



TAHOE FOREST HOSPITAL DISTRICT

# 2017-06-14 Board Governance Committee

Wednesday, June 14, 2017 at 3:00pm

Eskridge Conference Room - Tahoe Forest Hospital

10121 Pine Avenue, Truckee, CA 96161

# Meeting Book - 2017-06-14 Board Governance Committee

06/14/2017 Governance Committee

## AGENDA

2017-06-14 Governance Committee\_FINAL Agenda.pdf Page 3

ITEMS 1 - 4: See Agenda

## 5. CLOSED SESSION

## 6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

### 6.1. Policy Review

6.1.a ABD-21 Physician and Professional Service Agreements  
REDLINE VERSION.pdf Page 4

6.1.b ABD-21 Physician and Professional Service Agreements  
CLEAN VERSION.pdf Page 16

6.2. Board Committee Structure Discussion.pdf Page 25

## 7. APPROVAL OF MINUTES

2016-09-14 Governance Committee\_DRAFT Minutes.pdf Page 29

2017-02-15 Governance Committee\_DRAFT Minutes.pdf Page 32

ITEMS 8 - 10: See Agenda



# GOVERNANCE COMMITTEE AGENDA

Wednesday, June 14, 2017 at 3:00 p.m.  
Eskridge Conference Room - Tahoe Forest Hospital  
10121 Pine Avenue, Truckee, CA 96161

1. **CALL TO ORDER**

2. **ROLL CALL**

Randy Hill, Chair; Chuck Zipkin, M.D.

3. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**

4. **INPUT – AUDIENCE**

This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. **CLOSED SESSION**

5.1. **Approval of Closed Session Minutes: 02/15/2017**

5.2. **Hearing (Health & Safety Code § 32155)**

*Subject Matter: Compliance Report – Closed Session*

*Number of items: One (1)*

6. **ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION**

6.1. **Policy Review**

6.1.1. **ABD-21 Physician and Professional Service Agreements Policy ..... ATTACHMENT**

Governance Committee will review revisions to ABD-21 Physician and Professional Service Agreements Policy.

6.2. **Board Committee Structure Discussion ..... ATTACHMENT**

Governance Committee will discuss the current and proposed board committee structure.

7. **APPROVAL OF MINUTES OF: 09/14/2016, 02/15/2017**

8. **REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS**

9. **NEXT MEETING DATE**

The Governance Committee will discuss its next meeting date.

10. **ADJOURN**

\*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

## PURPOSE:

This policy ~~is intended to provide the~~provides Tahoe Forest Hospital District's Chief Executive Officer ("CEO") a ~~general~~framework for professional services contracting ~~and recognizes to ensure that flexibility may be required due to the broad scope of the~~ professional services that may be covered. ~~Further, to insure that the professional~~ service provider ~~is meeting~~meets the needs of Tahoe Forest Hospital District and IVCH ("TFHD" or "District") and the community~~s~~ that it serves, ~~as well as allowing the provider to update the actual services performed, a formal service review process will be utilized.~~

## POLICY:

Written professional service agreements will be prepared for all ~~physicians, physician groups, and~~ health professionals who qualify as independent contractors and ~~who~~ provide diagnostic or therapeutic services to TFHD's patients; or ~~who~~ provide certain medico-administrative duties within a hospital department or service.

The following ~~list exemplifies~~ physicians, physician groups, and health professionals ~~who will be~~ covered by this policy ~~including~~ ~~but not limited to~~:

- Anesthesiologists
- ~~Medical Directors of specific departments/services, and~~
- Medical Staff ~~Officers-officers~~
- Physicians providing services in the District's ~~Medical Services~~Multi-Specialty Clinics, Cancer Center or other professional practice settings operated by TFHD (collectively, "TFHD Practice Settings").
- Physicians serving in medical-administrative roles or on District committees
- Nuclear Medicine ~~Specialists-specialists~~
- Emergency Services physicians
- Occupational therapists
- Pathologists
- Physical therapists
- Radiologists
- Speech pathologists
- Emergency and urgent care providers
- Mid-level practitioners not employed by the District
- Hospitalists
- Other contracted ~~physicians~~ ~~health or medical service providers~~

## PROCEDURES:

~~A.1.~~ All professional service agreements will be developed between the ~~District's Chief Executive Officer~~CEO, or ~~the CEO's~~ designee, and ~~the~~ health professionals.

~~1.1.1.~~ Health professionals are not permitted to provide professional services ~~under any professional services agreement~~ until ~~the~~an agreement has been approved by the ~~Board of Directors~~District prior to the agreement effective date. Signatures will be obtained prior to the agreement effective date or in accordance with current Stark Law. Agreements containing amendments to the terms and conditions of the agreement must also be executed prior to the effective date and prior to the provision of professional services under the amended agreement.

~~2.1.2.~~ New and renewal agreements shall utilize the template agreement for the type of service required from the contracting professional (See Exhibit A, attached, for a list of available model agreements.)~~;~~ and

~~a.1.3.~~ All agreements shall be reviewed by the Compliance Department. ~~New A~~agreements not utilizing the template agreement ~~for the type of service required~~ shall also be reviewed by ~~the Compliance Department and~~ legal counsel.

~~b.1.3.1.~~ Agreements committing \$~~25400~~,000.00 or more in any ~~given~~ twelve-month period:

~~i.1.3.1.1.~~ Once agreement is reached between the ~~District's Chief Executive Officer~~CEO and health professional, CEO will ~~place~~represent the provider-signed ~~the professional services agreement onto the Board of Directors agenda and present with~~ the Contract Routing Form (or equivalent data summary report) with ~~the~~ principal terms and conditions ~~listed, and agreement to the Board of Directors~~ for their consideration. Principal terms and conditions include, but are not limited to, justification ~~for the agreement~~, ~~agreement~~ term, compensation, scope of duties, total cost of contract, and other pertinent information, as applicable, ~~in 6.2-6.4 below.~~

~~ii.~~ All agreements and amendments completed at least five (5) days prior to the designated Committee meeting will be reviewed by a Board Committee, as designated by the ~~By Laws or the Board of Directors.~~

~~iii.~~ The designated Committee will review agreements and make recommendations to the full Board of Directors.

~~iv.~~ The District's Chief Executive Officer will place the agreement on the agenda of the District Board of Directors for their consideration.

~~v.1.3.1.2.~~ Upon ~~their~~ review and consideration, the Board of Directors may request specific changes be made to the proposed terms and conditions; or direct a designated bBoard committee to review and make a recommendation to the Board of Directors and revised terms and conditions be submitted to the Board at its next scheduled or special meeting.

~~vi.1.3.1.3.~~ Board After approval by the Board of Directors, the CEO will present the agreement to the health professional for review and signature, indicating his or her acceptance of the included terms. Approval of a professional services agreement constitutes direction to by the Board of Directors directs the CEO to execute the professional service agreement.

~~vii.~~ In the rare event the health professional requests changes in the principal terms and conditions of the agreement, the CEO will present a modified Contract Routing Form (or equivalent) and agreement to the Board of Directors. The CEO will execute the agreement after approval by the Board of Directors.

~~viii.~~ The professional service agreement will become effective following the Board of Directors' approval, subject to the contract term identified in the agreement.

~~e.1.3.2.~~ ~~New and renewal a~~Agreements committing less than \$~~25400~~,000 per in any twelve-month period can may be authorized by the ~~District's Chief Executive Officer~~ without Board approval so long as when funds have been authorized appropriated in the District's operating budget for that the fiscal year.

~~Physician and other p~~Professional service agreements due for renewal may be held over for up to twelve months with no change in terms at the discretion of the CEO, and in accordance with the Stark Law and applicable regulations. Note: ~~the~~ Stark Law regulations currently permit unlimited holdover of physician professional service agreements as long as when the contract stays within the Fair Market Value.

#### 1.4.

##### 3. Urgent Services:

~~a.~~ At the discretion of the CEO, an professional service agreement required for urgent services may be executed if a Special Meeting presented directly to of the Board of Directors is not feasible.

~~b.~~ All terms and conditions must be included at the time of presentation.

~~4.~~ All physician and professional service agreements will be processed by the Chief Executive Officer's administrative staff. The following guidelines will be utilized:

~~a.~~ Material and checklists (provided in AGOV 10 Contract Review Policy) for agreements will be

~~presented to the Chief Executive Officer's administrative staff in a timely manner to ensure that adequate time is available for preparation of the agreement within the required time frames for timely execution and implementation.~~

~~b. Content and negotiations with health service professionals will remain the the responsibility of the Admin Council members.~~

1.5. -

B.2. Compensation under Professional Service Agreements (PSA) With Physicians Only

2.1. In all cases, the New and renewal agreement will specify the financial arrangements related to the provision of physician professional services.

2.1.1. In no case shall compensation to physicians take into account -the volume or value of anticipated or actual referrals physician's make to TFHD or IVCH. TFHD shall endeavor to maintain a flexible approach with physicians within a specialty and among various specialties or TFHD or IVCH Practice Setting, irrespective of referrals to TFHD or IVCH-generated; by an individual physician or the type of specialty or the TFHD/IVCH Practice Setting. The following methodologies may be utilized:

2.1.2. Management shall endeavor strive to create a model that is aligned with the following organizational goals, recognizing that simultaneous achievement of all goals may not be possible in all cases; however the first of these goals (paying within fair market value) cannot be compromised in any circumstance.

2.1.2.1. Pay within constraints of fair market value

2.1.2.2. Maintain internal equity within and between specialties

2.1.2.3. Provide sufficient compensation to recruit and retain physicians

2.1.2.4. Encourage quality and productivity

2.1.3. Be Clear and understandable to all parties

The methodologies in this section 2 may be utilized to determine compensation with physicians.

1.2.2. Hourly rates. Hourly rates are the preferred compensation method for administrative duties such as medical directorships, -preceptor, -medical staff leadership positions, or committee attendance, and may also be used when clinical and administrative duties are combined. Hourly rates or "per shift" rates with hours of coverage and response time specified are the preferred compensation method for on-call and hospitalist coverage.

2.2.1. Physicians shall be required to document and attest to the date, hours worked or shifts covered, spent, and

a.2.2.2. In addition, a description of work completed or meetings attended shall will be provided for all administrative duties.

~~b. On-call calendars maintained by the medical staff office may be utilized as documentation for on-call and hospitalist agreements.~~

2.3. Rate per unit of production. The Rate per Work Relative Value Unit (WRVU) is the preferred measure of physician productivity and should be used as the unit of production whenever feasible. Payment at a set rate per Work Relative Value Unit (WRVU) is an additional the preferred compensation method for multi-specialty clinic (MSC) physicians providing professional medical services under a professional service agreement in a TFHD Practice Setting, who are working full-time or less, and may also be utilized for other physicians when mutually agreed upon by the parties.

2.3.1. The preferred source for establishing the rate per WRVU shall be a three-year average of the National median ratio of compensation to WRVUs published in the MGMA Physician Compensation and Production Surveys, adjusted to account for inflation since the publication date of the surveys, although other approaches that yield fair market value compensation may be substituted based upon the circumstances of the negotiation, based on the same compensation and production survey data that is utilized for physicians working half time or more, and may include an allowance for malpractice and benefits.

2.3.2. An alternate measure of productivity such as visits may be used as deemed necessary

by management.

2.2.4. Base compensation plus bonus. Payment of a fixed base compensation plus bonus is ~~one-another~~ acceptable compensation method for physicians who are providing professional medical services, ~~more-than-half time~~ or more, under a PSA in a TFHD Practice Setting. This methodology may be utilized for newly recruited physicians during the start-up phase (generally a year), for physicians in specialties where community demand is insufficient to support a full-time practice, or in other situations in which such method is needed for physician retention.

~~a.1.1.1. Management shall endeavor to create a model that is aligned with the following organizational goals, recognizing that simultaneous achievement of all goals may not be possible in all cases; however the first of these goals (paying within fair market value) cannot be compromised in any circumstance.~~

~~i.1.1.1.1. Pay within constraints of fair market value~~

~~ii.1.1.1.1. Maintain internal equity within and between specialties~~

~~iii.1.1.1.1. Provide sufficient compensation to recruit and retain physicians~~

~~iv.1.1.1.1. Encourage quality and productivity~~

~~v.1.1.1.1. Be Clear and understandable to all parties~~

b.2.4.1. Base compensation shall be established based on an agreed upon percentage of the median compensation from one or more published compensation surveys, ~~adjusted for the physician's FTE status.~~

i.2.4.1.1. Base ~~Compensation~~ compensation is defined as compensation prior to inclusion of compensation related to benefits/benefits allowance, excess ED On-call services, or administrative medical services.

ii.2.4.1.2. FTE status shall be based on agreed number of days of work and/or hours of clinical availability, which may vary by specialty but which shall be consistent within each specialty.

iii.2.4.1.3. The ~~survey to be utilized~~ preferred source for establishing base compensation shall be the three-year average of the National median compensation published in the annual MGMA Physician Compensation and Production Surveys, adjusted to account for inflation since the publication date of the surveys, although other approaches to yield fair market value compensation may be substituted based on the circumstances of the negotiation.

~~iv. The Western Region median may be utilized.~~

~~v. Data shall be smoothed by utilizing a 3-year average of the median from the three most recently published surveys.~~

~~vi. In the event that, in management's professional opinion, the data from the MGMA survey in the Western Region is unreliable due to the low number of respondents or other factors, management may utilize the national median and/or data from other published surveys.~~

~~vii. Survey data shall be adjusted for inflation that has occurred since the data was collected.~~

~~viii. The percentage of median may be adjusted-established based on the physician's FTE status, historic productivity, years of experience, special expertise, or the difficulty of recruiting a particular specialty to the area. However:~~

~~a. In no case shall the percentage of median compensation paid as Base Compensation (before FTE adjustment) exceed 130% of the MGMA median.~~

~~b. Physician's Base Compensation may be adjusted once per year if: Physician's FTE status has changed or for market changes.~~

2.4.1.4. ~~Physician's prior year productivity has fallen below 90% of the prior year's target, and physician failed to reach this productivity level due to factors that are under the physician's control, such as leaving early or taking excessive time off. Determination of the reasons for any such failure shall be reviewed by a panel that includes the Executive Director of Physician services (or designee), the Medical Director of the Department, and at least one other physician.~~

2.4.2. A production-based bonus may be offered in addition to base compensation in order to encourage physician productivity.

2.4.2.1. Production shall be measured in WRVUs whenever possible.

2.4.2.2. A production target shall be established, and the production-based bonus shall be paid, only for production in excess of the established target.

2.4.2.3. A rate per unit of production shall be established as described above.

e-2.4.2.4. The preferred method for establishing the production target shall be dividing the rate per unit of production into the base compensation, provided however that the physician's cost of benefits and malpractice insurance may be considered in the calculation.

e-2.5. Malpractice insurance and benefits. The costs of malpractice insurance and benefits that are borne by the physicians shall be considered based on such reasonable methodology as may be developed by management, which may include but is not limited to:

2.5.1. ~~Adding the~~ Providing a fixed benefit allowance based on the estimated costs of malpractice insurance, health insurance, retirement benefits, employer-paid payroll taxes, and other benefits that are customarily paid by organizations with the ability to employ physicians.

i-2.5.2. Increasing the rate per WRVU or other unit of production on a percentage basis to account for such malpractice and benefit costs.

ii-2.5.3. Reducing the WRVU target by an amount that would enable physicians to earn all or a portion of those costs by reaching a production level that is commensurate with their compensation.

d-2.6. Quality Incentive. Physician contracts may include a ~~production and/or~~ quality incentive, ~~to encourage physicians to work to their full capacity,~~ provided:

i. ~~Productivity is measured in Work Relative Value Units (WRVUs), unless physician works in a specialty for which WRVU benchmark data is either unavailable or insufficient, in which case an alternate measure such as visits may be utilized.~~

ii. ~~The production incentive does not take into account the volume or value of anticipated or actual referrals of Tahoe Forest Hospital District OR IVCH facilities.~~

iii. ~~The production target is set based on the same survey benchmarks utilized for compensation, and is set at a level that is proportionate to base salary.~~

iv-2.6.1. Quality incentives, if any, are measurable and linked to factors that are within the physician's control.

v-2.6.2. The total projected compensation, including incentives, does not exceed fair market value.

~~3.1.1. Rate per Work Relative Value Unit (WRVU). Payment at a set rate per Work Relative Value Unit (WRVU) is an additional compensation method for multi-specialty clinic (MSC) physicians who are working full-time or less, and may also be utilized for other physicians when mutually agreed upon by the parties.~~

~~a.1.1.1. The rate per RVU shall be based on the same compensation and production survey data that is utilized for physicians working half-time or more, and may include an allowance for malpractice and benefits.~~

~~4. Percentage of professional fee collections. Payment based on a percentage of professional fees collected may be utilized for physicians in those instances where the District accepts responsibility for billing and collecting from the patient or any third party payer for professional services and is able to separately bill for professional service fees.~~

~~a. Remuneration based upon a percentage of combined facility and professional gross charges or collections is prohibited.~~

~~b. The District will remit the amounts collected, depending upon the agreement, to the physician, deducting a percentage to account for the estimated expenses of the District's billing and collection services and other administrative and support services, if provided.~~

~~c. If the payment to the healthcare provider is based upon billings rather than collections, a further percentage will be deducted so to account for the estimated incidents of bad debts and contractual allowances. Furthermore, if the payment to the healthcare provider is based upon billings rather than collections, a revenue collection analysis will be performed at least annually to ensure compliance to the above compensation provision.~~

~~d. All professional fee schedules shall be made a part of the agreement and appropriately referenced. Professional fee schedules may be revised annually. Any changes to the~~



~~professional fee schedule must be discussed between the District Chief Executive Officer and requesting physician prior to becoming effective. Requests shall conform to the following criteria:~~

- ~~i. Should provide sufficient detail to fully describe the professional services, relevant billing code numbers and professional fees;~~
- ~~ii. All professional fees shall be reasonable and customary and comparable to professional fees charged by their peers within our region. The mechanism for determining compliance to this criteria will be determined on a case by case basis between the professional provider and District Chief Executive Officer.~~
- ~~iii. Other relevant information should also be provided, e.g., changes required as a result of regulatory mandates; requests from individual physicians and Medical Staff; new service charges or extraordinary changes in provider costs not previously anticipated.~~
- ~~iv. Written agreement reflecting mutual acceptance of the proposed revisions as meeting the above criteria shall be required prior to the changes becoming effective.~~

~~5.2.7.~~ Payment per service. Payment at a specified rate per service is a permitted method for limited scope agreements in which the physician is providing clearly delineated clinical services. Examples include EKG interpretations, audiology reviews, and other services that are billed on a global basis by the hospital.

~~6.2.8.~~ Specialty call activation fee. In specialties where a regular on-call panel is either infeasible due to the number of physicians on the medical staff within that specialty or the low incidence of emergency need for that specialty, a specialty activation fee may be offered in the event that physician is called in to respond to an emergency.

~~7.2.9.~~ Fair Market Value. In all cases, physician's total compensation must be within fair market value and must be determined to be commercially reasonable.

~~a.2.9.1.~~ Fair market value for any individual contract shall generally be defined as an amount equal to or less than the 75th percentile of fair market value compensation, considering the physician's FTE status and production levels.

~~b.~~ However management shall endeavor to design a compensation model that maintains the average physician's compensation between the 40th and 60th percentiles, based on the [survey referenced in B.2.b.iii above MGMA Physician Compensation and Production Surveys.](#)

~~2.9.2.-~~

### ~~C.3.~~ Multiple ~~A~~greements

~~1.3.1.~~ Nothing in this policy shall prohibit TFHD from entering into multiple agreements with [physicians/health professionals](#); provided ~~however that~~ the designated hours/ ~~and~~ types of service are clearly segregated.

~~a.3.1.1.~~ Physicians whose professional duties under a PSA are ~~typically~~ during regular Monday through Friday daytime hours may ~~be paid~~ [have a separate agreement](#) for on-call coverage during evenings, weekends, and scheduled days off and/or for administrative duties performed during lunch or after regular clinic hours.

~~b.3.1.2.~~ Physicians working in a TFHD Practice Setting who provide hospitalist, on-call, or administrative services during normal scheduled clinic time shall receive WRVU credit in lieu of cash payment.

~~—~~ ~~The A~~ physician may perform administrative duties while on call, as long as clinical duties are not needed. If ~~the a~~ physician is needed for clinical duties, they may not bill administrative time when performing clinical duties.

~~3.1.3.~~

~~e.~~ Fair market valuations shall take into account the existence of multiple agreements with one contracting [professional/physician](#).

~~d.~~ ~~The multiple agreements of a contracting professional shall be referenced in each of the agreements with that contracting professional.~~

~~3.1.4.~~ -

#### D.4. Physician Qualifications

##### 1.4.1. Professional service agreements with physicians shall require:

4.1.1. A valid and unrestricted license to practice medicine in the state issued by the applicable state Medical Board;

a.4.1.2. Physician must achieve Board certification when eligible and/or maintain Board certification.

b.4.1.3. The ~~contracting~~ physician is not suspended or excluded from participating in any federal health program;

e.4.1.4. All appropriate certifications, registrations and approvals from the Federal Drug Enforcement Administration and any other applicable federal or state agency necessary to prescribe and dispense drugs under applicable federal and state laws and regulations, in each case without restriction;

d.4.1.5. Prompt disclosure of the commencement, resolution or ~~pending~~ pendency of any action, proceeding, investigation or disciplinary proceeding against or involving ~~Physician~~ physician, including, without limitation, any medical staff investigation or disciplinary action;

e.4.1.6. Prompt written notice of any threat, claim, or legal proceeding against TFHD ~~or IVCH~~ that ~~Physician~~ physician becomes aware of, and ~~cooperate~~ cooperation with TFHD in the defense of any such threat, claim, or proceeding and in enforcing the rights (including rights of contribution or indemnity) that TFHD may have against other parties or through its insurance policies;

f.4.1.7. No discrimination against a patient based on race, color, creed, religion, national origin, gender, sexual orientation, disability (including, without limitation, the condition(s) for which the patient seeks professional services from ~~Physician~~ physician), marital status, age, ability to pay or payment source, or any other unlawful basis.

##### 2.4.2. Physician Qualifications In Coordination With Medical Staff Bylaws:

a.4.2.1. Professional service agreements with physicians shall require their membership on the respective hospital's Medical Staff with appropriate privileges pertinent to the duties and responsibilities described by the professional service agreement.

b.4.2.2. Termination of the agreement will cause the physician to lose the contractual "right" to provide the services which are described in the agreement. However, this would not mean that the physician would lose ~~his~~ Medical Staff membership and privileges; he/she would simply lose the right to gain access to the service or department which is the subject of the exclusive agreement.

##### 3.4.3. Contract Termination Clause

a.4.3.1. In all cases, professional service agreements shall provide for a termination clause which allows for termination by either party without cause upon prior written notice.

b.4.3.2. The following language will be utilized:

i.4.3.2.1. "For cause" termination of a physician contract at any time during the term;

ii.4.3.2.2. "No cause" termination during the initial or subsequent term. In the event a "no cause" termination occurs during the first year of the agreement, the parties may not enter into a new agreement for substantially the same services until after the expiration of the initial one-year term of the agreement.

iii.—The time-frame for prior written notice may range from 60-180 days. Further, termination of the agreement does not afford the physician the right to request a medical staff hearing or any other review ~~pursuant to~~ under the Medical Staff By-Laws or rules and regulations, based on termination of the agreement.

4.3.2.3. -

#### E.5. Provisions For Health Professional Service Agreements

##### 1. ~~Compensation:~~

5.1. In all cases, the contract will specify the financial arrangements related to the provision of professional services. It is desirable that remuneration be based upon a set professional fee schedule

rather than a percentage of gross or net patient charges. However, it is recognized that a wide variety of other mechanisms may be utilized and such other mechanisms are left to the discretion of the ~~District Chief Executive Officer~~CEO and Board of Directors.

~~2-5.2.~~ Compensation for health professional service agreements shall not exceed fair market value of the services.

~~3-5.3.~~ Professional Fee Schedule

~~a-5.3.1.~~ When reimbursement is based upon professional fee schedules, ~~said-the~~ fee schedule ~~shall-will~~ be made a part of the agreement with the health professional. When provided for by agreement, professional fee schedule revisions will be considered once annually in a time-frame that coincides with the District's operating budget.

~~i-5.3.2.~~ Requests for revisions ~~must-should~~ be submitted to the ~~District Chief Executive Officer~~CEO by April of each year for implementation by July. The request should provide sufficient detail to fully describe the professional services, relevant code numbers and professional fees requested. The ~~District Chief Executive Officer~~CEO ~~will-determines~~ whether the acceptability of the proposed changes are acceptable.

~~4-5.4.~~ Health Professional Qualifications in Coordination with Medical Staff By-Laws:

~~a-5.4.1.~~ Professional service agreements may require certain health professionals to be members of the District's allied health professional staff with appropriate privileges pertinent to the duties and responsibilities described by the professional service agreement.

~~b-5.4.2.~~ Should a health services agreement be cancelled involving an allied health professional, termination of the agreement will cause the health professional to lose the contractual "right" to provide the services which are described in the agreement. However, this would not mean that the health professional would lose ~~his~~-allied health professional appointment or related privileges.

~~5-5.5.~~ Contract Termination Clause

~~a-5.5.1.~~ In all cases, professional service agreements shall provide for a termination clause which allows for termination by either party without cause upon written notice.

~~5.5.2.~~ The timeframe for prior written notice may range from 60-180 days. When the health professional is required to be an allied health professional, termination of the agreement will not afford the allied health professional the right to request ~~the-a~~ due process hearing ~~described by theunder any~~ Medical Staff ~~bylaw, rule,s and-or~~ regulations for allied health professionals, based on termination of the agreement.

~~b.~~ In all cases, professional service agreements will provide for termination "for cause" at any time during the contract term.

~~5.5.3.~~ -

~~F-6.~~ Physician and Health Professional Service Agreement Contract and Service Review

~~1.~~ Contract Review

~~a.~~ Prior to the end of a contract period, the Chief Executive Officer, or designee, may choose to conduct a contract review or at any time during the contract period.

~~b.~~ The Board of Directors can recommend that a contract review be done prior to most contract renewals but allows the CEO discretion to fore-go the review if the contract renewal is on an annual basis or if other factors indicate that the review is not necessary prior to that particular contract renewal.

~~c.~~ At a minimum of every five years, the Chief Executive Officer or CEO's designee will conduct a service review of the contract service provided by the physician, physician group and/or other professional service. The Chief Executive Officer will undertake the service review and a report based upon this service review will be made to the Board of Directors.

~~A.~~ Contract Review Elements

~~1.~~ Analyze the continuing need for the services covered by the contract.

~~2.~~ Ensure that the terms of the contract are being met as outlined in the service agreement.

~~3.~~ Review the service as it related to consistency with the District's compliance program.

~~4.~~ Assessment of patient, physician and staff opinions/input/complaints.

~~B.~~ Service Review Elements

- ~~1. As part of the service review, the Chief Executive Officer will request feedback from the medical and clinical staff regarding the following:~~
- ~~a. Quality of care being provided based on the specialty's identified standards of care.~~
- ~~b. Availability and responsiveness.~~
- ~~c. Consistency with the District's compliance program.~~
- ~~d. Patient, physician and staff opinions/inputs/complaints~~

~~C. Other Review Elements~~

~~In addition the Chief Executive Officer will:~~

- ~~1. Ensure that the terms of the contract are being met as outlined in the service agreement.~~
- ~~2. Review market conditions with appropriate benchmarking and response to changes in the marketplace, and make recommendations as to the continuation of the current contract.~~
- ~~3. Seek a fair market valuation via written opinion of an experienced professional valuation expert, for any agreement, for the same specialty/scope of services, where the previous valuation was completed more than two years prior to the anticipated renewal date.~~
- ~~4. Document the community need for the physician or other healthcare professional services provided under the agreement.~~
- ~~5. Document how the agreement furthers specific strategic, business or operational goals of the District, increases integration of services, avoids costs/reduces expenses that would otherwise be incurred by the District, or furthers needed research and development within the District.~~
- ~~6. Evaluate the use of less expensive alternatives.~~
- ~~7. Ensure that the fee schedule is appropriate for current market conditions.~~
- ~~8. Take in to consideration elements of the contractor's relationships with service providers, the District and the community.~~
- ~~9. Review standards and best practice recommendations set by professional and specialty organizations with appropriate consideration of our community and Hospital District.~~

~~D. The Chief Executive Officer will compile a report based upon the service review and present it to the Board of Directors with recommendations related to continuation of the contract or consideration of a Request For Proposal (RFP) process.~~

~~6.1. -~~

General Contract Inclusion Terms:

A.7. General Provisions: Physician and Health Professional Service Agreements

~~1.7.1. Professional Service Duties and Responsibilities: Each agreement will include a detailed and specific delineation of the duties and responsibilities to be performed by the health professional as well as the District. For example, extensive detail will be provided regarding:~~

~~a.7.1.1. Diagnostic and therapeutic services to be provided~~

~~b.7.1.2. Medico-administrative services to be provided~~

~~c.7.1.3. Coverage obligations to be assumed~~

~~d.7.1.4. The rights and obligations of the District and the health professional with regard to providing space, equipment, supplies, personnel and technicians.~~

~~2.7.2. Standards Of Practice: Each agreement shall specify that the health professional will provide the service in accordance with the Hospital Bylaws; Medical Staff Bylaws, Rules and Regulations, and if applicable, standards established by the Executive Committee of the Medical Staff; with the~~

~~ethical and professional standards of the American Medical Association and the California and/or Nevada Medical Association; the standards of the Healthcare Facilities Accreditation Program (HFAP) and in any applicable specialty college or society or governmental regulation.~~

- ~~3-7.3.~~ 3-7.3. Medicare and Medicaid Enrollment: Each agreement shall specify that the health professional is duly enrolled in the federal Medicare program and the applicable State Medicaid program (unless excepted by the District) and eligible to seek reimbursement under such programs for covered services rendered by the provider to beneficiaries of such programs. Every agreement must contain a provision in which the health professional agrees to notify ~~TFHS-TFHD~~ in the event participation terminates.
- ~~4-7.4.~~ 4-7.4. Quality Assessment: Professional service agreements shall require the health professional to participate in the Health System's Quality Improvement Program to ensure that the quality, safety and appropriateness of healthcare services are monitored and evaluated and that appropriate actions based on findings are taken to promote quality patient care. Furthermore, each agreement shall specify a process designed to assure that all individuals who provide patient care services under service agreements, but who are not subject to the Medical Staff privilege delineation process, are competent to provide such services. Whenever possible, information from customer satisfaction surveys shall be incorporated into the Quality Improvement Program for ~~said-the~~ service. Agreements which provide for Directorship responsibilities over a department or service shall require the health professional "Director" to be responsible for implementing a monitoring and evaluation process designed to improve patient care outcomes and which is integrated with the Health System Quality Improvement Program.
- ~~5-7.5.~~ 5-7.5. Assignability: It is desirable that all professional service agreements be non-assignable unless important to the successful negotiation of a contract where higher priority objectives may be achieved. Where assignability becomes necessary, assignability shall be allowed only with the condition that prior written consent of the ~~Board of Directors District~~ be obtained.
- ~~6-7.6.~~ 6-7.6. Contract Term: Professional service agreements shall specify ~~an effective date that is later than all requirements, including credentialing, being met. specific term and termination date (i.e., not automatically renewable for successive years).~~ In considering the term of the agreement, the termination date of related agreements should be considered by the ~~District Chief Executive Officer CEO~~ so as to minimize the likelihood of multiple agreements coming due on the same date or year. The length of the term shall be negotiable. Professional service contracts will typically range from one to four years in duration.
- ~~7-7.7.~~ 7-7.7. Professional Liability: In all cases, the health professional will be responsible for providing adequate professional liability insurance coverage at the health professional's expense. Limits of coverage for physicians will be a minimum of \$1,000,000 per occurrence, \$3,000,000 aggregate. For non-physicians, the minimum limits of coverage may vary depending on the standard established for that health profession ~~in consultation with the District's risk manager~~. The agreement shall also specify that the contracting health professional will, in turn, either require or arrange for professional liability insurance coverage for all sub-contracting health professionals. Furthermore, the professional liability insurance policy must be obtained from a professional liability insurer which is authorized to transact the business of insurance in the State of California (or Nevada in the case of professional services provided at the District's ~~Community Hospital in Incline Village, Nevada-based facilities~~). Also, the professional services agreement must require that the selected insurer will be responsible for notifying the District of any cancellation or reduction in coverage within thirty days of ~~said-such~~ action.
- ~~8-7.8.~~ 8-7.8. Regulatory Compliance: The agreement should include provisions in which both the District and the health professional commit to full compliance with all federal, state, and local laws. The contracting party should agree to keep confidential any financial, operating, proprietary, or business information relating to the District and to keep confidential, and to take the usual precautions to prevent the unauthorized use and disclosure of any and all Protected Health Information. The agreement should include provisions for amendment to the agreement in furtherance of maintaining compliance in the event of the adoption of subsequent legislation and/or regulations.
- ~~9-7.9.~~ 9-7.9. Recitals: Exclusive professional service agreements should include a carefully developed

description of the rationales for exclusivity in a particular clinical service or department. Furthermore, if the agreement does assign exclusive responsibility for a particular service, it should state so expressly not leaving this to inference or interpretation.

- ~~10~~7.10. Professional Relationships: The agreement should specify that the health professional is an independent contractor and is not an employee of the District.
- ~~11~~7.11. Government Audit: The agreement should include the standard provision recognizing that the agreement and certain other materials will be subject to audit and inspection by certain federal authorities with regard to payments made for Medicare services.
- ~~12~~7.12. Standard Contractual Language: The agreement should include certain standard provisions to the effect that the provisions of the contract are severable and, therefore, the ruling that any one of them is void does not invalidate the entire agreement, and that the waiver of breach of one provision does not constitute a continuing waiver, and that the written agreement constitutes the entire contract between the parties.
- ~~13~~7.13. Managed Care: The physician or health professional agrees to participate as a preferred provider with all of the managed healthcare plans (PPOs and HMOs) that the District has agreements with including agreements with insurance companies, health maintenance organizations and direct contracting with self-funded employers. Any deviation of this policy must be approved by ~~District Administration~~the CEO and the Board of Directors.

Related Policies/Forms:  
Contracts Routing Form, Model  
Agreements

References:

Policy Owner: Clerk of the Board

Approved by: Chief Executive  
Officer

## EXHIBIT A

No.	Contract Title	Last Date Modified
1	Call_Coverage_Agreement_Template_Individual_2015 (version dated 8/11/14 does not have Master List provision)	3/30/2015
2	Call_Coverage_Agreement_Template_Medical_Group_2015	4/16/2015
3	Confidentiality_Nondisclosure_Agreement_2015	3/25/2015

4	EKG_Letter_Agreement_Template_2014	10/29/2014
5	Non-Physician_Consultant_Agreement_Template_2014	9/25/2014
6	Hospitalist_Services_Agreement_Template_2014 <b>(Template has Master List provision Paragraph 2.4)</b>	<b>8/13/2014</b>
	Interim_Physician_Designee_Contract_2014	
7	<b>Version dated 02/23/2015 for Dr. Standteiner does not have Master List provision; add after 12. Governing Law)</b>	10/30/2014
	Medical_Director_Agreement_Individual_2014	
8	<b>(Dr. Tirdel's Med Dir of ICU &amp; RT version on 2/23/15 has paragraph 11.3)</b>	<b>8/13/2014</b>
9	Medical_Director_Agreement_Medical_Group_2015	6/26/2015
	MSC_PSA_Template_2014	
10	<b>(Template has Master List provision Paragraph 2.5)</b>	8/13/2014
11	Retention_Agreement_Template_2015	4/23/2015
	Recruitment_Agreement_Template_Co-obligors_2015	
12	<b>(No Master List provision; add to VII Miscellaneous)</b>	<b>2/20/2015</b>
	Recruitment_Agreement_Template_Physician-obligor_2015	
13	<b>(No Master List provision; add to VII Miscellaneous)</b>	<b>2/20/2015</b>
14	Rural_Prime_Site_Preceptor_Template_2015	4/30/2015
15	TF2020_Agreement_for_Medical_Advisor_Services_2015	4/3/2015

This list was last updated on July 29, 2015. It should be noted that some of the templates listed above have been sourced from recent agreements which have been reviewed and approved by outside counsel. It should also be noted that the templates listed above may require further review by outside counsel prior to implementation by TFHD staff due to the individualized nature of each agreement, and to ensure that the provisions of each agreement have been updated to reflect recent changes in law.

## **PURPOSE:**

This policy provides Tahoe Forest Hospital District's Chief Executive Officer ("CEO") a framework for professional services contracting to ensure the professional service provider meets the needs of Tahoe Forest Hospital District ("TFHD" or "District") and the communities that it serves.

## **POLICY:**

Written professional service agreements will be prepared for all health professionals who qualify as independent contractors and provide diagnostic or therapeutic services to TFHD's patients or provide certain medico-administrative duties within a hospital department or service.

The following health professionals are covered by this policy:

- Anesthesiologists
- Medical Directors
- Medical Staff officers
- Physicians providing services in the District's Multi-Specialty Clinics, Cancer Center or other professional practice settings operated by TFHD (collectively, "TFHD Practice Settings").
- Physicians serving in medical-administrative roles or on District committees
- Nuclear Medicine specialists
- Emergency Services physicians
- Occupational therapists
- Pathologists
- Physical therapists
- Radiologists
- Speech pathologists
- Emergency and urgent care providers
- Mid-level practitioners not employed by the District
- Hospitalists
- Other contracted health or medical service providers

## **PROCEDURES:**

1. All professional service agreements will be developed between the CEO, or the CEO's designee, and the health professional.
  - 1.1. Health professionals are not permitted to provide professional services until an agreement has been approved by the District prior to the agreement effective date. Signatures will be obtained prior to the agreement effective date or in accordance with current Stark Law. Agreements containing amendments to the terms and conditions of the agreement must also be executed prior to the effective date and prior to the provision of professional services under the amended agreement.
  - 1.2. New and renewal agreements shall utilize the template agreement for the type of service required from the contracting professional (See Exhibit A, attached, for a list of available model agreements.)
  - 1.3. All agreements shall be reviewed by the Compliance Department. Agreements not utilizing the template agreement shall also be reviewed by legal counsel.
    - 1.3.1. Agreements committing \$400,000.00 or more in any twelve-month period:
      - 1.3.1.1. Once agreement is reached between the CEO and health professional, CEO will present the provider-signed professional services agreement to the Board of Directors with the Contract Routing Form (or equivalent data summary report) with principal terms and conditions for their consideration. Principal terms and conditions include, but are not limited to, justification, term, compensation, scope of duties, total cost of contract, and other pertinent information, as applicable.



- 1.3.1.2. Upon review and consideration, the Board of Directors may request specific changes be made to the proposed terms and conditions or direct a designated Board committee to review and make a recommendation to the Board of Directors.
  - 1.3.1.3. Board approval of a professional services agreement constitutes direction to CEO to execute the professional service agreement.
  - 1.3.2. Agreements committing less than \$400,000 in any twelve-month period may be authorized by the CEO without Board approval when funds have been appropriated in the District's operating budget for the fiscal year.
  - 1.4. Professional service agreements due for renewal may be held over for up to twelve months with no change in terms at the discretion of the CEO and in accordance with the Stark Law and applicable regulations. Note: Stark Law regulations currently permit unlimited holdover of physician professional service agreements when the contract stays within the Fair Market Value.
  - 1.5. Urgent Services: At the discretion of the CEO, a professional service agreement required for urgent services may be executed if a Special Meeting of the Board of Directors is not feasible.
2. Compensation under Professional Service Agreements (PSA) With Physicians Only
    - 2.1. New and renewal agreement will specify the financial arrangements related to the provision of physician professional services.
      - 2.1.1. In no case shall compensation to physicians take into account the volume or value of anticipated or actual referrals physicians make to TFHD. TFHD shall endeavor to maintain a flexible approach with physicians within a specialty and among various specialties or TFHD Practice Setting, irrespective of referrals to TFHD generated by an individual physician or the type of specialty or the TFHD Practice Setting.
      - 2.1.2. Management shall strive to create a model that is aligned with the following organizational goals, recognizing that simultaneous achievement of all goals may not be possible in all cases; however the first of these goals (paying within fair market value) cannot be compromised in any circumstance.
        - 2.1.2.1. Pay within constraints of fair market value
        - 2.1.2.2. Maintain internal equity within and between specialties
        - 2.1.2.3. Provide sufficient compensation to recruit and retain physicians
        - 2.1.2.4. Encourage quality and productivity
      - 2.1.3. Be clear and understandable to all parties
 

The methodologies in this section 2 may be utilized to determine compensation with physicians.
    - 2.2. Hourly rates. Hourly rates are the preferred compensation method for administrative duties such as medical directorships, preceptor, medical staff leadership positions, or committee attendance, and may also be used when clinical and administrative duties are combined. Hourly rates or "per shift" rates with hours of coverage and response time specified are the preferred compensation method for on-call and hospitalist coverage.
      - 2.2.1. Physicians shall be required to document and attest to the date, hours worked or shifts covered.
      - 2.2.2. In addition, a description of work completed or meetings attended will be provided for all administrative duties.
    - 2.3. Rate per unit of production. The Work Relative Value Unit (WRVU) is the preferred measure of physician productivity and should be used as the unit of production whenever feasible. Payment at a set rate per WRVU is the preferred compensation method for physicians providing professional medical services under a professional service agreement in a TFHD Practice Setting, and may also be utilized for other physicians when mutually agreed upon by the parties.
      - 2.3.1. The preferred source for establishing the rate per WRVU shall be a three-year average of the national median ratio of compensation to WRVUs published in the MGMA Physician Compensation and Production Surveys, adjusted to account for inflation since the publication date of the surveys, although other approaches that yield fair market value compensation may be substituted based upon the circumstances of the negotiation.
      - 2.3.2. An alternate measure of productivity such as visits may be used as deemed necessary

- by management.
- 2.4. Base compensation plus bonus. Payment of a fixed base compensation plus bonus is another acceptable compensation method for physicians who are providing professional medical services, half time or more, under a PSA in a TFHD Practice Setting. This methodology may be utilized for newly recruited physicians during the start-up phase (generally a year), for physicians in specialties where community demand is insufficient to support a full-time practice, or in other situations in which such method is needed for physician retention.
- 2.4.1. Base compensation shall be established based on an agreed upon percentage of the median compensation from one or more published compensation surveys.
- 2.4.1.1. Base compensation is defined as compensation prior to inclusion of compensation related to benefits/benefits allowance, excess ED On-call services, or administrative medical services.
- 2.4.1.2. FTE status shall be based on agreed number of days of work and/or hours of clinical availability, which may vary by specialty but which shall be consistent within each specialty.
- 2.4.1.3. The preferred source for establishing base compensation shall be the three-year average of the national median compensation published in the MGMA Physician Compensation and Production Surveys, adjusted to account for inflation since the publication date of the surveys, although other approaches to yield fair market value compensation may be substituted based on the circumstances of the negotiation.
- 2.4.1.4. The percentage of median may be established based on the physician's FTE status, historic productivity, years of experience, special expertise, or the difficulty of recruiting a particular specialty to the area.
- 2.4.2. A production-based bonus may be offered in addition to base compensation to encourage physician productivity.
- 2.4.2.1. Production shall be measured in WRVUs whenever possible.
- 2.4.2.2. A production target shall be established, and the production-based bonus shall be paid, only for production in excess of the established target.
- 2.4.2.3. A rate per unit of production shall be established as described above.
- 2.4.2.4. The preferred method for establishing the production target shall be dividing the rate per unit of production into the base compensation, provided however that the physician's cost of benefits and malpractice insurance may be considered in the calculation.
- 2.5. Malpractice insurance and benefits. The costs of malpractice insurance and benefits that are borne by the physicians shall be considered based on such reasonable methodology as may be developed by management, which may include but is not limited to:
- 2.5.1. Providing a fixed benefit allowance based on the estimated costs of malpractice insurance, health insurance, retirement benefits, employer-paid payroll taxes, and other benefits that are customarily paid by organizations with the ability to employ physicians.
- 2.5.2. Increasing the rate per WRVU or other unit of production on a percentage basis to account for such malpractice and benefit costs.
- 2.5.3. Reducing the WRVU target by an amount that would enable physicians to earn all or a portion of those costs by reaching a production level that is commensurate with their compensation.
- 2.6. Quality Incentive. Physician contracts may include a quality incentive, provided:
- 2.6.1. Quality incentives, if any, are measurable and linked to factors that are within the physician's control.
- 2.6.2. The total projected compensation, including incentives, does not exceed fair market value.
- 2.7. Payment per service. Payment at a specified rate per service is a permitted method for limited scope agreements in which the physician is providing clearly delineated clinical services. Examples include EKG interpretations, audiology reviews, and other services that are billed on a global basis by the hospital.
- 2.8. Specialty call activation fee. In specialties where a regular on-call panel is either infeasible due to

the number of physicians on the medical staff within that specialty or the low incidence of emergency need for that specialty, a specialty activation fee may be offered in the event that physician is called in to respond to an emergency.

2.9. Fair Market Value. In all cases, physician's total compensation must be within fair market value and must be determined to be commercially reasonable.

2.9.1. Fair market value for any individual contract shall generally be defined as an amount equal to or less than the 75th percentile of fair market value compensation, considering the physician's FTE status and production levels.

2.9.2. However management shall endeavor to design a compensation model that maintains the average physician's compensation between the 40th and 60th percentiles, based on the MGMA Physician Compensation and Production Surveys.

### 3. Multiple Agreements

3.1. Nothing in this policy shall prohibit TFHD from entering into multiple agreements with health professionals, provided the designated hours and types of service are clearly segregated.

3.1.1. Physicians whose professional duties under a PSA are during regular Monday through Friday daytime hours may have a separate agreement for on-call coverage during evenings, weekends, and scheduled days off and/or for administrative duties performed during lunch or after regular clinic hours.

3.1.2. Physicians working in a TFHD Practice Setting who provide hospitalist, on-call, or administrative services during normal scheduled clinic time shall receive WRVU credit in lieu of cash payment.

3.1.3. A physician may perform administrative duties while on call, as long as clinical duties are not needed. If a physician is needed for clinical duties, they may not bill administrative time when performing clinical duties.

3.1.4. Fair market valuations shall take into account the existence of multiple agreements with one contracting physician.

### 4. Physician Qualifications

4.1. Professional service agreements with physicians shall require:

4.1.1. A valid and unrestricted license to practice medicine in the state issued by the applicable state Medical Board;

4.1.2. Physician must achieve Board certification when eligible and/or maintain Board certification.

4.1.3. The physician is not suspended or excluded from participating in any federal health program;

4.1.4. All appropriate certifications, registrations and approvals from the Federal Drug Enforcement Administration and any other applicable federal or state agency necessary to prescribe and dispense drugs under applicable federal and state laws and regulations, in each case without restriction;

4.1.5. Prompt disclosure of the commencement, resolution or pendency of any action, proceeding, investigation or disciplinary proceeding against or involving physician, including, without limitation, any medical staff investigation or disciplinary action;

4.1.6. Prompt written notice of any threat, claim, or legal proceeding against TFHD that physician becomes aware of, and cooperation with TFHD in the defense of any such threat, claim, or proceeding and in enforcing the rights (including rights of contribution or indemnity) that TFHD may have against other parties or through its insurance policies;

4.1.7. No discrimination against a patient based on race, color, creed, religion, national origin, gender, sexual orientation, disability (including, without limitation, the condition(s) for which the patient seeks professional services from physician), marital status, age, ability to pay or payment source, or any other unlawful basis.

4.2. Physician Qualifications In Coordination With Medical Staff Bylaws:

4.2.1. Professional service agreements with physicians shall require their membership on

the respective hospital's Medical Staff with appropriate privileges pertinent to the duties and responsibilities described by the professional service agreement.

4.2.2. Termination of the agreement will cause the physician to lose the contractual "right" to provide the services which are described in the agreement. However, this would not mean that the physician would lose Medical Staff membership and privileges; he/she would simply lose the right to gain access to the service or department which is the subject of the exclusive agreement.

#### 4.3. Contract Termination Clause

4.3.1. In all cases, professional service agreements shall provide for a termination clause which allows for termination by either party without cause upon prior written notice.

4.3.2. The following language will be utilized:

4.3.2.1. "For cause" termination of a physician contract at any time during the term;

4.3.2.2. "No cause" termination during the initial or subsequent term. In the event a "no cause" termination occurs during the first year of the agreement, the parties may not enter into a new agreement for substantially the same services until after the expiration of the initial one-year term of the agreement.

4.3.2.3. The time-frame for prior written notice may range from 60-180 days. Further, termination of the agreement does not afford the physician the right to request a medical staff hearing or any other review under the Medical Staff By-Laws or rules and regulations, based on termination of the agreement.

### 5. Provisions For Health Professional Service Agreements

5.1. In all cases, the contract will specify the financial arrangements related to the provision of professional services. It is desirable that remuneration be based upon a set professional fee schedule rather than a percentage of gross or net patient charges. However, it is recognized that a wide variety of other mechanisms may be utilized and such other mechanisms are left to the discretion of the CEO and Board of Directors.

5.2. Compensation for health professional service agreements shall not exceed fair market value of the services.

#### 5.3. Professional Fee Schedule

5.3.1. When reimbursement is based upon professional fee schedules, the fee schedule will be made a part of the agreement with the health professional. When provided for by agreement, professional fee schedule revisions will be considered once annually in a time-frame that coincides with the District's operating budget.

5.3.2. Requests for revisions should be submitted to the CEO by April of each year for implementation by July. The request should provide sufficient detail to fully describe the professional services, relevant code numbers and professional fees requested. The CEO determines whether the proposed changes are acceptable.

#### 5.4. Health Professional Qualifications in Coordination with Medical Staff By-Laws:

5.4.1. Professional service agreements may require certain health professionals to be members of the District's allied health professional staff with appropriate privileges pertinent to the duties and responsibilities described by the professional service agreement.

5.4.2. Should a health services agreement be cancelled involving an allied health professional, termination of the agreement will cause the health professional to lose the contractual "right" to provide the services which are described in the agreement. However, this would not mean that the health professional would lose allied health professional appointment or related privileges.

#### 5.5. Contract Termination Clause

5.5.1. In all cases, professional service agreements shall provide for a termination clause which allows for termination by either party without cause upon written notice.

5.5.2. The timeframe for prior written notice may range from 60-180 days. When the health professional is required to be an allied health professional, termination of the agreement will not afford the allied health professional the right to request a due process hearing under any Medical

Staff bylaw, rule, or regulation for allied health professionals, based on termination of the agreement.

5.5.3. In all cases, professional service agreements will provide for termination “for cause” at any time during the contract term.

6. Physician and Health Professional Service Agreement Contract and Service Review

6.1. At a minimum of every five years, the CEO or CEO’s designee will conduct a service review of the contract service provided by the physician, physician group and/or other professional service.

7. General Contract Inclusion Terms: Physician and Health Professional Service Agreements

7.1. Professional Service Duties and Responsibilities: Each agreement will include a detailed and specific delineation of the duties and responsibilities to be performed by the health professional as well as the District. For example, extensive detail will be provided regarding:

7.1.1. Diagnostic and therapeutic services to be provided

7.1.2. Medico-administrative services to be provided

7.1.3. Coverage obligations to be assumed

7.1.4. The rights and obligations of the District and the health professional with regard to providing space, equipment, supplies, personnel and technicians.

7.2. Standards of Practice: Each agreement shall specify that the health professional will provide the service in accordance with the Hospital Bylaws; Medical Staff Bylaws, Rules and Regulations, and if applicable, standards established by the Executive Committee of the Medical Staff;

7.3. Medicare and Medicaid Enrollment: Each agreement shall specify that the health professional is duly enrolled in the federal Medicare program and the applicable State Medicaid program (unless excepted by the District) and eligible to seek reimbursement under such programs for covered services rendered by the provider to beneficiaries of such programs. Every agreement must contain a provision in which the health professional agrees to notify TFHD in the event participation terminates.

7.4. Quality Assessment: Professional service agreements shall require the health professional to participate in the Health System Quality Improvement Program to ensure that the quality, safety and appropriateness of healthcare services are monitored and evaluated and that appropriate actions based on findings are taken to promote quality patient care. Furthermore, each agreement shall specify a process designed to assure that all individuals who provide patient care services under service agreements, but who are not subject to the Medical Staff privilege delineation process, are competent to provide such services. Whenever possible, information from customer satisfaction surveys shall be incorporated into the Quality Improvement Program for the service. Agreements which provide for Directorship responsibilities over a department or service shall require the health professional "Director" to be responsible for implementing a monitoring and evaluation process designed to improve patient care outcomes and which is integrated with the Health System Quality Improvement Program.

7.5. Assignability: It is desirable that all professional service agreements be non-assignable unless important to the successful negotiation of a contract where higher priority objectives may be achieved. Where assignability becomes necessary, assignability shall be allowed only with the condition that prior written consent of the District be obtained.

7.6. Contract Term: Professional service agreements shall specify an effective date that is later than all requirements, including credentialing, being met. In considering the term of the agreement, the termination date of related agreements should be considered by the CEO so as to minimize the likelihood of multiple agreements coming due on the same date or year. The length of the term shall be negotiable. Professional service contracts will typically range from one to four years in duration.

7.7. Professional Liability: In all cases, the health professional will be responsible for providing adequate professional liability insurance coverage at the health professional's expense. Limits of coverage for physicians will be a minimum of \$1,000,000 per occurrence, \$3,000,000 aggregate. For non-physicians, the minimum limits of coverage may vary depending on the standard established for that health profession in consultation with the District's risk manager. The agreement shall also specify

that the contracting health professional will, in turn, either require or arrange for professional liability insurance coverage for all sub-contracting health professionals. Furthermore, the professional liability insurance policy must be obtained from a professional liability insurer which is authorized to transact the business of insurance in the State of California (or Nevada in the case of professional services provided at the District's Nevada-based facilities). Also, the professional services agreement must require that the selected insurer will be responsible for notifying the District of any cancellation or reduction in coverage within thirty days of such action.

- 7.8. Regulatory Compliance: The agreement should include provisions in which both the District and the health professional commit to full compliance with all federal, state, and local laws. The contracting party should agree to keep confidential any financial, operating, proprietary, or business information relating to the District and to keep confidential, and to take the usual precautions to prevent the unauthorized use and disclosure of any and all Protected Health Information. The agreement should include provisions for amendment to the agreement in furtherance of maintaining compliance in the event of the adoption of subsequent legislation and/or regulations.
- 7.9. Recitals: Exclusive professional service agreements should include a carefully developed description of the rationales for exclusivity in a particular clinical service or department. Furthermore, if the agreement does assign exclusive responsibility for a particular service, it should state so expressly not leaving this to inference or interpretation.
- 7.10. Professional Relationships: The agreement should specify that the health professional is an independent contractor and is not an employee of the District.
- 7.11. Government Audit: The agreement should include the standard provision recognizing that the agreement and certain other materials will be subject to audit and inspection by certain federal authorities with regard to payments made for Medicare services.
- 7.12. Standard Contractual Language: The agreement should include certain standard provisions to the effect that the provisions of the contract are severable and, therefore, the ruling that any one of them is void does not invalidate the entire agreement, and that the waiver of breach of one provision does not constitute a continuing waiver, and that the written agreement constitutes the entire contract between the parties.
- 7.13. Managed Care: The physician or health professional agrees to participate as a preferred provider with all of the managed healthcare plans (PPOs and HMOs) that the District has agreements with including agreements with insurance companies, health maintenance organizations and direct contracting with self-funded employers. Any deviation of this policy must be approved by the CEO and the Board of Directors.

Related Policies/Forms:  
Contracts Routing Form, Model  
Agreements

References:

Policy Owner: Clerk of the Board

Approved by: Chief Executive  
Officer

## **EXHIBIT A**

No.	Contract Title	Last Date Modified
1	Call_Coverage_Agreement_Template_Individual_2015 <b>(version dated 8/11/14 does not have Master List provision)</b>	<b>3/30/2015</b>
2	Call_Coverage_Agreement_Template_Medical_Group_2015	4/16/2015
3	Confidentiality_Nondisclosure_Agreement_2015	3/25/2015
4	EKG_Letter_Agreement_Template_2014	10/29/2014
5	Non-Physician_Consultant_Agreement_Template_2014	9/25/2014
6	Hospitalist_Services_Agreement_Template_2014 <b>(Template has Master List provision Paragraph 2.4)</b>	<b>8/13/2014</b>
7	Interim_Physician_Designee_Contract_2014 <b>Version dated 02/23/2015 for Dr. Standteiner does not have Master List provision; add after 12. Governing Law)</b>	10/30/2014
8	Medical_Director_Agreement_Individual_2014 <b>(Dr. Tirdel's Med Dir of ICU &amp; RT version on 2/23/15 has paragraph 11.3)</b>	<b>8/13/2014</b>
9	Medical_Director_Agreement_Medical_Group_2015	6/26/2015
10	MSC_PSA_Template_2014 <b>(Template has Master List provision Paragraph 2.5)</b>	8/13/2014
11	Retention_Agreement_Template_2015	4/23/2015
12	Recruitment_Agreement_Template_Co-obligors_2015 <b>(No Master List provision; add to VII Miscellaneous)</b>	<b>2/20/2015</b>
13	Recruitment_Agreement_Template_Physician-obligor_2015 <b>(No Master List provision; add to VII Miscellaneous)</b>	<b>2/20/2015</b>
14	Rural_Prime_Site_Preceptor_Template_2015	4/30/2015

This list was last updated on July 29, 2015. It should be noted that some of the templates listed above have been sourced from recent agreements which have been reviewed and approved by outside counsel. It should also be noted that the templates listed above may require further review by outside counsel prior to implementation by TFHD staff due to the individualized nature of each agreement, and to ensure that the provisions of each agreement have been updated to reflect recent changes in law.



## Rochefort, Martina

---

**From:** Dale Chamblin <dalechamblin@gmail.com>  
**Sent:** Thursday, April 27, 2017 7:45 PM  
**To:** Rochefort, Martina  
**Cc:** Chamblin, Dale  
**Subject:** governance

**Follow Up Flag:** Follow up  
**Flag Status:** Flagged

**WARNING: This email originated outside of Tahoe Forest Hospital District.  
DO NOT CLICK links or attachment unless you recognize the sender and know the content is safe.**

Martina,

Please forward this information to the governance committee:

During the last Finance Committee meeting, Greg Jellinek and I discussed with staff the need for our committee to meet on a regular monthly basis. We considered such options as continuing to meet monthly, reducing the meeting frequency to quarterly or meeting only on an ad hoc basis. It was the consensus that while other committees may review material that could be best presented only once at a full board meeting, avoiding redundancy, the Finance Committee often digs more deeply into subjects that are not regularly reviewed at a full board level. Moreover, questions raised at the Finance Committee can be researched by staff prior to the following board meeting in keeping with our "no surprises" policy.

While we believe there opportunities to reduce the time spent at Finance meetings, we continue to believe that regular monthly meetings are in the best interest of the TFHD.

Dale

Date: May 27, 2017

To: Martina Rochefort  
Governance Committee

From: Alyce Wong, Chair of the Personnel Committee

Subject: For review of Board committees

The Personnel Committee met on May 16 with an agenda topic that was the Review of the Purpose, structure and function of the committee and the Retirement Plan Subcommittee.

In a second attachment, a crosswalk between the Bylaws for the Personnel-Retirement Committee and the Charter of the committee with content that can be eliminating because of conflict in documents or not domain of the committee.

The following information is being sent to the Governance Committee for its consideration when reviewing the Board Committees as outlined in the Bylaws.

1. In Bylaws for the Personnel Committee, clarification on intent of the statements
  3. b Chief Executive Officer/Board of Director Liaison.
  4. Memorandum of Understanding with District Bargaining Units
2. The Retirement subcommittee can function without the presence of the Board members. It could be a HR committee that submits a regular report to the Personnel Committee on the TFHD Money Purchase Pension Plan and the TFHD Deferred Compensation Plan.
3. Elimination of 4.a "Establish and administer the district's Investment Policy Statement." If it is referring to policy ABD 15, it is not investments that the Retirement Subcommittee oversees.

The Personnel Committee will draft its charter if that is the consensus of the Board.

Please contact me if there are any questions.

**Board Personnel Committee  
(Board Bylaws Page 11)**

D. Personnel committee

1. The Committee shall comprise two (2) Board Members appointed by the Board President
2. The committee shall meet as needed
3. The committee shall have following responsibilities pursuant to the policies of the Board of Directors:
  - a. Chief Executive Officer Relations
    1. Employment Agreement
    2. Performance Evaluation
    3. Incentive Compensation Program
  - b. Chief Executive Officer/Board of Directors Liaison Clarification needed
4. Memorandum of Understanding with District Bargaining Units Clarification needed

E. Retirement Plan Committee As HR committee it can be eliminated from bylaws

1. The Committee is a subcommittee of the Personnel Committee Make HR committee reporting regularly to the Personnel committee
2. The Committee shall comprise ~~the two (2) Board Members of the Personnel Committee appointed by the Board President,~~ Chief Executive Officer or his designee, CFO and Chief Human Resources Officer
3. The committee shall meet as needed
4. The Committee shall have the following responsibilities:
  - a. Establish and administer the District's Investment Policy Statement.
  - b. Provide administrative oversight for the Tahoe Forest Hospital District Money Purchase Pension Plan and the Tahoe Forest Hospital District Deferred Compensation Plan.

**Personnel Committee Charter  
(G\Admin\BOD\Committees)**

**A. Purpose**

The principal purpose of this committee is to make recommendations to the Hospital board of Trustees related to executive compensation and performance, evaluation, review of the Tahoe Forest Hospital district meeting its goals to be the best place to work and practice, and review of contracting for physician and professional services.

**B. Responsibilities**

1. Chief Executive Officer Relations
  - a. Recruitment and selection of the CEO
  - b. Review and approval of a senior executive development plan and CEO succession plan
  - c. Review and approval of incentive expectations for the CEO
  - d. Review of the CEO's compensation package
2. Foundation of Excellence – People-Best Place to work and Practice
  - a. Review Employee and Physician satisfaction survey results, targets and improvement plans
  - b. Represent the Board on matters regarding employees' Memoranda of Understanding
  - c. Review and approve employee benefits and compensation philosophy Is there a philosophy?
3. Physician and Professional Service Contracts
  - a. Review contracts for Physicians and Professional Services
  - b. Review and oversight of Services Reviews for Physician and Professional Services

All actions taken by the Personnel Committee shall be recorded in minutes and reported at

| this is part of the charter the next meeting of the Board of Directors for affirmation

#### Personnel Committee (cont'd)

##### **C. Composition**

The committee shall consist Of two independent Board Members appointed by the Board President. The CEO and the Director of Human Resources are members of this committee. The CEO will not be present when his or her compensation is discussed except to hear the results of the committee's evaluation of the CEO.

##### **D. Procedures**

The Personnel Committee shall meet as needed

# GOVERNANCE COMMITTEE

## DRAFT MINUTES

Wednesday, September 14, 2016 at 8:00 a.m.  
Tahoe Conference Room - Tahoe Forest Hospital  
10054 Pine Avenue, Truckee, CA 96161

### 1. CALL TO ORDER

Meeting called to order at 8:00 a.m.

### 2. ROLL CALL

Board: Greg Jellinek, M.D., Acting Chair; Chuck Zipkin, M.D., Board Member

Staff: Harry Weis, Chief Executive Officer; Judy Newland, Chief Operations Officer; Ted Owens, Executive Director of Governance and Business Development; Stephanie Hanson, Compliance Officer; Gayle McAmis, MSC; Martina Rochefort, Clerk of the Board

### 3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

No changes were made to the agenda.

### 4. INPUT – AUDIENCE

No public comment was received.

### 5. CLOSED SESSION

Discussion was held on a privileged matter.

### 6. APPROVAL OF MINUTES OF: 07/20/2016

Director Zipkin moved approval of the Governance Committee Minutes of July 20, 2016, seconded by Director Jellinek.

### 7. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

#### 7.1. Contracts

##### 7.1.1. Robert Mancuso, M.D. – Professional Services Agreement

Dr. Mancuso is moving from a locum tenens position to a permanent role in the Multi-Specialty Clinics.

The agreement is for a three year term. It is a fixed amount for first year and then based on production for the following two years.

Director Jellinek asked about malpractice insurance in the contract. The physician receives a specific amount they can use towards their liability insurance, medical benefits, payroll taxes, retirement plan contribution, etc. This is still 1099 income for the physician.

Director Zipkin inquired about other contracts having Emergency Department call provisions but this contract does not.

Otorhinolaryngology is not an Emergency Medical Treatment and Labor Act (EMTALA) required specialty. Compliance noted the physician does receive a specialty activation fee if he was called into the hospital.

COO added that one physician practices are not expected to be on call every day. It is not required nationally or by EMTALA.

Dr. Chase had never provided an on-call schedule but would take calls if available.

The expectation is that the physician would use their best efforts to be available.

Director Jellinek commented he had recently spent time with Dr. Mancuso and he would like to do facial traumas, etc in the future.

Jim Hook of The Fox Group added there is a Stark Law exception that allows rural hospitals to provide liability coverage specifically for obstetricians. Physicians can use their benefit allowance towards coverage.

#### **7.1.2. David Kitts, M.D. – Professional Services Agreement**

The ED coverage agreement with Dr. Kitts is being enhanced from to include work in the clinic office on a part time basis.

This expanded coverage offers the opportunity for vascular and thoracic procedures to be performed.

No questions were received from committee members.

#### **7.1.3. Ephraim Dickinson, M.D. – Professional Services Agreement**

Dr. Dickinson is an Orthopedic Surgeon coming from the Bay Area.

This is a two year agreement. The first year of the agreement is for part time work. Year two and beyond are based on production.

CEO commented the physician wanted to be employed by the District.

Contracts Coordinator noted it is stated in the contract the physician can transfer employment to the Friendly PC when it is operable.

#### **7.1.4. Kevin Cahill, M.D. – Professional Services Agreement**

The agreement for Dr. Cahill allows additional flexibility for the District to utilize him beyond just ER call coverage. This will transition Dr. Cahill to more clinic time.

He would eventually like to become full time.

### **7.2. Policies**

#### **7.2.1. Professional Courtesy Policy**

Committee reviewed the Professional Courtesy Policy as presented.

Tahoe Forest Hospital recently had 2 measles patients. Physicians and staff were exposed to these patients and there was no information about their immunizations.

A Medical Staff policy will be created to establish physician immunization history at time of credentialing.

The policy offers a professional courtesy discount to Medical Staff and Allied Health Professionals for MMR, Varicella, Tdap, Hep B, influenza and TB screenings. One exception to the policy is those who are eligible for Medicare.

The policy is a Stark Law exception and must be approved by the Board of Directors. This will be classified as a board policy.

CEO stated he wanted to have one standard across the entire team for immunizations.

Director Zipkin asked about the verbiage of item C under the Policy section. The immunizations in E1 of the Definitions section will be provided at no cost.

Jim Hook of The Fox Group noted the policy is a bit of a mash up of two different Stark Law exceptions. The second exception is a 100% discount for the MMR, Varicella and Tdap immunizations.

**8. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS**

No discussion was held on this item.

**9. NEXT MEETING DATE**

The next Governance Committee meeting is scheduled for October 19, 2016 at 8:00 a.m.

**10. ADJOURN**

**Meeting adjourned at 8:28 a.m.**

# GOVERNANCE COMMITTEE

## DRAFT MINUTES

Wednesday, February 15, 2017 at 9:00 a.m.  
Tahoe Conference Room - Tahoe Forest Hospital  
10054 Pine Avenue, Truckee, CA 96161

### 1. CALL TO ORDER

Meeting called to order at 9:03 a.m.

### 2. ROLL CALL

Board: Greg Jellinek, M.D., Chair; Randy Hill, Board Member

Staff: Harry Weis, Chief Executive Officer; Judy Newland, Chief Operations Officer; Ted Owens, Executive Director of Governance and Business Development; Tammi Allowitz, Contracts Coordinator; Gayle McAmis, Director of Finance TFHCS; Scott Baker, Executive Director of Physician Services; Sarah Jackson, Executive Assistant; Crystal Betts, Chief Financial Officer; Carl Blumberg, Risk Management; David Ruderman, General Counsel (phone); Jim Hook, Compliance, The Fox Group (phone); Stephanie Hanson, Compliance Analyst (phone);

### 3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

No changes were made to the agenda.

### 4. INPUT – AUDIENCE

No public comment was received.

### 5. CLOSED SESSION

Discussion was held on a privileged matter.

**Open Session reconvened at 9:45am.**

### 6. APPROVAL OF MINUTES OF: 11/16/2016

Director Jellinek moved approval of the Governance Committee Minutes of November 16, 2016, seconded by Director Hill.

### 7. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

#### 7.1. Corporate Compliance Program Annual Report

Mr. Hook reviewed the Open Session 2016 Corporate Compliance Program Annual Report.

Item 6.2 should read “The 2016 Corporate Compliance Work Plan were completed in 2016.”

#### 7.2. Corporate Compliance Work Plan

Mr. Hook reviewed the requirements to have a Corporate Compliance Work Plan. The Work Plan contains 7 mandatory elements which are listed in the 2017 TFHS Work Plan.

The Work Plan elements may change year to year based on guidance and requirements of the Office of Inspector General (OIG). The OIG plan generally comes out in November of the prior year for the



future year's requirements.

### **7.3. Contracts**

#### **7.3.1. Jacob Blake, M.D. – Professional Services Agreement**

The PSA is a standard approved PSA template with the addition of a California permit for Fluoroscopy.

**Director Hill moved to recommend the acceptance of Dr. Blake's PSA as presented, seconded by Director Jellinek.**

#### **7.3.2. UC Davis Health System Cancer Center Network Participation and License Agreement**

This a renewal of an annual contract that includes an increase of \$100,000 to the contract. The amendment includes services that were previously paid through other contracts, so the net increase would be approximately \$50,000.

Administration and Dr. Heifetz are in support of this contract as amended, although the increase is not budgeted in this fiscal year.

**Director Jellinek moved to recommend the acceptance of the UC Davis contract as presented, seconded by Director Hill.**

### **7.4. Policies**

#### **7.4.1. ABD-03 Board of Directors Compensation and Reimbursement Policy**

Director Hill reviewed and requested clarification on ABD-03 Policy Section C and Procedure Section E. Wording "following election or appointment" is confusing and contradictory.

Policy will be reviewed and a draft policy will be brought to a future Governance Committee Meeting for approval.

*David Ruderman, General Counsel, departed the meeting by phone.*

### **8. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS**

No discussion was held on this item.

### **9. NEXT MEETING DATE**

The next Governance Committee meeting is tentatively scheduled for March 14, 2017 at 8:00 a.m.

### **10. ADJOURN**

**Meeting adjourned at 10:24 a.m.**