Hospitals and Health Systems: A Compliance Approach for Medical Directorships

Scott Becker & Emily C. Balfe

Health care systems often develop medical director arrangements on an ad hoc basis as the relationships between the system and particular specialists evolve. Because these arrangements can differ greatly from specialty to specialty in compensation and responsibilities, they can raise significant issues from a regulatory perspective. For example, issues may arise regarding why one doctor receives higher compensation than another for seemingly similar roles. Many systems would benefit from a standardization of such relationships. This article provides guidance on a method and process for standardizing such relationships.

REGULATORY SCHEMES

There are three principal federal statutes which impact the payment of medical director fees. These include the Medicare-Medicaid Anti-Kickback Statute (the “Fraud and Abuse Statute”),¹ The Stark Act,² and the requirements of the Internal Revenue Code pursuant to § 501(c)(3).

The Fraud and Abuse Statute prohibits giving remuneration to induce or in exchange for the referral of Medicare or Medicaid business. There is a safe harbor which can be applied to medical director compensation. The principal requirements include that (i) payments must be made for medical director services that are actually needed, (ii) the payment amount be fixed on an annual basis, and (iii) the amount paid must reflect fair market value for the services being provided.³

The Stark Act prohibits physicians from having a financial relationship with an entity that they make referrals to for designated services. However, there is an exception for the provision of personal services, which includes medical director services. Here, the most important requirements are that compensation be set in advance, and not in a manner that varies based on the volume or value of referrals. Unlike the Fraud and Abuse Statute, the amount need not be fixed in aggregate for the year.

The Stark Act personal service arrangement exception provides:

(3) PERSONAL SERVICE ARRANGEMENTS.—

Scott Becker is a partner and Emily C. Balfe is an associate at Ross & Hardy in Chicago, Illinois.
(A) IN GENERAL.—Remuneration from an entity under an arrangement (including remuneration for specific physicians’ services furnished to a nonprofit blood center) if ... the arrangement is set out in writing, signed by the parties, and specifies the services covered by the arrangement, the arrangement covers all of the services to be provided by the physician (or an immediate family member of such physician) to the entity, the aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement, the term of the arrangement is for at least 1 year, the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and except in the case of a physician incentive plan described in subparagraph (B), is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties, the services to be performed under the arrangement do not involve the counseling or promotion or a business arrangement or other activity that violates any State or Federal law, and the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

Section 501(c)(3) of the Internal Revenue Code requires that no contract be entered into or compensation be paid for the purpose of providing private benefit or private inurement. Rather, the contract must further community benefits. In assessing whether a contract meets these overriding requirements, the Internal Revenue Service through regulations has developed guidelines by which an agreement with a physician can be deemed to be presumptively valid. These include the requirements that: (1) the contract be the product of arm’s length negotiation, (2) the contract be independently approved by the Board of Directors or an independent compensation committee of the Board, and (3) the contract be supported by independent data indicating the appropriateness of the compensation or payment amount.

In 1998, the IRS published proposed regulations for Section 4958 of the Internal Revenue Code which addresses taxes on excess benefit transactions (the “Proposed Regulations”). In the Proposed Regulations, the IRS addressed the issue of reasonable compensation stating, “compensation paid may not exceed what is reasonable under all the circumstances. Compensation for the performance of services is reasonable if it is only such amount as would ordinarily be paid for like services by like enterprises under like circumstances.” The IRS goes on to state standards for a rebuttable presumption that a transaction is not an excess benefit transaction as follows:

Payments under a compensation arrangement between an applicable tax-exempt organization and a disqualified person shall be presumed to be reasonable ... if the following conditions are satisfied: (1) The compensation arrangement ... [is] approved by the organization’s governing body composed entirely of individuals who do not have a conflict of interest with respect to the arrangement or
transaction, (2) the governing body, or committee thereof, obtained and relied upon appropriate data as to comparability prior to making its determination, and (3) the governing body or committee adequately documented the basis for its determination concurrently with making that determination.

According to the Proposed Regulations, relevant information for determining comparability includes: compensation levels paid by similarly situated organizations, both taxable and tax-exempt, for functionally comparable positions; the availability of similar services in the geographic area of the applicable tax-exempt organization; and independent compensation surveys compiled by independent firms.

**ASSESSING MEDICAL DIRECTORSHIPS**

There are a handful of questions which can be used to establish the validity or appropriateness of medical directorship arrangements. These include:

(1) Is there a need for a medical director for a specified service or department?

(2) Has an estimate been made of the number of hours the medical director will need to provide services on an annual basis? These would be an estimate of hours spent handling administrative responsibilities and not providing professional services. Thus, if a physician is separately billing for his professional time, this time should not count towards the calculation of hours needed as a medical director.

(3) Is the hourly payment amount reasonable in light of the skill needed to perform the services? Hourly rates of anywhere from $100 per hour on the low end to $200-$250 per hour on the high end have been utilized depending on the circumstances and geographical location of the practice, among other things. In unusual cases, higher amounts might be used.

(4) Is the total compensation amount reasonable in light of national or regional averages for persons performing similar services? Sources available to assess medical director compensation include independent consultants and surveys provided by organizations such as the Medical Group Management Association (MGMA) or American Hospital Association or other public surveys. For example, the MGMA publishes an annual survey of physician and non-physician medical director compensation, which is broken down into various categories, including geography, practice type (e.g., single specialty or multi-specialty), and by the various types of qualifications that a medical director might bring to the position.

**DEVELOPING CRITERIA AND MANAGING THE MEDICAL DIRECTORSHIP PROGRAM**

First, for each medical director position, it is helpful for the vice president of medical affairs or another senior corporate officer to develop a short description of
the principal roles that the particular medical director will handle. This may be supplemented by contractual language or by definitions that can be obtained from outside sources. All of this material should be formalized into a standard procedure written and record.

Second, the vice president of medical affairs, preferably together with physicians and the compliance officer, would assess and determine an estimate of the number of hours per week or per year that will be spent devoted to medical director responsibilities. Here, there is no absolute guideline as to the actual number of hours that might be devoted to these responsibilities. Rather, there may be significant flexibility between departments.

The central concern is that the number of hours not be related to the volume or value of business. In addition, there may also be situations in which a physician spends a great deal more time per year or per hour managing a department of the hospital. The principal goal would be to have the Board, through an independent compensation committee, approve the total hours and total compensation package based on the input of the vice president of medical affairs. Again, the overriding concept in developing total hours and compensation packages must be that neither be influenced by the volume or value of referrals developed by the medical director. As the vice president of medical affairs and the corporate compliance officer develop an expected range of hours, a higher burden of proof may be required if a medical directorship will provide pay for more than, for example, ten hours per week.

Third, overall compensation will be a product of the number of hours worked and the amount of compensation per hour agreed to by the hospital. A hospital may use a standard compensation rate that does not differ by specialty. Alternatively, it may be reasonable to have salary range. A neurosurgeon's time may legitimately be more valuable than that of another physician who does not generate the same level of professional fees per hour. Again, the actual compensation to be paid (per hour and per annum) would be approved by the Board or an independent compensation committee of the Board. Neither a financial officer nor any other party should utilize or consider the admissions of the physician in assessing the compensation paid to any medical director.

Courts have enforced these concepts. For example, in the case *United States v. Anderson*, when the physicians entered into a new medical director contract with a hospital, referrals rose significantly at that hospital. At the same time referrals to the hospital the physicians previously worked at dropped significantly. This was viewed by the Court as evidence that the medical directorship fees paid by the new hospital were an inducement for referrals. In addition, the Court found it noteworthy that the medical directors did not actually perform most of the services they were required to perform under the medical director agreement. In fact, many of the services specified in the contracts were services related to the care of their own patients.

The medical director would be required to track the number of hours he/she
devotes to medical director work per year. This may be done through monthly accounting for time. The time keeping would be monitored by the corporate compliance department or by another officer of the hospital.

**CONTRACT FORM**

The hospital or health system as a whole would generally be advised to utilize a standard form of medical director agreement where the specific description or role, the actual number of hours expected per year, and perhaps the compensation per hour could be placed on an attachment to the form agreement.

**CHARTING AND RECORDKEEPING**

On an annual basis, the medical director responsibilities for the hospital would be charted. The chart might include the following columns:

1. title of medical directorship;
2. description of medical directorship duties;
3. number of hours per annum;
4. compensation per hour;
5. who approved the medical directorship (board committee or the board, chief financial officer, corporate compliance officer, etc.);
6. what data was used to support medical directorship compensation (MGMA, AHA, independent consultant);
7. whether compliance with timekeeping responsibilities has occurred;
8. date for renewal of medical directorship; and
9. management or other insider role of physician.

As a further effort, on an annual basis, an outside consultant may provide a review of the aggregate compensation paid and offer insight as to the information on the chart.

As the preliminary review effort is completed, efforts and projected amounts can be checked against outside resources such as those mentioned here to help assure the hours and designation appear reasonable and appropriate in light of outside studies. As this initial effort is being completed, timekeeping and monitoring mechanisms and the charting mechanism to keep overall track of the medical directorships of the organization can be developed. Throughout the process, it is prudent to share the plan and its development on a periodic basis with an independent committee of the Board such as a compensation committee or a compliance committee.

By approaching medical directorship programs and compensation in this manner, a strong procedure for medical directorships can be developed that should be reasonably defensible from the investigative perspective of the Office of the Inspector General and the Internal Revenue Service.
1. 42 U.S.C. § 1320a-7b.


3. The Fraud and Abuse Statute safe harbor provides that:

"Remuneration" [as defined in the Statute] does not include any payment made by a principal to an agent as compensation for the services of the agent, as long as all of the following six standards are met—(i) the agency agreement is set out in writing and signed by the parties; (ii) the agency agreement specified the services to be provided by the agent; (iii) if the agency agreement is intended to provide for the services of the agent on a periodic, sporadic or part-time basis, rather than on a full-time basis for the term of the agreement, the agreement specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals; (iv) the term of the agreement is for not less than one year; (v) the aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or a State health care program; (vi) the services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law.

42 C.F.R. 1001.952(d).

