ARTICLE

PHYSICIAN COMPENSATION

Auditing Ancillary Compensation Agreements Provides Key Insights for High-Performing Networks

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Many hospitals and health systems lack a robust strategy and/or approach for managing and reviewing compliance (and organizational value for that matter) related to physician contracts that are outside of direct employment (W-2) or professional services agreements (PSAs)/independent contractor arrangements for clinical services. This article outlines the reasoning for, and the processes involved in, auditing ancillary physician agreements and arrangements, such as contracts not directly related to the physician's capacity as a patient care provider. These additional arrangements are typically medical directorships, advanced practice provider ("APP") supervision stipends, on-call compensation arrangements, co-management agreements, and even recruitment agreements/net income guarantees.

Many health care organizations admit that the proliferation of these types of arrangements has escaped the control of management. This issue comes up frequently – particularly with medical directorships and APP supervision stipends. One slightly frustrated health system executive quipped, "we've passed out medical directorships like candy." There are a variety of reasons why and how this happens. Rather than delving into the many reasons that can lead to this situation, this piece focuses on determining the actual current state of the contractual arrangements, their validity, and their execution. Undertaking a comprehensive audit process will illuminate how well an organization is managing its contractual arrangements with physicians.

AUDIT SCOPE

A comprehensive audit process universally starts with assembling a complete list (or inventory) of active contracts with physicians across all agreement types (collated by type). The total count of agreements by type determines the extent of the audit process. Auditing a minimum of ten percent (10%) of the active agreements by type is a reasonable guideline for determining the current state of affairs. However, the audit should include a suitable number of each agreement type for a true reflection of the overall situation and issues with every kind of agreement. That caveat may require 100% review of certain, low volume or high-risk agreement types—even if the organization thinks it has a firm grasp on these arrangements.

An example might be co-management agreements, which are reasonably complex and typically very well scrutinized by management and legal counsel alike. Although co-management agreements usually are not "passed out like candy" and proliferation is less of a worry, that doesn't mean they should be excluded from the audit as there may be other issues worth flushing out.

An alternative approach is to methodically review each agreement by agreement type at regular intervals, e.g., selecting an agreement type to check every six months. This approach is even more comprehensive and maybe more efficient as only one type of agreement is dealt with at one time. This approach also tends to shed light on issues related to non-standardization by agreement type. In this instance, perhaps all medical directorships are reviewed between January and June, then all call coverage arrangements are reviewed between July and December, and so on.

Some organizations limit agreement review to the time of renewal. If using this approach, organizations must start well in advance of the expiration date (at least six months) and be mindful of the heightened tensions, mounting pressures, and defensive posturing that may be inherent in this approach.

AUDIT PROCESS

Once the size and scope of the audit are determined, and you've selected the physician agreements for inclusion, follow these steps in the audit process:

1 | Data Collection.

Some data and information will be the same across agreement types. Other data points and pieces of information will differ slightly based on the type of agreement. Universally, and most obviously, you need the executed contract and any amendments/addendums. Other data points include:

- Documentation of hours.
  For medical directorships and co-management agreement base fees, physicians should be keeping and submitting timesheets and logs of their hours of service – three example timesheets are provided at the end of this article under *Exhibit* A. Not only should you review the timesheets that were submitted, but also the compiled spreadsheets and logs that were created and used by finance/accounting to calculate and process payment.

- Corresponding payments.
  Review records of the medical director, co-management, on-call, or supervisory stipend payments made during a given contract period.

- Logs of meeting attendance.
  For medical directorships and co-management agreements, there may be required meeting attendance with corresponding records of attendance at those meetings. If so, this is another data point that should be reviewed to cross-reference the timesheets and determine if the physician is truly fulfilling the agreement's requirements.

- On-call schedules and logs.
  In the case of on-call arrangements, there should be a schedule and/or log of on-call physicians or groups by day and service area against which the agreement's parameters can be validated.

- Fair market value and commercial reasonableness opinions.
  Are there current and valid FMV opinions? HSG's FMV opinions typically are considered good for three years. An agreement with a four- or five-year term could be due for a new and updated FMV opinion. Not only must there be documentation and confirmation that the hourly rate of compensation to the physician is FMV, but it must also be commercially reasonable. Is the position needed and based on a sound business reason? Is the position duplicative—in other words, does it overlap with a co-management agreement, or are there others serving in the same position providing the same services?

  In the case of net income guarantee agreements for the recruitment of a new physician to the community, does the hospital have official documentation of community need, as well as an FMV opinion related to the financial aspects of the arrangement?

2 | Match documented hours with the hourly/daily rates, total payments, and the contract.

An appropriately structured medical director contract should state an hourly rate, an expected number of service hours, and maximum annual payment. As such, reconciling documented service hours times the contractual hourly rate should equal the total payments, and the total payments should not exceed the maximum stated in the contract. Obviously, total payments could be less if the physician provided fewer hours of service than expected, but total payments should not be more than the maximum.

If documentation of hours is lacking, clearly, you've uncovered an issue that must be addressed.

Co-management agreements have a base management fee which, like a medical directorship, is tied to an hourly rate times documented service hours. As such, evaluation of the base management fee should mirror your review of medical directorships.

For on-call arrangements, a group's or a physician's total payment should reconcile in a similar manner. In the case of on-call compensation, days of on-call coverage provided times the daily rate equals the annual payment maximum. Note that some on-call arrangements require that the physician or group provide a specific number of uncompensated on-call days (gratis days). Be sure that these days are fulfilled and not included in the compensation totals.

> **... the contractual hourly rate should equal the total payments,** and the total payments should not exceed the maximum stated in the contract.

3 | Conduct stakeholder interviews.

Interview individuals responsible for and closest to the arrangements being reviewed to ensure that the documentation matches reality. Based on the inventory of arrangements selected for the audit, make a list of individuals to interview (having an organizational chart handy may help you compile your interviewee list). Obviously, the list of interviewees needs to be large enough to gather a variety of perspectives and provide a sample size that will yield reliable information. However, it cannot be too large to be feasible. Interviewing 50 people is a daunting task to undertake. Fortunately, there will usually be considerable individual overlap in terms of responsibility and knowledge of the organization's agreements. Positions such as CFO, Chief Legal Counsel, COO, and CMO can offer a broad, holistic perspective across agreements. As such, this will help to make your list of interviewees manageable. Keep in mind that the number of individuals with a broad perspective may not have intimate and firsthand knowledge of daily operations and personal experience with the physician in his or her role. Their input should be balanced against individuals who are intimately aware of or involved with executing the agreement requirements. It is critical to interview those closest to the action, those engaged where "the rubber meets the road," such as service line directors. Finding the right balance is important, so use your judgement. Sometimes discovering that balance just comes with experience of the audit process and knowledge of the organization. A typical interviewee list might include the following positions and roles:

- CEO
- COO
- CMO
- CFO
- Controller;
- HR, Medical Staff Office, or other personnel charged with processing payments
- Chief Legal Counsel
- CNO
- Specific service line directors
- Chiefs of service or clinical departments
- Practice managers
- Nurse practitioners and/or Physician Assistants in a specific service line or practice
- Nurse managers

4 | Compare and contrast interviewee responses with contractual expectations, duties, and responsibilities.

Information learned from interviews will help answer the following questions:

- How are hours documented, reported, and logged?
- Do key stakeholders and those closest to the arrangement perceive that expectations, duties, and responsibilities are being fulfilled and completed?

  For advanced practice provider supervisory stipends, there should be duties, responsibilities, and expectations for payment. The stipend should not be automatic just for being in the same practice or location with a nurse practitioner or physician assistant. We believe there should be legitimate and needed duties and responsibilities of the physician to receive payment. An example of typical duties and responsibilities is outlined in *Exhibit B* at the end of this article.

- Is the organization achieving value with the agreement? Sometimes arrangements and physicians do not live up to expectations. Other times the terms of an agreement outlive its need. Perhaps there was a need for the medical directorship in its early days, but the situation has changed, and the issues that were present initially no longer exist. Maybe the agreement has now become irrelevant. We have seen APP supervision stipends that have outlived their need. The degree of mentoring, consultation and availability of a physician needed early in the APPs tenure may no longer be needed now that he or she is experienced. We have also witnessed co-management agreements that have outlived their usefulness or just never materialized. In these cases, it might be time to shut it down and move on.

CONCLUSION

All hospitals and health systems can benefit from conducting a comprehensive audit of physician arrangements, even those with tight management of their agreements. Beyond concerns of unmanaged agreement proliferation, organizations and marketplaces are dynamic and always changing—any agreement's relevance and value to the organization may come into question over time. Actively questioning the need and importance of arrangements is healthy for an organization. Maintaining the status quo is not always advantageous.

Additionally, there could be weaknesses and gaps in how agreements are managed and tracked. Although the agreement design is critical, the execution of the agreement is even more crucial. A comprehensive agreement audit will shed light on execution issues that must be addressed immediately regarding payment processing, physician reporting, agreement structuring, and other areas.

With audit results in hand, organizations can make informed decisions regarding the next steps for each of its physician agreements—including relevance and value. We advise organizations to think twice about delaying determinations of agreement execution, relevance, and value until a contract is almost expiring and/or up for renewal. Tensions can be heightened, pressures can be mounting, and objective thought processes may not prevail in these instances. Being more proactive, asking the right questions of the correct people while systematically and methodically reviewing each agreement may allow the organization to be better prepared when agreements are expiring and/or up for renewal.

ABOUT HSG

HSG is a national healthcare consulting firm that focuses on building high-performing employed physician networks and physician integration so health systems can address complex changes with confidence. We work as a part of your team to build an operationally efficient, strategically valuable provider network. If physician employment is not an option, we define the best model for integration of private groups, the model that best aligns strategy and incentives.

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Summary of Physician's Monthly Statement

EXHIBIT A - EXAMPLE 1

Physician Information	
Physician's Name *(required)*	**Report for the Month/Year** *(required)*

Date	Description of Work	Time (15 minute increments)
	TOTAL	

ATTESTATION STATEMENT

I certify the above information to be a true and attest to the accuracy.

Physician's Signature (required)	Title	Date (MM/DD/YYYY)
Service Line Director Signature (required)	Title	Date (MM/DD/YYYY)
CAO or CMO Signature (required)	Title	Date (MM/DD/YYYY)

TIME RECORDS ARE DUE BY THE 5TH OF EACH MONTH. THE HOSPITAL SHALL NOT ACCEPT NOR SHALL PAYMENT BE ISSUED FOR TIME RECORDS SUBMITTED BY PHYSICIAN (OR HIS/HER DESIGNEE) SIXTY DAYS OR MORE PAST THE DUE DATE.

Summary of Physician's Time Allocation

Physician Information	
Physician's Name (required)	**Report for the Month/Year** (required)

Administrative Services	Hours
Policies/Procedures/Protocols	
QA & I Activities	
Patient Care Consultation	
Equipment Selection/Advice	
In-Services/Education	
Budget Development/Planning	
Presentations to Medical Staff, Hospital Board or Hospital Administrative Personnel	
Medical Liaison	
Regulatory Surveys, TJC	
Other	

Physician's Signature (required) _____ Title _____ Date (MM/DD/YYYY) _____

Co-Management Agreement Time Document

EXHIBIT A - EXAMPLE 3

Physician Information	
Physician's Name (required)	**Report for the Month/Year** (required)

Date	Activity	Dedicated Time (Minutes)
	Meeting Attendance	
	Quality, Utilization Review	
	Peer Review	
	Staff Education Session(s)	
	Policy and Procedure Review/Revision	
	Operations and HR/Staffing Input	
	Budget - Operational, Capital	
	Community Outreach	
	Collegial Outreach	
	APP Protocol Review/Revision	
	Risk Management	
	Other (specify)	
	Other (specify)	
	Other (specify)	
	Other (specify)	

Physician's Signature (required) _____ Title _____ Date (MM/DD/YYYY) _____

The following are the quality assurance standards for a collaborative supervisory APP practice agreement:

A. Availability

The primary or backup supervising physician(s) and the APP shall be continuously available to each other for consultation by direct communication or telecommunication. This shall not be construed for APPs that the physician must be physically present at the time and place the services are rendered.

B. Collaborative/Supervisory Practice Agreement

- Agreed upon and signed by both the primary supervising physician and the APP and maintained in each practice site.
- Reviewed at least yearly.
- Includes the drugs, devices, medical treatments, tests, and procedures that may be prescribed, ordered, and performed by the APP.
- Includes a pre-determined plan for emergency services.

C. Quality Improvement Process

- The primary supervising physician and the APP shall develop a process for the ongoing review of the care provided in each practice site, including a written plan for evaluating the quality of care provided for one or more frequently encountered clinical problems.
    - 10% of the APP's charts will be formally reviewed each quarter and discussed.
    - Specific chart review information should be forwarded for utilization in the medical staff performance improvement and credentialing processes.
- The quality improvement process shall include scheduled meetings between the primary supervising physician and the APP at least every six months after the initial six months of monthly meetings.

D. APP-Physician Consultation

The following requirements establish the minimum standards for consultation between the APP and the primary supervising physician(s) in addition to daily interactions:

- During the first six months of a collaborative practice agreement between an APP and the primary supervising physician, monthly meetings will be held to discuss practice-relevant clinical issues and quality improvement measures. After that, the primary supervising physician and the APP shall meet at least once every six months.
- Documentation of the meetings shall: Identify clinical issues discussed and actions taken, be signed and dated by those who attended, and be available for review by members or agents of the hospital for the previous five calendar years and be retained by both the APP and primary supervising physician.

Expectations of the supervising MD:

– Review and sign off charts according to state and medical staff requirements.
– Review and amend charges if incorrect.
– Provide support and give constructive feedback to the APP through daily interactions and scheduled collaborative meetings.
– Actively establish an educational and collaborative partnership with the APP.