a lesser amount should be paid in order to comply with regulatory requirements. These instances can occur within any market but most often arise in those positions in which a primary care provider is all that is actually required to perform the services. Many times, a sub-specialty physician is contracted to provide the services. In these instances, despite the provider engaged, the rate paid should reflect those of the actual requirement (e.g., internal medicine).

Compliance Tip: The application development continues to fall within the “planning phase” of a medical director position. Therefore, several prerequisite questions remain to ensure commercial reasonableness is adequately considered.

At this phase of the position development, these prerequisite matters include the following:

- Whether a less expensive level of services would be appropriate (i.e., non-physician provider or non-specialty physician);
- Whether the amount of time required under a particular arrangement has been considered, particularly in combination with other duties required of the physician;
- Whether the size of the hospital and its patient population is commensurate with the proposed services; and,
- Whether the need for and specific purposes of the arrangement are documented.

These types of considerations collectively aim to ensure that the arrangement is not duplicative, that it is appropriate in terms of provider, facility, and community, and that key factors are thoroughly considered, assessed, and documented.

Step Three: The Interview Process

The decision on which applicant has the best credentials to provide the necessary services under the medical directorship should be made by the key stakeholders in the program. While some of these stakeholders will have an interest in the volume of referrals (e.g., bonuses based on the profit of the program or hospital), ensuring individuals that do not have such an interest are included in the decision is critical to remove any perception of impropriety. These employees may include staff nurses or independent physicians on the medical staff with an interest in the program.

Compliance Tip: The interview and selection process should (i) be comprehensively documented and (ii) include individuals that do not have an interest in the profit of the program or hospital.

By ensuring that both the interview and selection process includes individuals of sufficient independence, any perceived or actual misconduct will be minimized and therefore a certain amount of compliance risk will be mitigated. Clearly, the interview process as well as candidate selection should reflect both the services and skill set required as part of the position and application planning processes.

A factor that may not be as clear is the pool of individuals to consider for the position. For instance, many hospitals contend with ambiguity and uncertainty around whether such services should be provided by employed or independent contractor providers. Employed and independent contractor providers can both provide medico-administrative services and, in fact, benchmark respondents (from industry resources providing compensation benchmarks) for such services comprise both populations serving in these roles. Regardless of whether the candidate is employed or independent, the important matters to consider remain similar. Most notably are those factors which have been previously outlined related to specialty required, ability to provide services, and necessity.



Step Four: Determining Agreement Terms

Medical director agreements entail several terms that must be carefully considered to ensure compliance with regulatory requirements, including the standards of commercial reasonableness and fair market value. These agreement components include:

- Length of the agreement;
- Required number of hours;
- Services provided; and,
- Compensation.

Length of the Agreement

Like most physician services arrangements (as further discussed in other chapters within this Guide), medical director agreements are required to remain effective for a minimum of one year. With regard to the overall arrangement, the term of a medical director agreement may vary up to three years with automatic one-year renewals and remain commercially reasonable. However, this statement is quite broad and assumes many factors, including those previously outlined in this chapter (e.g., necessity, actual performance, oversight, etc.).

Compliance Tip: Regardless of the length of the agreement, hospitals should regularly review both the need for the medical director services and also how well the medical director is performing against time and service objectives.

Required Number of Hours

Prudent medical director agreements will include a maximum number of hours (or a capped annual compensation amount based on projected time). For flat rate medical director agreements, which are rarer than hourly agreements, the medical director agreement will include a minimum number of hours.

Compliance Tip: A minimum number of hours creates additional compliance risks as physicians must now achieve a certain amount of time to report (i.e., rather than achieved objectives).

The required number of hours may vary based on the following factors:

- Number of departments covered by the agreement (e.g., a system with multiple campuses might have a single medical director for the non-invasive cardiology department at multiple campuses);
- Number of services provided within the department (e.g., a cardiology department might include invasive and interventional in one hospital while each service line might have its own medical director in another hospital);
- Revenue of the department; and,
- Number of physicians on the medical staff that perform services in the department.

Based on these types of factors, the required number of hours for medical director services will vary in relation to the duties and expectations. However, it is common to observe that time requirements generally do not exceed 20 hours per month per department. This number of hours equates to approximately five hours per week. Should a medical director position demand an inordinate (i.e., in comparison to the “standard” number of hours) amount of time, a hospital must consider further implications related to both fair market value and commercial reasonableness. Valuing these types of arrangements – which include clinical and administrative (and potentially additional) components – often require the expertise of a third-party valuator given the complexities with evaluating aggregate annual (i.e., stacked) compensation, particularly in the case of employed physicians. For instance, should a medical director agreement require 50 hours of services per month, this time will most likely have a material impact on the physician’s clinical production.⁶ Further, the initial hour projection may need to be reduced over time as the physician will likely gain efficiencies when multiple departments are covered (e.g., a medical director can represent the multiple departments in a single quality assurance meeting). Such factors should be carefully considered to ensure not only regulatory compliance but also to maintain objective achievement.

Services Provided

Fundamentally, a medical director denotes a critical team member who coordinates between the health system/hospital, physicians, and other clinical staff. These physician leaders who are engaged to provide medical director services work to develop and confirm adherence with policies, protocols, and procedures that are required to operate a hospital program efficiently and at the highest level of quality. In addition, the medical director must also help manage the work environment with an interest in the professional wellbeing of the physicians on the medical staff and other employees within the department.

Although these duties and responsibilities take many forms and involve varying objectives (as listed and discussed previously in this chapter), medical director services are generally broken down into the following broad categories:

- Policy, protocols, and procedures;
- Quality improvement and assurance;
- Peer review; and,
- Research, publishing, and teaching.

Compliance Tip: A hospital can split the duties over multiple medical directors but should not hire multiple medical directors to provide the same services.

DOJ SETTLEMENT:

United States ex rel. Beaujon v. Hebrew Homes Health Network, Inc., et al., Case No. 12-20951 CIV (S.D. Fla.)

Hebrew Homes Health Network, Inc. settled with the Department of Justice on June 16, 2015. Hebrew Homes paid \$17 million to settle all claims.

The United States alleged that Hebrew Homes’ medical director agreements were for ghost positions, and that most of the medical directors were required to perform few, if any, of their contracted job duties. Instead, they were allegedly paid for their patient referrals to the Hebrew Homes facilities, which increased exponentially once the medical directors were put on the payroll.⁷

⁶Also refer to commercial reasonableness considerations related to the time required under the agreement as previously cited in this chapter.

⁷Refer to <https://www.justice.gov/opa/pr/florida-skilled-nursing-facility-agrees-pay-17-million-resolve-false-claims-act-allegations>.

Services performed in connection with medical directorship positions are generally paid on an hourly basis. Most compliance professionals require that the physician serving as a medical director (i.e., or other consulting/administrative position) document the actual services performed. On a rare occasion, the hospital may have a standard form in which the physician affirms compliance without documenting specific times and duties performed at those specific times.

Compliance Tip: If time sheets are provided, the duties listed should be reviewed prior to any compensation paid. Additionally, time sheets alone (without review and oversight) are not sufficient to ensure an arrangement is commercially reasonable.

DOJ SETTLEMENT:

U.S. V. Campbell, 2011 WL 43013, No. 08-1951 (D. N.J., Jan. 4, 2011)

The University of Medicine and Dentistry of New Jersey (UMDNJ) paid \$8.3 million to the federal government. Under the facts of the case, UMDNJ entered into employment agreements with cardiologists to serve as part time Clinical Assistant Professors. The cardiologists received fixed compensation for the provision of certain services. After a five-month investigation, the federal monitor determined that the cardiologists did not provide these services but did receive compensation. Accordingly, the agreement was deemed an illegal scheme to pay the cardiologists for their referrals. The Department of Justice later filed a case against the cardiologists.⁸

Compensation

As discussed in the previous sections of this chapter, several material factors affect the fair market value compensation for medical director services provided, including (i) the required specialty, (ii) the number of hours (i.e., time commitment required), and (iii) enumerated duties.⁹

With regard to benchmarking resources, limited published data is available for administrative compensation paid to physicians. However, several key observations associated with compensation for medical directorships include the following:

- Such positions are a blend of independent contractor and employed arrangements;
- The most common compensation methodology for these position is a pre-defined hourly rate; and,
- Pre-defined hours associated with duties and outcomes becomes critical (which not only affects fair market value but also commercial reasonableness).

For illustration purposes, we provide a typical example of reported data for consideration related to orthopedic surgery as most hospitals have some type of orthopedic surgery medical directorship. A total of 62 respondents from two surveys presenting data on medical directorships is less than 1% of the total orthopedic directorships in the country. In fact, some hospitals will have multiple orthopedic surgeons performing director services because the hospitals have multiple orthopedic programs such as:

- | | |
|-------------------------------------|--|
| • Hand and upper extremity program; | • Hip preservation program; |
| • Sports medicine program; | • Orthopedic trauma program; and, |
| • Joint replacement program; | • Sports medicine and concussion clinic. |

⁸U.S. v. Campbell, 2011 WL 43013, No. 08-1951 (D. N.J., Jan. 4, 2011).

⁹In some unique and specific circumstances, other additional factors may impact fair market value compensation (e.g., challenges in recruiting physicians to facilities in rural locations, provider supply and demand, and market competition and limitations).

Specialty	Number of Providers	25th Percentile	Median	75th Percentile	90th Percentile
Orthopedic Surgery	62	\$197	\$245	\$308	\$350

Considering the limited amount of public data related to directorships and administrative services, most valuers will supplement this data. One such method entails researching compensation paid to orthopedic surgery leaders at not-for-profit hospitals. This data may be included in IRS Form 990 disclosures if the leader is one of the top compensated employees of the organization.

Provider Type		Annual Compensation
Academic Research Institute - Midwest Region	An academic center employs two orthopedic surgeons as Chairman of the Department of Orthopedic Surgery and Associate Professor, Orthopedic Surgery for an average of \$1,159,135.	\$1,159,535
Academic Research Institute - South Region	An academic research institute employs an orthopedic surgeon as Department Chairman, Department of Orthopedic Surgery in the South region.	\$1,039,370
Orthopedic Hospital - East Region	An orthopedic surgeon serves as Medical Director and Chairman of the Department of Orthopedic Surgery at an orthopedic hospital in the East region.	\$1,990,132

Because this information is reported on an annual basis, an additional step is required to convert said annual compensation to an hourly rate. With regard to this calculation, we note that the Centers for Medicare & Medicaid Services (CMS) adopted a “safe harbor” in the Stark II, Phase II regulations that is associated with annual hours. Specifically, the safe harbor involved dividing the average of the median data results as reported by four benchmark surveys by 2,000 hours.

Compliance Tip: While CMS later removed the safe harbor, it does provide guidance for converting annual compensation to hourly rates (i.e., by dividing annual compensation by 2,000 annual hours as previously endorsed by the federal government).

Collectively, the primary factors associated with agreement terms – (i) length of agreement, (ii) required number of hours, (iii) services provided, and (iv) compensation – will shape the administrative position and comprise some of the key items for consideration and oversight.

Step Five: Agreement Execution and Beyond

More often than not, a significant focus is placed on ensuring regulatory compliance prior to entering into medical director arrangements via determining agreement terms (as outlined in Step Four). However, particularly with regard to administrative arrangements and in light of increased government scrutiny, additional review and focus should continue beyond the initial execution of such an agreement. Specifically, key facts may change which are relevant to the commercial reasonableness or fair market value of a medical director position, or both. Because of the potential for factual changes, it is critical that hospitals develop and maintain a framework for monitoring medical director positions on an ongoing basis in the event that updated facts arise which could call into question the relevance, reasonableness, or value of such an arrangement.

Compliance Tip: While many health systems focus on regulatory compliance during the planning phases of medical directorships, many of the factors associated with commercial reasonableness are particularly relevant after the agreement is in effect.

As facts change during the course of an agreement (e.g., patient demand decreases, service line offerings are modified), attorneys and compliance officers should note these updates.

Compliance Tip: Many multi-year agreements call for periodic review in the event facts do change which may impact the value or reasonableness, particularly in the case of administrative positions.

As part of ongoing due diligence, hospital leaders should monitor key facts as well as prepare thorough documentation relevant to continued or changing needs. For example, inquiries such as the following may affect commercial reasonableness after agreement execution (i.e., versus in the planning phase):

- Whether safeguards are maintained to reduce risks of abuse (e.g., payments for unnecessary or duplicated services);
- Whether the hospital has a process which will formally evaluate administrative arrangements;
- Whether the hospital will use performance assessments to evaluate whether medical director arrangements are effective and/or needed;
- Whether the hospital will maintain documentation detailing the actual performance of services and the resulting outcomes; and,
- Whether the hospital will engage in oversight to ensure services are actually performed (including periodic audits of timesheets and verification of time performed).

These queries to determine commercial reasonableness are intended to mitigate compliance risk on an on-going basis. Primarily, particularly after the passage of the PPACA, medical directorships should not only be necessary but should ideally advance objectives that are in furtherance of quality and efficiency. These services must not only be actually provided, but achievement of pre-defined objectives should be documented.

Compliance Tip: Timesheets alone are likely not sufficient to document the provision of medical director services. The hospital should also monitor and document outcomes.

In certain instances, medical director duties may need to be expanded, while in others, a medical director position may not be required after the achievement of certain objectives. Hospital leaders should be fully cognizant of such objectives and ready to take swift action to eliminate duplicative or unnecessary medical director positions. By following these steps and maintaining oversight during the term of medical director arrangements, hospital leaders can more successfully manage compliance risk and also sustain an effective program of medico-administrative services.



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Pinnacle Healthcare Consulting's Commercial Reasonableness Checklist

What is Commercial Reasonableness?

Generally accepted regulatory definitions & guidelines related to commercially reasonable healthcare arrangements include:

An arrangement [which is commercially reasonable] appears to be a sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of any potential referrals.

An arrangement will be considered 'commercially reasonable'... if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential designated health services ("DHS") referrals.

Scope of Review

Commercial reasonableness, which can be done internally or via an external resource, is a broad and somewhat abstract concept. As a result, a first step in ensuring regulatory compliance with this requirement is to develop a framework for evaluating each arrangement. This framework should comprise at least three key components related to the specific factors involved, including those which are:

1. Qualitative,
2. Quantitative, and
3. Administrative.

Example Facts & Circumstances to Document Commercial Reasonableness

Qualitative

- Development of a particular service line or introduction of new service;
- Competitive targets including specialized service offerings or market share expansion;
- Achievement of higher quality targets and patient care satisfaction;
- Increased departmental efficiencies, including streamlining of scheduling and proper adherence to applicable standards;
- Improvement in provider education and training targets aimed to improve operations or enable more expedient service line ramp up of new policies; and/or
- Reduction in overcrowding within emergency or operating departments.

Quantitative

- Physicians' compensation which may reflect their specialty, experience, etc., but which is causing losses to a hospital's service line on a sustained basis;
- Lack of volume for the number of providers being compensated/staffed which causes losses within a particular department;
- Staffing on a non-leveraged basis that results in payments from the hospital which are higher than necessary (i.e., when the use of mid-level providers may be appropriate);
- Payment on a market comparable basis in lieu of a cost-to-build model; and/or
- Arrangements with physicians in lieu of negotiating with other providers or substituting alternate staffing models (e.g., hospitalist, laborist).

Administrative

- Physicians receiving compensation for services that they do not actually provide;
- Hospitals entering into or continuing an arrangement without proper documentation and approval; and/or
- Physicians providing services under agreements for which there are no performance reviews or determinations of continued need.

For more information on commercial reasonableness, please contact:

Allison Carty, Principal of Compensation Valuation, at 865-247-6761 or ACarty@AskPHC.com

Basic Framework & Checklist

Qualitative

- ☐ Whether the arrangement is necessary in addition to the resources already available to the hospital (e.g., physicians providing services at the hospital, duties required of the medical staff, and protocols at affiliated facilities)
- ☐ Whether the arrangement has a defined and specified purpose
- ☐ Whether the arrangement will further the goals of the hospital (e.g., business, clinical, or community)
- ☐ Whether the arrangement has a particular objective (e.g., profit contribution or services development)
- ☐ Whether the arrangement will meet patient needs (e.g., access to a particular specialty or service)
- ☐ Whether the patient acuity levels indicate the need for the arrangement

Quantitative

- ☐ Whether a less expensive level of service would be appropriate (i.e., non-physician provider or non-specialty physician)
- ☐ Whether additional considerations exist which may affect compensation (e.g., provider experience or market conditions such as a provider shortage within a particular specialty)
- ☐ Whether an alternate model may result in similar services at lower costs (e.g., hospitalist coverage, equipment purchase in lieu of service leasing)
- ☐ Whether the amount of time required under a particular arrangement has been considered, particularly in combination with other duties required of the physician
- ☐ Whether market comparable data exists which is relevant to the proposed arrangement
- ☐ Whether patient demand justifies the level or amount of service being contemplated
- ☐ Whether the size of the hospital and its patient population is commensurate with the proposed services

Administrative

- ☐ Whether the need for and specific purposes of the arrangement are documented
- ☐ Whether a written agreement contains the material terms of the arrangement
- ☐ Whether the hospital will appropriately engage in the management and attorney review of the proposed arrangements
- ☐ Whether approval of the arrangement will come from decision-makers of sufficient independence (including the board)
- ☐ Whether safeguards are maintained to reduce risks of abuse (e.g., payments for unnecessary or duplicated services)
- ☐ Whether the hospital has a process which will formally evaluate arrangements
- ☐ Whether the hospital will use performance assessments to evaluate whether arrangements are effective and/or needed
- ☐ Whether the hospital will maintain documentation detailing the actual performance of services and the resulting outcomes
- ☐ Whether the hospital will engage in oversight to ensure services are actually performed