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Ensuring medical directorship agreements are accountable

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The U.S. Department of Health and Human Services Office of Inspector General (OIG) focus on false claims, Stark Law, and kickback issues with medical director agreements continues to increase. In 2009 alone, the Justice Department made numerous fines and settlements surrounding medical director arrangements. To demonstrate the importance of compliance surrounding these financial arrangements, we have listed a few cases. including the penalties faced by hospitals.

Illustrative Cases

Case 1

In November 2009, the Justice Department announced that Universal Health Services McAllen Hospitals LP (d/b/a South Texas Health System) agreed to pay the United States $27.5 million to settle claims that it violated the False Claims Act, the Anti-kickback Statute, and the Stark Law between 1999 and 2006, by paying illegal compensation to doctors in order to induce them to refer patients to hospitals within the group. The government alleged that these payments were disguised through a series of sham contracts, including medical directorships.

Case 2

In October 2009, after it self-disclosed conduct to the OIG, Medina General Hospital (MGH) in Ohio, agreed to pay $240,298 for allegedly violating the Civil Monetary Penalties Law provisions applicable to kickbacks and physician self-referrals. OIG alleged that MGH's financial relationships with a family practice physician, occupational health services physicians, and a cardiologist failed to meet Stark Law requirements. Specifically, the financial relationships were during periods when there were no written service agreements or payments were not made consistent with the contracts.

Case 3

In August 2009, after it self-disclosed conduct to the OIG, Cushing Memorial Hospital (CMH) in Kansas, agreed to pay $50,000 for allegedly violating the Civil Monetary Penalties Law provisions applicable to kickbacks and physician self-referrals. OIG alleged that CMH's financial relationship with a cardiologist failed to meet Stark Law requirements. Specifically, the cardiologist was engaged to provide medical director services to CMH's cardiac rehabilitation unit. However, the written agreement was not signed.

Case 4

In February 2009, after it self-disclosed conduct to the OIG, Jewish Hospital and St. Mary's Healthcare (JHSMH) in Kentucky, agreed to pay $130,000 for allegedly violating the Civil Monetary Penalties Law provisions applicable to kickbacks and physician self-referrals. OIG alleged that JHSMH entered into an arrangement with a physician for a medical director position that included the physician being paid compensation in excess of his medical director duties and receiving free nurse services for his private practice without any contractual entitlement to such services.

The cases referenced above highlight four different issues:

1. the medical director services were not actually being provided (i.e., sham contracts);
2. the payments were not consistent with the contracts;
3. the medical director agreement was not signed (i.e., executed); and
4. the medical director compensation being paid was above fair market value (FMV) and the physician was receiving free services.

The following guidelines draw attention to the compliance issues that should be considered when establishing medical director agreements, to prevent you from heading down a road that should not be traveled:

1. All medical director arrangements should be in the form of a written agreement. The agreement should be signed by both parties as evidence there is a mutual understanding of the terms.
2. The written agreement should outline all the medical director duties to be performed under the agreement. Unlike the South Texas Health System case above, it is critical the services are legitimate and are actually performed by the medical director.
3. The physician's qualifications should be summarized in the agreement to document why the physician's expertise is necessary and appropriate for the intended medical director services.

4. The term of the agreement should be at least for one year.
5. The agreement should state the time commitment required (i.e., per week or per month) to perform the medical director duties. The hours should be reasonable and reflect the time to be spent performing such duties.
6. The agreement should require the physician to submit regular time records documenting the services actually provided.
7. Health care executives and compliance office should frequently monitor all medical director arrangements to ensure the medical director services are actually being performed, and the amount being paid is equal to the amount specified in the agreement.
8. The compensation to be paid should be consistent with fair market value (FMV). The amount should be set in advance in an arms-length transaction, and should not be determined in a manner that takes into account the value or volume of referrals.

When Stark Phase III was released, it eliminated a Safe Harbor that determined a fair market value hourly rate for physicians in either clinical or administrative roles. Hospital executives and compliance officers were forced to rethink how to determine fair market value. The Centers for Medicare and Medicaid Services (CMS) did provide some guidance to determining administrative compensation.

> "A fair market value hourly rate may be used to compensate physicians for both administrative and clinical work, provided that the rate for clinical work is fair market value for the clinical work performed and the rate paid for administrative work is fair market value for the administrative work performed. We note that the fair market value of administrative services may differ from the fair market value of clinical services."[1]

Given this guidance, a FMV opinion should address the distinction between clinical and administrative services and the corresponding levels of compensation for each type of service in order to be compliant with Stark. It is advisable to keep an independent third party written opinion on file justifying FMV.

Suggestions to rejuvenate your medical director arrangements

When we speak to CEOs and compliance officers from hospitals across the country, we recognize that many are becoming frustrated over medical director agreements that appear to have no substantive value, other than locking in the physician to participate in some of the management decisions that affect the hospital. Instead, many CEOs are now are evaluating their medical directorships and terminating them, unless they add value. When entering into a new agreement or renewing a contract, one should consider asking the following questions:

1. What value does the Medical Directorship offer my organization?
2. Can we measure the value the medical director provides with this agreement?
3. Is the medical director at risk for the services they provide?
4. Can we measure the impact of this position every quarter?
5. Has it passed the review of our Medical Director Review Board?

In order to hold the medical director arrangement accountable to providing substantial value to an organization, health care executives should consider the development of an incentive compensation arrangement structured as follows:

1. A job description developed and approved by the Medical Director Review Board
2. A clause specifying that the medical director will be paid an hourly rate with an "at risk withhold" component
3. The risk withhold can be based upon four criteria. The criteria should be consistent with the same goals on which the CEO and chief medical officer (CMO) are frequently measured. Typically, the four criteria are achievement of quality core measures, implementation of clinical pathways, improvement in readmission rates, and improvement in patient satisfaction measures. The risk component can have a +/- 20% earnings value.

Takeaways for accountability of medical director agreements

To avoid the fines and settlements mentioned in Case 1 through 4 outlined above, one should consider the following:

- Maintain an executed contract on file.
- A well-written medical director contract will provide substantial value to the hospital.
- Maintain time records to document that the services were actually provided.
- Ensure compensation is within FMV.
- Consider an risk withhold component to align goals within the organization. ■

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