Trustee Services

PHYSICIAN Compensation: Managing the Risks

By Daniel M. Grauman

Hospitals and health systems generally employ more physicians than executives. At the same time it's likely that the board of directors spends far more time on compensation issues in the C-suite than on physician compensation and its associated regulatory and business risks. As physician employment grows, it's time to give physician compensation the attention it deserves.

Even when healthcare organizations aren't paying physicians on a full-time basis, total payments for physician compensation arrangements may be considerable (see box, "Follow the Money"). These compensation arrangements expose the organization to significant risk, but they also present an opportunity to align physician compensation with strategic goals.

This article reviews regulatory and business risks associated with payments to physicians by a hospital or health system, and lays out an approach to effectively manage those risks and align compensation with strategy.

Follow the Money

To understand a hospital's compensation patterns, and how much it is spending for physicians, consider potential expenses in each of the following categories:

- Fully employed primary care physicians
- Fully employed specialists
- Fully employed hospitalists
- Fully employed intensivists
- Medical directorships (generally part-time)
- Administrative, Supervisory and Training (AS&T) arrangements (generally part-time)
- On-call coverage arrangements
- Other contractual arrangements or part-time employment for specific clinical services
- Professional services arrangements in which physicians provide clinical interpretation services
- Space and equipment rentals

Regulatory Risk

While tax-exempt hospitals are not covered under the Sarbanes-Oxley Act, many of the practices required by the act are rapidly becoming standard governance practice in the hospital industry. Boards of directors are increasingly

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concerned with and paying attention to compensation-related issues.

Rule number one is: "All payments by a healthcare organization to physicians must be made at fair market value." This includes payments for clinical services, teaching and administration, physician rent payments and more. Boards should be aware of several key sets of regulations (and of regulators!)

They include:

- *IRS regulations* prohibit "private benefit" (aka inurement – where a transaction or exchange between a tax-exempt organization and one of its "insiders" furthers private interests rather than the public interest). To avoid inurement, a compensation arrangement must:
  - Be consistent with exempt purposes
  - Result from arm's-length bargaining
  - Result in "reasonable" compensation

Hospitals that pay more than fair market value for services can lose their tax-exempt status under IRS regulations. Tax-exempt status is based on the premise that an entity is using its assets for the public good. Modern Health Care Services, a Florida hospital, lost its tax-exempt status when the IRS concluded that it did not provide services in a charitable manner because it operated for the private, rather than public, interest. In this case, excessive spending by management for private benefit was the culprit. However, the ruling specifically identifies physician employees as potential recipients of these public assets.

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- *The Medicare and Medicaid Patient Protection Act of 1987* (the "Anti-Kickback Statute") makes it a crime to pay physicians in return for referrals or recommendations to purchase supplies and services. In 2002, a whistle-blower brought action against McLeod Regional Medical Center (Florence, S.C.) for purchasing practices and paying physicians well above fair market value to ensure strong referral relationships, in violation of Stark II and the Anti-Kickback Statute. The hospital agreed to pay more than $15 million and enter into a corporate integrity agreement with the Office of the Inspector General.

- The *physician self-referral law* (Stark, Stark II, and now Stark III) prohibits physicians from making referrals for certain "designated health services to an entity to which they have a financial relationship (ownership or compensation)" unless that relationship is at fair market value. In Barbera vs. Tenet Healthcare, North Ridge Medical Center (Ft. Lauderdale, Fla.) was accused of paying physicians above fair market value, allegedly in return for referrals. It cost Tenet Healthcare a whopping $22.5 million to resolve these violations. Subsequently, the in-house counsel at the time was brought to court for submitting false documents to the Department of Health and Human Services stating that Tenet had complied with the Physician Self-Referral Act.

Managing the Regulatory Risk

Managing regulatory risk requires careful analysis and benchmarking to ensure that all physician remuneration is at fair market value, plus rigorous documentation to show that this is the case. Benchmarking for all physician compensation arrangements must be performed on a regular and systematic basis (annually), as fair market value changes based on varying market conditions.

Several reference sources are available to help hospitals analyze and benchmark compensation levels. Compensation for certain subspecialists or for highly specialized clinical

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programs and services can be particularly challenging, and data may need to be developed or extrapolated from multiple sources. In these complex situations, it often helps to have the assistance of an objective third party in the benchmarking process.

Many part-time employment arrangements set compensation based on actual time spent by the physician and a fair market value hourly rate. Also, a hospital's healthcare legal counsel is an expert on these matters and can offer detailed information on fair market value regulations. For example, health attorneys generally advise that hospitals must ensure there is proper record-keeping (time sheets) to support physician payments.

Business Risk

Physician compensation systems should be designed to achieve specific goals for the hospital or health system, congruent with its overall philosophy and strategy. Business risk is, very simply, the risk that compensation models and systems either will not or cannot achieve those goals. Strategic business goals may include successfully serving specific populations, growing new clinical programs and services, and achieving specific financial results.

The hospital may believe that employed physicians, taken as a whole, need to be a "break-even enterprise." That is, the hospital or health system can't afford to, or believes it should not, subsidize physician income, so the physicians collectively need to bring in income that is at least equal to their compensation and related expenses of operating the practices.

Other hospitals and health systems take the view that employed physicians can help support and build clinical programs and services. That strategic perspective allows them to accept defined losses on the physician enterprise as long as the financial health of the hospital or health system overall is strong.

For hospitals serving low-income communities, employing physicians may be the only way for the hospital to achieve its mission, serve the community, and maintain economic viability.

Managing Business Risk: Alternative Compensation Models

To manage the business risks of physician compensation, the hospital or health system must design compensation models that will align physician incentives with hospital goals.

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In the late 1990s and into 2000, many hospitals and health systems lost a substantial amount of money on their hospital-owned practices, resulting in many divestitures. In most cases, physicians were paid too much, with little of their compensation at risk.

Over the years, several general compensation models have evolved, with some degree of overlap and each with numerous variations. The right model for a given situation will take into account the differing realities of hospital-based and community-based primary care, and of specialty care.

- **The Fixed Salary Model:** This model may be useful when trying to attract new physicians, particularly in a shortage situation, or where the aim is to entice a physician to locate in a strategically important spot for the hospital. Because there is no incentive to increase productivity or to control costs, this model can lead to decreased productivity and increased expenses. It is therefore not appropriate if the organization seeks a break-even physician enterprise.

- **Net Economic Contribution Model:** In this model, which can be applied individually or on a practice basis, the amount of compensation equals net revenues minus expenses. Losses and gains can be shared in a risk-sharing arrangement. From a strategic viewpoint, this model supports both goals relating to clinical activity (productivity) and to profitability (expense management).

The model poses certain practical problems, such as a difficulty in assessing the physician or practice

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"contribution." It also does not take into account the payer mix of a practice, which may be beyond physician control. This model does not address goals which may support the mission of a hospital or health system, such as caring for patients with Medicaid or no insurance at all.

❇ **Production Incentive At-Risk Salary Model:** Here, total compensation is targeted. A lower base salary is set while a bonus pool of 20-25% of total compensation is established. If a physician meets his or her productivity goals, then the physician receives a bonus. Productivity can be measured by visits, or more typically by RVUs ("relative value units," a standard measure of the relative value of various physician services).

This model provides a clear incentive for higher productivity, but may foster competition among physicians in a given practice or setting, rather than encouraging them to work toward common goals. Typically, this model does not account for mission objectives, payer mix, or expense management. It may be useful in a location with an unfavorable payer mix.

❇ **Multiple Incentive Model:** This model is appropriate in large, sophisticated hospitals and health systems that have the administrative systems and resources to measure and track multiple performance metrics. Again, base salaries are set at 75-80% of total targeted compensation, and bonuses are based on performance on indicators relating to productivity, expense management, patient satisfaction, quality measures, citizenship, etc. Weighting factors are typically used to determine the relative importance of each indicator.

Experience shows that multiple incentive models retain stability over time, and promote focus on broader objectives, not just productivity. Their downside is the greater time and resources required to monitor these models, and the risk of excessive complexity.

There are also public relations considerations regarding physician compensation. When payments to physicians become public knowledge, the hospital wants them to make sense to the public. Each year many local newspapers publish a list of the most highly compensated employees of a city's hospitals and medical centers. This list often includes many doctors, and the average reader thinks that the payments are absurd. Trying to defend figures based on formulas that are not intuitively obvious is a public relations nightmare.

If the hospital has done its homework on complying with regulations and dealing with strategic risk, it is likely to be in a much better position from a public relations viewpoint. The hospital will have the documentation it needs to respond in a calm and convincing way and a cohesive strategic framework from which to speak.

Questions Boards Should Ask

In the coming decade, it is likely that physician employment will be a growing concern to hospitals and health systems. By giving these issues the attention they deserve, a hospital board can provide physician compensation without putting itself in jeopardy, and achieve maximum benefit from its payments to physicians.

Therefore, boards ought to be asking these questions of their CEO, CMO, general counsel, and expert physician compensation consultants:

1. Is there a comprehensive list of all physician compensation arrangements?
2. Are there current contracts in place?
3. Are all payments at fair market value? What is the support for conclusions around fair market value?
4. For employed physicians, how were the compensation models designed, and what were the guiding principles?
5. Are financial results of employed practices consistent with the organization's philosophy and strategy?
6. How frequently are payment arrangement and compensation models reviewed and evaluated, from both the fair market value and business perspectives?