ARTICLE

COMPENSATION AND COMPLIANCE

Compliance & Best Practices: Medical Directorships and APP Supervision

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Many of the hospitals and health systems that HSG consults with on provider compensation, employed practice operations, and hospital-based services arrangements lack a robust strategy and/or approach for managing and reviewing compliance related to physician agreements for medical directorships and advanced practice providers' (APP) collaboration and supervision. Because these functions are typically outside of (or ancillary to) an agreement for clinical/direct patient care services (the primary focus of the agreement), they often do not receive the oversight and attention they deserve. Hospitals and health systems across the industry often, inappropriately, view these agreements as legitimate mechanisms through which the compensation of a physician, or group of physicians (if referring to a Professional Services Agreement (PSA) for clinical services) can be "padded." A fair share of these organizations has admitted that the proliferation of these types of arrangements escaped the control of their management. One slightly frustrated health system executive quipped, "We've passed out medical directorships like candy."

In this article, we will review the concerns and problems we've encountered through our consulting work with hospitals and health systems across the country. First, we will focus on some common missteps (what not to do), followed by a discussion of best practices for management and compliance connected with medical directorships and APP oversight programs and associated stipends.

MEDICAL DIRECTORSHIPS PROGRAM (WHAT NOT TO DO)

Between medical directorships and APP collaboration/supervision agreements, medical directorships certainly seem like they've been around for ages. We frequently encounter legacy medical directorship arrangements, as well as legacy approaches to their management. An age-old complaint we hear with medical directorships is, "they (physicians) don't like having to track their time" or "they're too busy to document their time." This is an area that needs to be non-negotiable from the regulatory standpoint but unfortunately, that is not always the case. From our perspective, there are two factors that tend to complicate time tracking and reporting:

- The first factor occurs when hospitals and health systems do not provide their physicians with the tools to make the process easier. This topic is not merely about software programs, smartphone applications, or a spreadsheet; it also includes something far simpler: the standard paper timesheet.
- The second factor involves a lack of physician education on the importance of tracking and reporting dedicated medical director time to their organization. Leaders who do not explain how time reporting benefits both the individual and the organization are setting themselves up for failure and frustration. Some of the busiest physicians have no problem reporting their time accurately and on a timely basis. They do so because they understand the importance of the task and take it seriously. Where there is a will, there is a way, especially if they are assisted in the process!

Physicians should not shoulder all the blame when it comes to not taking medical directorship management seriously—hospital administration is responsible and accountable as well. In our audits of medical directorship "programs," we've compared submitted timesheets with the duties and responsibilities specified in medical director agreements. Submitting as documentation "sent email to Dr. Smith" or "meeting with service line leader" is not sufficient detail to justify completion of specific duties and expectations in a medical director job description. The documented tasks need to be linked with and represent required activities, such as "Assisted the Hospital in assuring the Imaging and Outpatient Radiology Services comply with the standards of The Joint Commission, licensure requirements, Medicaid and Medicare standards, and state licensing surveys by completing a review of Outpatient Radiology policies and procedures" or "Participated in Oncology Service Line quality assurance and improvement activities by leading the quarterly service line meeting to review quality data." The activities noted in the cryptic entries may in fact represent direct medical director activities, but the entries do not delineate the connection … the "why." Despite the lack of detail and specificity, we have seen many timesheets with the aforementioned sparse level of detail that were approved for payment by hospital management. Both medical directors and responsible management need to be held accountable for complying with appropriate tracking and reporting standards.

We previously mentioned legacy medical directorships. A common issue we encounter in this regard is a lack of periodic review for relevance and need. All too often, medical directorships are allowed to continue even though their relevance, importance, and organizational need no longer exist, or ever existed in the first place. Perhaps the hospital now has a co-management agreement in place and the leadership and guidance that was once provided by a single medical directorship is now provided through a group of physicians who are all part of a co-management arrangement, which may make the medical directorship redundant and an unnecessary added expense. In either case, allowing a medical directorship to auto-renew without periodic review for relevance is problematic, as an intentional review is the only realistic mechanism to ensure continued pertinence.

Another common issue is using a medical directorship as a compensation band-aid, i.e., adding to total compensation through a separate mechanism. This practice forms a critical element of compliance scrutiny, which can be addressed through a couple of actions: the aforementioned reviews for necessity and through established fair market value (FMV) and commercial reasonableness processes. Most hospitals and health systems now know that separate medical director compensation market data and surveys exist; those specialty-specific rates are not the same as that which a physician can earn in his or her clinical capacity. However, while organizations know this on one level, they often lack reliable processes to regularly review market data and fair market values.

An additional factor is the "reasonableness" criteria and whether accomplishing the medical directorship responsibilities is even feasible. For some physicians, adding medical directorship responsibilities on top of their already-demanding clinical activities may be exceptionally challenging, some would even argue not humanly impossible. Hospitals should ask themselves whether physicians who are producing and earning well above the 90th percentile are the best candidates for a medical director role. Can they commit enough time and effort that the position needs and deserves? Does the organization want the compliance risk of adding more compensation to a physician who is already well above the 90th percentile for his or her specialty?

Lastly, naming a physician as the medical director of his or her own outpatient practice is, in our experience, a uniformly bad idea because normal day-to-day office tasks find their way into a timesheet. **While physician leadership at the point of care is necessary and indispensable, drawing the line between normal clinical administrative duties in daily practice and actual administrative leadership can become blurred, and everything that is not directly related to seeing/treating a patient cannot become a billable medical director activity.**

MEDICAL DIRECTORSHIP PROGRAM (BEST PRACTICES)

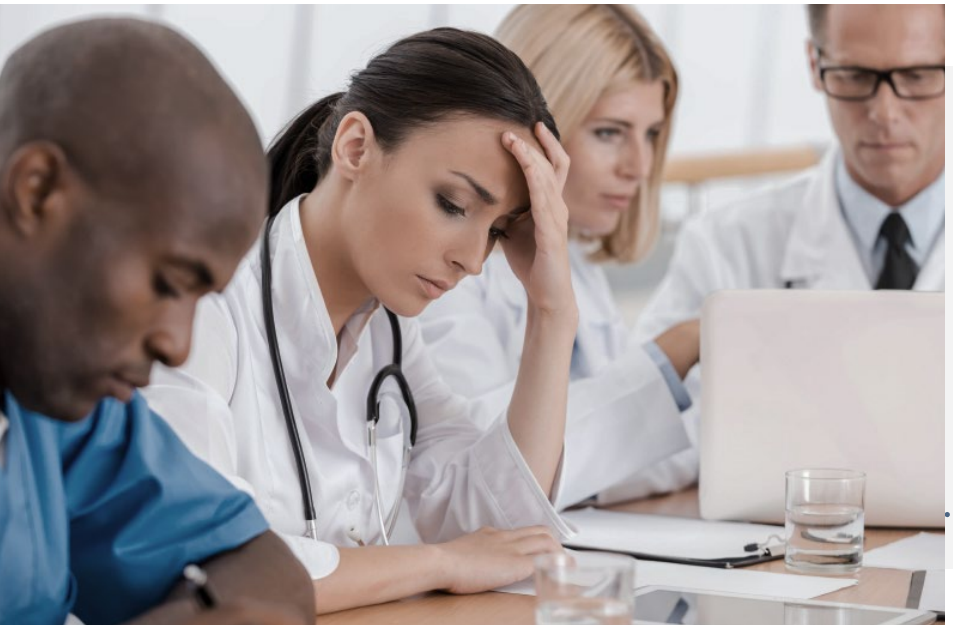
Now that we've talked about some of the issues and concerns that we encounter in our consulting work, let's review some best practices related to creating practical, sustainable, mutually beneficial and compliant medical directorships.

1 | Educate and communicate

Communicate to your physicians the importance of demonstrating compliance related to tracking and reporting of medical director time. Provide group educational sessions that cover medical directorships and other compliance-related topics. Provide one-on-one medical director education regarding what to do and how to do it when medical directorship agreements are executed. In addition, ensure that organizational policies and procedures related to medical directorships explicitly contain background information about the federal rules and regulations governing hospital-physician relationships and compensation arrangements, such as medical directorships. Promote educational references for both the involved physicians and administrative management.

2 | Provide tools and resources for time tracking and reporting

Hospital and health system executives need to provide physicians with the tools and resources they need to be successful and compliant in both their clinical and administrative duties. This is especially true when the physicians have been contracted to provide clinical leadership and expertise in a medical director role. One of the most "obvious" areas of assistance is related to time tracking and reporting. Providing a simple hard copy timesheet that delineates the various medical director duties for easy selection and comment may serve this purpose. However, the process can be streamlined for all involved by utilizing a technological solution. One example is provided by the technology company Ludi and its DocTime suite of technology solutions that enables physicians to track their medical director time via smartphone mobile app, tablet, laptop, and/or desktop computer. The DocTime suite also provides a seamless platform for managing physician compensation calculations and payments on the backend.



> Provide group educational sessions **that cover medical directorships and other compliance-related topics.**

3 | Have someone "close to the action" review submitted timesheets

Even organizations that have a process by which someone in administration/management reviews medical director timesheets prior to stipend payment often do not go "far enough" in their reviews. In these instances, the person reviewing the timesheet is usually not "close enough" to the medical director or the hospital function or service line for which the physician is providing direction. In other words, he or she neither sees nor interacts with the medical director—or even with other leaders or staff who interact with the medical director—on a daily, weekly, or even monthly basis. As a result, they don't truly know if the work is being done, i.e., routinely attending required meetings, educating staff, acting as a liaison between the hospital and referring physicians, and fulfilling the host of other duties required of medical directors.

To have the timesheet review process add meaningful value, assign the review process to someone with intimate knowledge of the role, function, and/or service line. That individual should also be required to sign the timesheet after completion of review.

4 | Make sure timesheets reflect the job description

As mentioned previously, "sent email to Dr. Smith" or "meeting with service line leader" does not provide enough detail to indicate fulfilment of medical director responsibilities. Do these statements reflect any of the duties provided in a medical director job description, and in what context? Perhaps the medical director was thinking of a specific task from the job description when she made her documentation but without further details, who can tell? The tasks and services documented by the physician must clearly align with the job description. As stated in best practice number two (2) above, by providing physicians with the resources and tools they need to make the fulfillment of their director-related jobs easier (e.g., a technology-based solution or a timesheet with the duties already listed and prepopulated), they will more likely be consistent and compliant with their timesheets.

Additionally, ensure that timesheets that do not document fulfillment of the job description are not blanketly approved. If the timesheet submission is not adequate, circle back to best practice number one (1) and educate the medical director as to why the submission is inadequate and what is expected now and in the future. Only after a satisfactory timesheet is submitted should the stipend be approved for payment.

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[1] Ludi, Inc. is a health care technology company that makes it easier for hospitals to pay physicians. Ludi's DocTime Suite automates the payment process for any type of physician arrangement from a signed contract to payment. Ludi is trusted by hundreds of hospitals nationwide to help them track, manage and audit payments to physicians. (www.ludiinc.com).
[2] With DocTime, physicians can easily track their time worked through an intuitive mobile app, making it easier for them to get paid and gain full visibility into their payment history. On the backend, DocTime helps administrative teams by centralizing and streamlining their entire contract payment process by offering a single repository of contract information, automated calculations, built-in approval workflows, ample compliance safeguards, and flexible reporting for handoffs to AP/Payroll.

5 | Periodically audit timesheets for accuracy, completeness, and relevance

An audit process and detailed evaluation for relevance should be undertaken at least every three (3) years, to review compliance with timesheet submission and completeness expectations. Does the timesheet accurately reflect the current position description responsibilities? Do completed/submitted timesheets fulfill the position's dedicated hour and activity requirements? Have the timesheets gone through the full approval process with necessary review/signatures before stipend payments were authorized? Discovered deviations represent opportunities for timesheet revision, process revision, or execution education.

6 | Periodically review compensation rates for fair market value

Typically, our FMV opinions are valid for three (3) years. As such, we'd recommend reevaluating your medical director rates, expected hours, and total compensation limits at least every three (3) years. Provided in Figure 1 below is a three (3) year trend of medical director hourly compensation data that was extracted from MGMA's Medical Directorship Compensation 2022 Report Based on 2021 Data via MGMA's DataDive platform. The table presents the median hourly compensation rate for eight (8) common specialties as reported for data years 2019, 2020, and 2021. The data shows some significant increases, some noteworthy decreases, and some that have not changed at all. We also recommend following Stark III guidance, i.e., that "reference to multiple, objective, independently published salary surveys remain a prudent practice for evaluating fair market value." Therefore, other available surveys and local or regional sources should also be consulted and evaluated during these reviews.

Medical Directorship Compensation I 2022 REPORT BASED ON 2021 DATA
Hourly Rate Compensation Trending

Specialty	2019 50th %tile	2020 50th %tile	2021 50th %tile	Overall
Anesthesiology: Al	$200.00	$205.68	$166.67	-16.67%
Emergency Medicine	$187.00	$163.62	$183.04	-2.12%
Family Medicine: All	$126.97	$137.09	$146.61	15.47%
Hematology/Oncology	$200.00	$197.69	$223.07	11.54%
Internal Medicine	$126.00	$150.00	$150.00	19.05%
Obstetrics/Gynecology	$150.00	$150.00	$150.00	*
Pediatrics: General	$133.00	$125.00	$125.00	-6.02%
Surgery: General	$163.00	$175.00	$180.00	10.43%

7 | Ensure no duplication or overlap with other agreements

Overlapping can be extreme, such as two (2) physicians having the same medical director role when only one (1) is needed, or less extreme, such as the overlapping of a few tasks or duties in two (2) separate medical directorships. The former is more acute, but both are problematic from a compliance perspective and should be dealt with appropriately.

Overlapping can also occur when new and different agreements are introduced. Perhaps your hospital decides that a co-management agreement in orthopedics is necessary to unify disparate orthopedic groups to tackle the process of care, quality and outcomes, cost of care, patient satisfaction, and variations in transitions of care and appliance utilization. Historically, these efforts were handled at your facility by the orthopedic service line medical director, who would also participate in the co-management agreement. Would that medical director have held on to his or her medical directorship? The answer is usually not in the form it currently exists or at the level it once did. Duties that could exist outside the co-management arrangement should be rolled into the co-management arrangement, which could also include a newly defined lead or directorship role within the arrangement.

8 | Don't use a medical directorship merely as a vehicle to increase compensation

Imagine the following scenario, which has often played out in reality between physician and hospital: a physician really wants to earn $350,000, but the hospital is not comfortable going above $300,000 in base salary, which an FMV and commercial reasonableness opinion supports. Despite the physician's desire for a higher base salary, the hospital should not create a medical directorship role to merely "pad" a physician's compensation. If the hospital has not already determined a legitimate need for a medical director, subsequently creating such need to fulfill a physician's desire for a higher base salary will not be received well by others and is difficult to justify.

9 | Don't use a medical directorship to obtain or encourage leadership in a practice

Asking a physician to count his or her hours for every administrative interaction or expression of leadership on a daily basis is not the way to encourage leadership within an individual practice or broader physician network. This mindset may be an outgrowth of best practice number eight (8) above or a reaction to a physician who has expressed the belief that any non-revenue- or wRVU-production bonus-generating activities should be compensated separately and on top of "clinical compensation," otherwise, "why would someone put up with it?" First of all, such a mindset and attitude are probably not reflective of someone a hospital would want to lead a vitally important practice in its physician network. Secondly, perhaps there is something amiss with the structure of the physician compensation model's incentives if wRVU bonuses and production are the only motivators.

APP OVERSIGHT PROGRAM (WHAT NOT TO DO)

As previously noted, we commonly encounter organizations that do not have robust oversight programs related to APP collaboration and supervision. These organizations risk noncompliance with state regulatory requirements as well as physician compensation requirements related to collaboration/supervision stipends. While medical directorship programs have already garnered national scrutiny, APP oversight programs are ripe to be next in the physician compensation external audit spotlight.

States regulate APP oversight and typically generate broad guidance regarding the minimum expectations that must be met, regardless of practice type or location of care within the state. Organizational requirements can be more stringent than the state regulatory requirements but must comply with the published minimum state requirements. Not all states have the same requirements, so it is important to have a working knowledge of what is required in your state and keep abreast of changes to ensure ongoing regulatory compliance. Many organizations have not identified an individual(s) responsible for knowing current state requirements and ensuring that the organization's program fulfills those requirements. This is the first potential programmatic gap in APP oversight.

A second area of concern arises when the organization does not create specific parameters or programmatic elements to implement the broad state requirements in a detailed, facility-specific manner. A common example is related to "quality of care reviews," which are required by most states' regulations but are not specifically defined by many of them. The state often delegates the details of "quality of care reviews" to the organization, which often fails to specifically do so through collaboration agreements or policy. Another example involves "written protocols" or scopes of practice, whose requirements may be stated in a collaboration agreement but without any defining details.

> "...we commonly encounter organizations that **do not have robust oversight programs...**

Organizations that define "quality of care reviews" through specific chart review requirements often face physician resistance as the process represents "yet another" time-consuming requirement that impacts work-life balance and burnout risk. Creating realistic requirements, providing tools to more readily accomplish and document the reviews, linking the reviews with systemic quality and privileging programs, promoting APP mentorship, and rewarding the extra effort through APP collaboration/supervision stipends can help offset these concerns.

Finally, some organizations have implemented APP collaboration/supervision stipends for physicians without defining the requirements for a stipend payment or having a process in place to monitor compliance with stipend requirements, including state regulation mandates. The former represents a federal Stark compliance risk while the latter represents a state regulatory compliance risk. In addition, many organizations neither utilize external benchmarking or obtain FMV opinions when establishing stipend amounts nor determine their impact on total compensation.

APP OVERSIGHT PROGRAM (BEST PRACTICES)

As is done for medical directorships, proposed best practices can address issues and concerns presented in APP collaboration and supervision situations. The ultimate goal is to establish and maintain a practical, sustainable, mutually beneficial, compliant APP oversight program.

1 | Develop a robust policy that comprehensively defines the organization's APP Oversight Program

An effective policy should clearly define roles and responsibilities while establishing the specific parameters and expectations for the APP Oversight Program and apply them across the entire organization.

Key elements to outline in the policy include, but would not be limited to, the following:

- Program management/coordination
- Physician collaborator/supervision assignment and limitations
- Documentation submission/retention requirements
- Program parameter compliance and quality monitoring process

Details related to each of these elements are expounded upon in the following paragraphs on page 10.

Program management and coordination should fall under a designated APP Oversight Program Manager with specifically defined responsibilities for which the individual is accountable. Some of these responsibilities would include:

- Ensuring that state-required forms are initially submitted and/or renewed in a timely manner and in accordance with state regulations.
- Maintaining a file of signed Nurse Practitioner Collaboration and Physician Assistant Supervision Agreements.
- Tracking and monitoring collaboration/ supervision relationships to ensure that current statuses are known and accounted for. This process usually involves creating and maintaining a matrix to document and monitor the relationships. Such a matrix allows the program manager to ensure that each physician collaborator/supervisor does not exceed the designated number of individual APP full time equivalents (FTEs) collaborated with or supervised and to readily track APP and physician collaborators/supervisor comings and goings. This latter element requires reliable connectivity with operational elements in the organization so that the information can be adjusted on a real-time basis.
- Collaborating with designated provider leadership to identify and approach potential physician collaborators/supervisors and to receive assistance with assuring compliance with APP collaboration/ supervision agreement requirements, including chart reviews.
- Ensuring the required chart reviews are received prior to submitting payroll processing for physicians who receive APP collaboration/supervision stipends.
- Forwarding required chart reviews to the pertinent quality and credentialing/ privileging entities within the organization.

The physician collaborator/supervision assignment process involves several sequential steps that utilize collaboration with pertinent provider leadership, from initially identifying appropriate and willing specialty-specific or scope of practice-specific potential collaborators/supervisors, to ensuring the corresponding APP collaboration/supervision agreements are completed, to verifying that all state-required forms are completed and submitted. A separate responsibility within this realm is ensuring periodic review of the APP collaboration/supervision agreements to ensure ongoing state regulatory compliance and organizational programmatic pertinence.

Although some states specify the number of APPs that can be overseen by any given physician, others do not. Organizations should determine a practical number of APP FTEs collaborated with and/or supervised based on the collaboration/supervision requirements, but not to exceed state parameters. Most organizations find that the maximum practical number of APPs to be collaborated with or supervised is 4 FTEs as long as the state permits that number.

Documentation submission/retention requirements include expectations of formal chart review, documentation of the reviews, submission of the reviews in a timely fashion, and retention of the reviews. These expectations should be explicitly defined or referenced in the APP collaboration/supervision agreement. Creating and distributing a standard electronic or hard copy chart review form facilitates this process tremendously.

2 | Ensure that the APP collaboration/supervision agreements meet state requirements while explicitly outlining the organization's program and expectations

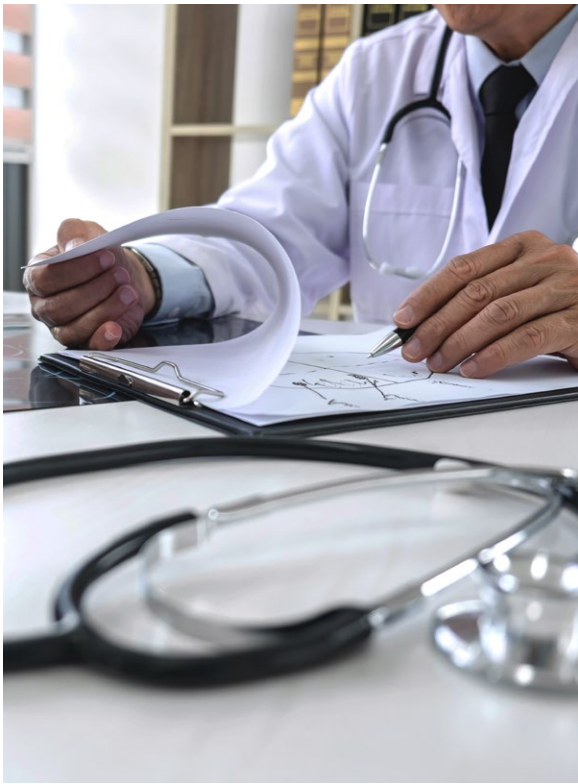
Many states indicate that quality-of-care reviews and written protocols be in place, but often do not define specifics related to these requirements.

The most common form of quality-of-care review is the traditional chart review process. Charts should be randomly selected but represent the scope of services performed by the APP. Involving the APP in the chart selection process is usually perceived favorably, but it does present a potential double-edged sword. On the one hand, APP involvement permits the selection of cases that highlight specific questions or concerns, which is counterbalanced by the risk that the APP might "cherry-pick" charts with favorable documentation. Programs that advocate APP involvement in case selection promote the chart review process as a mentoring and learning opportunity, not as a "grading" process. This emphasis places the review process in a more favorable light and tends to actively involve both the APP and the reviewer in a more constructive process, thereby resulting in the intended educational outcome.

Explicitly defining the number of charts to be reviewed through either the APP Oversight Program policy or APP collaboration/supervision agreement—or preferably both—will unambiguously establish expectations for all involved. The numbers are usually based on a percentage of APP patient encounters for the interval in question (often monthly) with or without a maximum absolute number. Generally, at least 5-10 charts per month should be reviewed. Providing a standard review documentation form facilitates the process and ensures greater interrater reliability of the review process. Appendix A on page 13 provides a sample chart review form.

In addition to involving the APP in the case selection process and utilizing a standard review form, the following additional points of emphasis and interaction tend to promote the chart review process in a positive light and minimize perceptions of solely being an unwelcome, onerous task:

- **Consider the reviews to be a mentoring opportunity.** This tends to elicit thoughts of a positive, mutually beneficial relationship that is more voluntarily accepted and often results in both parties looking forward to the interactions.
- **Schedule time each month.** "Finding time" is a primary complaint. Scheduling time on both schedules before or after patient care provides a "deadline" to keep the review process on track, but more importantly, it creates common expectations for discussing clinical care and professional development.
- **Capture "real-time" interactions.** Performing reviews of care in real-time during the actual patient encounter can save time and is often easier to capture than trying to recreate the situation and provide feedback after time has passed. Having forms at the ready facilitates these opportunities.
- **Regularly emphasize additional benefits.** Formal care reviews can enhance physicians' professional relationships with APPs, instill confidence that patients are receiving high-quality care, and mitigate the risk of "negligent supervision" concerns.



Indicating that the APP's practice is defined by granted clinical privileges and organizational policy and procedure is usually adequate for developing "written protocols" for practice in most situations. However, as always, reference state-specific requirements to be sure that the regulations are adequately addressed in this manner. For instance, some states require the delineation of acceptable reference textbooks or guides.

3 | Establish a standardized approach to APP collaboration/supervision stipends

We believe that the effort involved with fulfilling specific collaboration/supervision criteria, such as formal chart review, exceeds the standard professional practice of being available for patient care consultation. Establishing a policy that APP collaborators/supervisors will receive an additional stipend for complying with APP Oversight Program requirements emphasizes the importance of the effort and rewards the primary collaborators/supervisors for their effort. The following caveats apply:

- A written agreement needs to be in place that outlines expectations and payments, e.g., the APP collaboration/supervision agreement.
- Stipends need to be consistent with documented national or regional benchmarks, which are readily available and help define FMV parameters.
- Stipend payment should not be made until program requirements for the payment interval are fulfilled.

Stipends can either be flat—a given amount per APP FTE—or tiered, usually based on the level of APP productivity. The flat amount is more common, especially since many programs indicate a maximum number of charts to be reviewed. The tiered amount is intended to acknowledge that APPs with higher patient volumes tend to have more frequent interactions with their collaborators/supervisors and more charts for the collaborator/supervisor to review (if a percentage-based chart review process is utilized). This methodology recognizes collaborator/supervisor effort and does not reward them for APP expended effort (e.g., get credit for APP-generated wRVUs), which risks a Stark violation.

Adopting these suggested best practices for medical directorships and APP oversight will allow the development of fundamentally sound, sustainable, compliant programs that will avoid commonly experienced pitfalls.

APPENDIX A

APP CHART REVIEW DOCUMENTATION

Review Time Frame (month, year) _____

Medical Record Identifier				
Date of Service				
HPI, ROS, PMH appropriate for Chief Complaint				
Physical exam appropriate for Chief Complaint				
Differential diagnoses appropriate for evaluation				
Lab evaluation appropriate for diagnosis/ differential				
Imaging evaluation appropriate for diagnosis/ differential				
Treatment appropriate for diagnosis/ differential				
Follow up and other elements of Plan of Care appropriate				
Specific Comments related to care rendered				
Suggestions to improve level of care rendered				

Authentication

_____
Date Discussed

_____
Name of Physician Reviewer

_____
Name of APP Reviewed

_____
Signature of Physician Reviewer

_____
Signature of APP Reviewed

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