TAHOE FOREST HOSPITAL DISTRICT

2016-07-20 Board Governance Committee

Wednesday, July 20, 2016 at 8:00 a.m.

Tahoe Conference Room - Tahoe Forest Hospital

10054 Pine Avenue, Truckee, CA 96161

Meeting Book - 2016-07-20 Board Governance Committee

7/20/16 Goverance Committee

TAHOE FOREST HOSPITAL DISTRICT

GOVERNANCE COMMITTEE AGENDA

Wednesday, July 20, 2016 at 8:00 a.m.
Tahoe Conference Room - Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER

2. ROLL CALL
Greg Jellinek, M.D., Acting Chair; Dale Chamblin, Board Member

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. Conference with Legal Counsel; Anticipated Litigation
(Gov. Code § 54956.9(d)(2) & (d)(3))
A point has been reached where, in the opinion of the District Board, on the advice of its legal counsel, based on the below-described existing facts and circumstances, there is a significant exposure to litigation against the District.

Facts and circumstances that might result in litigation but which the District believes are not yet known to potential plaintiff or plaintiffs.
(Gov. Code § 54956.9(e)(1))

5.2. Approval of Closed Session Minutes: 06/15/2016

6. APPROVAL OF MINUTES OF: 06/15/2016

7. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

7.1. Contracts
New, amended, and auto renewed contracts are submitted to the Governance Committee for review and consideration for recommendation of approval by the Board of Directors.

- **7.1.1. Gina Barta, M.D. – Hospitalist Services Agreement** ..... ATTACHMENT
- **7.1.2. Richard Ganong, M.D. – Hospitalist Services Agreement** ..... ATTACHMENT
- **7.1.3. Reini Jensen, M.D. – Hospitalist Services Agreement** ..... ATTACHMENT
- **7.1.4. Paul Krause, M.D. – Hospitalist Services Agreement** ..... ATTACHMENT

7.1.5. David Kitts, M.D. – Fourth Amendment to Agreement to Provide Emergency Department Professional Services ……ATTACHMENT

7.2. Policies

7.2.1. ABD-21 Physician and Professional Service Agreements..... ATTACHMENT

Committee will discuss revisions for ABD-21 Physician and Professional Service Agreements policy.

7.3. Memorandum Regarding Rates for District Residents and Non-Residents..... ATTACHMENT

8. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

9. NEXT MEETING DATE

The next Governance Committee meeting is scheduled for August 17, 2016 at 8:00 a.m.

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.

TAHOE FOREST HOSPITAL DISTRICT

GOVERNANCE COMMITTEE
DRAFT MINUTES

Wednesday, June 15, 2016 at 8:00 a.m.
Tahoe Conference Room - Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER
Meeting was called to order at 8:06 a.m.

2. ROLL CALL
Board: John Mohun, Chair; Greg Jellinek, M.D., Board Member

Staff: Harry Weis, CEO; Judy Newland, COO; Ted Owens, Director of Governance and Community Relations; Stephanie Hanson, Compliance Analyst; Gayle McAmis, MSC; Tammi Allowitz, Contracts Coordinator; Tom Wright, Interim Director of Multi-Specialty Clinics; Martina Rochefort, Clerk of the Board

Other: Jon di Cristina, acting General Counsel

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA
Item 7.2.1. will be moved up to accommodate Counsel's schedule.

4. INPUT – AUDIENCE
No public comment was received.

5. CLOSED SESSION
5.1. Approval of Closed Session Minutes: 04/20/2016
Discussion was held on a privileged matter.

6. APPROVAL OF MINUTES OF: 05/18/2016
Director Mohun approved the Governance Committee minutes of May 18, 2016, seconded by Director Jellinek.

7. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION
7.1. Contracts
7.1.1. John Foley, M.D. – Physician Professional Services Agreement
Dr. Foley will be returning to the District on a part time basis.

7.1.2. Christopher Arth, M.D. – Physician Professional Services Agreement
No discussion was held on this item.

7.1.3. Else Uglum, M.D. – Physician Professional Services Agreement
No discussion was held on this item.

7.1.4. Oleg Vayner, M.D. – Physician Professional Services Agreement
No discussion was held on this item.

7.1.5. Lisanne Burkholder, M.D. – Amendment to Professional Services Agreement for Multi-Specialty Clinics and Hospitalist Services

Dr. Burkholder requested the nine (9) holidays be called out in the amendment for clarity. This is being updated for her.

7.1.6. Joshua Scholnick, M.D. – Second Amendment to Professional Services Agreement for Multi-Specialty Clinics and Hospitalist Services

No discussion was held on this item.

7.1.7. Sierra MultiSpecialty Medical Group, Inc. – Second Amendment to Professional Services Agreement for Multi-Specialty Clinics and Hospitalist Services

No discussion was held on this item.

7.1.8. Greg Tirdel, M.D. – Second Amendment to Professional Services Agreement for Multi-Specialty Clinics and Hospitalist Services

Stephanie Hanson stated Dr. Tirdel's FMV report will be updated today.

7.1.9. Nina Winans, M.D. – Amendment to Professional Services Agreement for Multi-Specialty Clinics

No discussion was held on this item.

7.1.10. Stephen Forner, M.D. – Amendment to Professional Services Agreement for Multi-Specialty Clinics

No discussion was held on this item.

7.1.11. Ellen Cooper, M.D. – Amendment to Agreement to Provide Coverage of Emergency Department Professional Services

No discussion was held on this item.

7.1.12. Jeff Camp, M.D. – Second Amendment to Provide Coverage of Emergency Department Professional Services

After speaking with counsel on this agenda item, Director Mohun will recuse himself on this item for Governance Committee as well as the Board Meeting.

7.1.13. Silver State Hearing and Balance, Inc. – Amendment to Professional Services Agreement for Multi-Specialty Clinics

No discussion was held on this item.

7.2. Committee Education

7.2.1. Health & Safety Code § 32125(b)

Jon di Cristina joined the meeting at 8:16 a.m.

The District could create different customer classes but that does not say anything about creating cost

differentials.

Legal Counsel will prepare a version of document for the public.

Ted Owens inquired if second homeowners would be excluded from residency. Mr. di Cristina discussed that "residency" can have different meaning depending on the context.

Mr. di Cristina stated there would need to be a cost based nexus and there does not appear to be one based on the proportion of property taxes revenue to total District revenue.

Mr. di Cristina stated the memo by Hooper, Lundy and Bookman indicated a discount could not be offered to Medicare, Medi-Cal and Commercial Insurance patients.

CEO stated the uninsured get significant discounts as well as TFHD has financial assistance policies. CEO also respectfully suggested that residents are receiving a discount already as it relates to low cost hospitals.

Director Jellinek asked how outmigration is accounted for. CEO responded that outmigration has many reasons. For example, outmigration could occur for services the District does not provide.

CEO stated the budget presentation will show how the District's costs are lower on a macro and micro basis.

Jon di Cristina departed the meeting at 8:32 a.m.

CEO would like to bring the matter to educate the full board at the next meeting.
Director Jellinek commented the public will want to hear this matter.

CEO indicated that bringing down underinsured or uninsured visits will bring down costs. CEO provided an example of the State of Maryland who has solved this problem by applying for a federal and state waiver where there is no cost shifting.

8. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

None.

9. NEXT MEETING DATE

The next Governance Committee meeting is set for July 20, 2016 at 8:00 a.m.

10. ADJOURN

Meeting adjourned at 8:40 a.m.

7.1. Contracts

Contracts redacted.

Available for public viewing via a Public Records request.

	TahoeForest Health System				
	Title: Physician and Professional Service Agreements			**Policy/Procedure #:** ABD-21	
	Responsible Department: Board of Directors				
Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	
☒	Board	1/90	5/00; 01/12; 1/14	02/14; 07/15; 5/16; 06/16	
☐	Medical Staff				
☐	Departmental				
Applies to: ☒System ☐TahoeForestHospital ☐InclineVillageCommunityHospital					

PURPOSE:

This policy is intended to provide the District's Chief Executive Officer a general framework for professional services contracting and recognizes that flexibility may be required due to the broad scope of professional services that may be covered. Further, to insure that the professional service provider is meeting the needs of Tahoe Forest Hospital District and the community 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 Tahoe Forest Hospital District'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
- Physicians providing services in the District's Medical Services Clinics and Cancer Center
- Physicians serving in medical-administrative roles or on ~~hospital~~ 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 physicians

Procedures

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

1.1 Health professionals are not permitted to provide professional services under any professional services agreement until the agreement has been ~~fully signed and executed~~approved by the Board of Directors prior to the agreement effective date ~~by the parties~~. 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 amemded agreement.

Commented [A1]: Statute? Stephanie to reference.

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

1.2.1 All ~~new~~ agreements shall be reviewed by the Compliance Department. New agreements not utilizing the ~~model~~ template agreement for the type of service required shall be reviewed by the Compliance Department and legal counsel~~ prior to submission to the District's Board of Directors.~~

1.2.2 Agreements committing $25,000.00 or more in any given twelve-month period:

1.2.2.1 Once agreement is reached between the District's Chief Executive Officer and health professional, CEO will present 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, ~~purpose/need~~justification for the agreement, agreement term, compensation, scope of duties, ~~other similar agreements and differences with this agreement,~~ total cost of contract, and other pertinent information, as applicable, in 6.2-6.4 below.

1.2.2.2 All agreements and amendments completed at least five (5) days prior to the Governance Committee meeting will be reviewed by the Governance Committee.

1.2.2.3 Governance Committee will review agreements and make recommendations to the full Board of Directors.

~~1.2.2.1~~1.2.2.4 The District's Chief Executive Officer will place the agreement on the agenda of the District Board of Directors for their consideration.

~~1.2.2.2~~

~~1.2.2.3~~1.2.2.5 Upon their review and consideration, the Board of Directors may request specific changes be made to the proposed terms and conditions, and revised terms and conditions be submitted to the Board at its next scheduled or special meeting.

~~1.2.2.4~~1.2.2.6 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.

~~1.2.2.5~~ 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.

~~1.2.2.6~~1.2.2.7 The CEO will execute the agreement after approval by the Board of Directors.

~~1.2.2.7~~1.2.2.8 ~~The District's Chief Executive Officer will place the agreement on the agenda of the District Board of Directors for their consideration.~~

~~1.2.2.8~~1.2.2.9 The professional service agreement will become effective following the Board of Directors' approval, subject to the contract term identified in the agreement.

~~1.2.2.9~~1.2.2.10 ~~The CEO will execute the agreement after approval by the Board of Directors.~~

1.2.3 New and renewal agreements committing less than $25,000 per twelve-month period can be authorized by the District's Chief Executive Officer without Board approval so long as funds have been authorized in the District's operating budget for that fiscal year.

~~1.3 Renewal agreements:~~

~~1.3.1 All renewing agreements shall utilize the model agreement for the type of service required from the contracting professional.~~

~~1.3.1.1 Agreements committing $25,000.00 or more in any given twelve-month period:~~

~~1.3.1.1.1 Once agreement is reached between the District's Chief Executive Officer and health professional, CEO will present the Contract Routing Form (or equivalent) with the principal terms and conditions listed, to the Board of Directors for their consideration. Principal terms and conditions include, but are not limited to, purpose/need for the agreement, agreement term, compensation, scope of duties, other similar agreements and differences with this agreement, total cost of contract, and other pertinent information.~~

~~1.3.1.1.2 Upon their review and consideration, the Board of Directors may request specific changes be made to the proposed terms and conditions, and revised terms and conditions be submitted to the Board at its next scheduled or special meeting.~~

~~1.3.1.1.3 After approval by the Board of Directors, the CEO will present the agreement to the contracting professional~~

~~for review and signature, indicating his or her acceptance of the included terms~~

~~1.3.1.1.4 In the event the contracting professional requests changes in the principal terms and conditions of the agreement, the CEO will present a modified Contract Routing Form (or equivaent) to the Board of Directors~~

~~1.3.1.1.5 The District's Chief Executive Officer will place the agreement on the agenda of the District Board of Directors for their consideration.~~

~~1.3.1.1.6 The professional service agreement will become effective following the Board of Directors' ratification, subject to the contract term identified in the agreement.~~

~~1.3.2 Renewal agreements committing less than $25,000 per twelve-month period can be authorized by the District's Chief Executive Officer without Board approval so long as funds have been authorized in the District's operating budget for that fiscal year.~~

~~1.4~~1.3 Physician and other 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 Stark Law and regulations. Note: the Stark regulations currently permit unlimited holdover of physician professional service agreements.

~~1.5~~1.4 Urgent Services:

Commented [A2]: Keep "urgent"?

~~1.5.1~~1.4.1 At the discretion of the CEO, an agreement required for urgent services may be presented directly to the Board of Directors.

~~1.5.1.1~~1.4.1.1 All terms and condition must be included at the time of presentation.

~~1.5.1.2~~1.4.1.2 The signature of the health professional will be required on such agreements at the time of presentation to the Board.

~~1.6~~1.5 All physician and professional service agreements will be processed by the Chief Executive Officer's administrative staff. The following guidelines will be utilized:

~~1.6.1~~1.5.1 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 timeframes for timely execution and implementation.

~~1.6.2~~1.5.2 Content and negotiations with health service professionals will remain the the responsibility of the Admin Council members.

2.0 Compensation under Professional Service Agreements With Physicians Only.

In all cases, agreement will specify the financial arrangements related to the provision of physician professional services. In no case shall compensation to physicians vary with the physician's referrals to TFHD. TFHD shall endevour to maintain a consistent approach with physicians within a specialty and among various specialties, irrespective of referrals to TFHD gererated, by an individual physician or the type of specialty. The following methodologies may be utilized:

2.1 Hourly rates. Hourly rates are the preferred compensation method for administrative duties such as medical directorships, medical staff leadership positions, or committee attendance. 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.

2.1.1 Physicians shall be required to document the date, hours spent, and a description of work completed for all administrative duties.

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

2.2 Base compensation plus bonus. Payment of a fixed base compensation plus bonus is the preferred compensation method for multi-specialty clinic (MSC) physicians who are working more than half time. A consistent model for the compensation of MSC physicians shall be utilized, which may be subject to modification annually.

2.2.1 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.

2.2.1.1 Pay within constraints of fair market value

2.2.1.2 Maintain internal equity within and between specialties

2.2.1.3 Provide sufficient compensation to recruit and retain physicians

2.2.1.4 Encourage quality and productivity

2.2.1.5 Be Clear and understandable to all parties

2.2.2 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.

2.2.2.1 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.

2.2.2.2 The survey to be utilized shall be the annual MGMA Physician Compensation and Production Survey.

2.2.2.3 The Western Region median may be utilized.

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

2.2.2.5 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.

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

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

2.2.2.7.1 In no case shall the percentage of median compensation paid as base compensation (before FTE adjustment) exceed 130% of the median.

2.2.2.7.2 Physician's base compensation may be adjusted once per year if:Physician's FTE status has changed.

2.2.2.7.3 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 (or designee), the Medical Director and at least one other physician.

2.2.3 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:

2.2.3.1 Adding 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.

2.2.3.2 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.

2.2.4 Physician contracts may include a production and/or quality incentive, to encourage physicians to work to their full capacity, provided:

2.2.4.1 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.

2.2.4.2 The production incentive is in no way tied to referrals or to use of Tahoe Forest Hospital facilities.

2.2.4.3 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.

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

2.2.4.5 The total projected compensation, including incentives, does not exceed fair market value.

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

2.3.1 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.

2.4 Percentage of professional fee collections. Payment based on a percentage of professional fees collected may be utilized for physicians who are not part of the MSC 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.

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

2.4.2 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.

2.4.3 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.

2.4.4 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:

2.4.4.1 Should provide sufficient detail to fully describe the professional services, relevant code numbers and professional fees;

2.4.4.2 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.

2.4.4.3 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.

2.4.4.4 Written agreement reflecting mutual acceptance of the proposed revisions as meeting the above criteria shall be required prior to the changes becoming effective.

2.5 Payment per service.Payment at a specified rate per service is the preferred 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.

2.6 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.

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

2.7.1 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.

2.7.2 However management shall endeavor to design a compensation model that maintains the average physician's compensation within +/- 10% of the median (or between the 40th and 60th percentiles) based on the survey referenced in 2.2.2.2 above.

3.0 Multiple agreements

3.1 Nothing in this policy shall prohibit the hospital from entering into multiple agreements with physicians; provided however that the designated hours of service are clearly segregated.

3.1.1 Physicians whose MSC duties are typically during regular Monday through Friday daytime hours may be paid 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 MSC physicians 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 The physician may perform administrative duties while on call, as long as clinical duties are not needed. If the physician is need for clinical duties, they mayt 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 professional.

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

4.0 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 The contracting professional is not suspended or excluded from participating in any federal health program;

4.1.3 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;

4.1.4 Prompt disclosure of the commencement or pendency of any action, proceeding, investigation or disciplinary proceeding against or involving Physician, including, without limitation, any medical staff investigation or disciplinary action;

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

4.1.6 No discrimination against a patient based on race, creed, national origin, gender, sexual orientation, disability (including, without limitation, the condition(s) for which the patient seeks professional services from Physician), ability to pay or payment source.

4.2 Physician Qualifications In Coordination With Medical Staff Bylaws:

4.2.1 Professional service agreements with physicians shall require their membership on the District'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 "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.

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 timeframe 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 the Medical Staff By-Laws.

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5.0 Provisions For Health Professional Service Agreements

5.1 Compensation:

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 Officerand 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, said fee schedule shall 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 timeframe that coincides with the District's operating budget.

5.3.1.1 Requests for revisions must be submitted to the District Chief Executive Officer 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 will determine the acceptability of the proposed changes.

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 "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 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 the due process hearing described by the Medical Staff rules and regulations for allied health professionals.

6.0 Physician and Health Professional Service Agreement Contract and Service Review

6.1 Contract Review

6.1.1 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.

6.1.2 The Board of Directors can recommend that a contract review be done prior to most contract renewals but allows the CEO discretion to forego 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.

At a minimum of every five years, the Chief Executive Officer 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.

6.2 Contract Review Elements

6.2.1 Analyze the continuing need for the services covered by the contract.
6.2.2 Ensure that the terms of the contract are being met as outlined in the service agreement.
6.2.3 Review the service as it related to consistency with the District's compliance program.
6.2.4 Assessment of patient, physician and staff opinions/input/complaints.

6.3 Service Review Elements

6.3.1 As part of the service review, the Chief Executive Officer will request feedback from the medical and clinical staff regarding the following:

6.3.1.1 Quality of care being provided based on the specialty's identified standards of care.
6.3.1.2 Availability and responsiveness.
6.3.1.3 Consistency with the District's compliance program.
6.3.1.4 Patient, physician and staff opinions/inputs/complaints

6.4 Other Review Elements: In addition the Chief Executive Officer will:

6.4.1 Ensure that the terms of the contract are being met as outlined in the service agreement.
6.4.2 Review market conditions with appropriate benchmarking and response to changes in the marketplace, and make recommendations as to the continuation of the current contract.

6.4.3 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.

6.4.4 Document the community need for the physician or other healthcare professional services provided under the agreement.

6.4.5 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.

6.4.6 Evaluate the use of less expensive alternatives.

6.4.7 Ensure that the fee schedule is appropriate for current market conditions.

6.4.8 Take in to consideration elements of the contractor's relationships with service providers, the District and the community.

6.4.9 Review standards and best practice recommendations set by professional and specialty organizations with appropriate consideration of our community and Hospital District.

6.5 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 (RPF) process.

Contract Inclusion terms:

7.0 General Provisions: 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 standards established by the Executive Committee of the Medical Staff; with the ethical and professional standardsof 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.

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 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 said 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 SystemQuality ImprovementProgram.

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 be obtained.

7.6 Contract Term: Professional service agreements shall specify a 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 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 $l,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. 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). 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 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 theeffect 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 District Administration 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 **(Template has Master List provision Paragraph 2.4)**	**8/13/2014**
7	Interim_Physician_Designee_Contract_2014 **Version dated 02/23/2015 for Dr. Standteiner does not have Master List provision; add after 12. Governing Law)**	10/30/2014
8	Medical_Director_Agreement_Individual_2014 **(Dr. Tirdel's Med Dir of ICU & RT version on 2/23/15 has paragraph 11.3)**	**8/13/2014**
9	Medical_Director_Agreement_Medical_Group_2015	6/26/2015
10	MSC_PSA_Template_2014 **(Template has Master List provision Paragraph 2.5)**	8/13/2014
11	Retention_Agreement_Template_2015	4/23/2015
12	Recruitment_Agreement_Template_Co-obligors_2015 **(No Master List provision; add to VII Miscellaneous)**	**2/20/2015**
13	Recruitment_Agreement_Template_Physician-obligor_2015 **(No Master List provision; add to VII Miscellaneous)**	**2/20/2015**
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.

TAHOE FOREST HOSPITAL DISTRICT

TAHOE FOREST HOSPITAL DISTRICT
OFFICE OF THE GENERAL COUNSEL
M E M O R A N D U M

TO:	Board of Directors Harry Weis, CEO
FROM:	David J. Ruderman, Asst. General Counsel Jon R. di Cristina, Asst. General Counsel
CC:	Michael G. Colantuono, General Counsel
DATE:	June 28, 2016
SUBJECT:	Rates for District Residents and Non Residents

We write to address whether Section 32125(b) of the Local Hospital District Law permits the Tahoe Forest Hospital District to charge discounted rates to its residents. Specifically, this memo focuses on state and federal constitutional requirements that govern Section 32125(b)'s application — we do not address additional requirements from federal statutes, programs such as Medicare and Medi-Cal, or the District's contractual obligations with commercial insurance companies.

In sum, we conclude it is difficult if not impossible to set rates that charge residents less than nonresidents in a way that is constitutional, as such rates must be based on real differences in the District's cost to serve residents versus nonresidents. The only such difference appears to be that some residents contribute property tax revenue to the District while, of course, the District does not receive such revenue from nonresidents. However, because property tax revenue accounts for a relatively small proportion of the District's overall revenue, and because not all residents pay property taxes, we do not recommend relying on this distinction to charge discounted rates to residents.

As relevant here, Section 32125(b) says the District "may establish different rates for residents of the district than for persons who do not reside within the district." This language has remained unchanged since it was adopted with the original Local Hospital District Law in the 1940s. It was immediately challenged as part of a lawsuit addressing various provisions of that law but, in 1946, the California Supreme Court held it was

"facially" valid — meaning that, hypothetically, the District could set rates that discriminate between residents and nonresidents in favor of residents.[1]

However, two factors lead us to conclude the District's authority under Section 32125(b) is less clear today than it was in 1946. First, most if not all applicable federal and state healthcare laws (for example, Medicare and Medi-Cal) post-date the original Local Hospital District Law, and those newer laws affect, restrict, or completely preempt the District's authority in various areas. As noted above, the details of these more recent laws are beyond the scope of this memo, but the important point here is that the law has not been static in the last 70 years, and thus it is not clear Section 32125(b) would be upheld again if challenged today.

Second, and more importantly, we must read an important caveat in Section 32125(b) based on principles in both the California and U.S. Constitutions, which govern statutes like the Local Hospital District Law.[2] Specifically, the District may charge residents less than nonresidents **only if there is a rational financial basis to do so**. Courts are very skeptical when agencies like the District charge different rates based only on where their customers live. There must be something more — there must be a nexus between different rates and the costs to serve different groups of customers.

Accordingly, if the District wishes to charge residents less than nonresidents, it must demonstrate that this differential treatment (1) covers a unique burden nonresidents place on the District's services, or (2) approximates tax revenue the District receives only from residents to provide benefits nonresidents also enjoy. We are aware of no unique burden on the District from nonresidents as such, but residents do support the District through their property taxes.

However, three issues arise if the District wishes to use property tax revenue to justify differential rates. First, property tax revenue constitutes a small proportion of the District's overall revenue. Second, while the District has flexibility in defining who a "resident" is under Section 32125(b), the benefit of a discount must go to persons who pay property taxes. But not everyone who lives in the District's service area is a property owner who pays property taxes, and because the District serves a resort community many property owners (i.e., property taxpayers) have their primary residence elsewhere. Third,

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[1] *Paso Robles War Memorial Hospital Dist. v. Negley* (1946) 29 Cal.2d 203, 207.

[2] These constitutional principles stem from the Privileges and Immunities Clause, the Commerce Clause, and the Equal Protection Clause.

under other federal and state healthcare laws, the District may not provide a discount to residents covered by Medicare, Medi-Cal, or commercial insurance.

In short, any discount the District provides under Section 32125(b) will be restricted as follows:

- It may only go to some residents.
- It must be based on a relatively small contribution to the District from property taxpayers who do not necessarily reside within the District.
- The residents who benefit from the discount may or may not be the same persons who pay property taxes to the District.

We do not see a court upholding such a discount as valid.

If you have any questions or concerns regarding the topics covered above, please let us know.