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Physician Compensation Requires Enhanced Board Oversight

As hospitals and physicians move toward closer alignment to deliver better, more accountable care and service to patients and other stakeholders, it is no surprise that board responsibility for overseeing physician compensation is increasing. Current trends in hospitals' acquiring physician practices, evolving compensation models and a changing legislative and regulatory landscape are just some issues that represent new terrain for governing boards.

Getting a firm grasp on this area of board responsibility will be critical to managing risk under new models of care delivery and payment and avoiding regulatory and compliance missteps. Physician compensation programs that are properly designed and structured also can support hospital-physician integration efforts and drive business success. Boards that understand the trends and requirements and effectively oversee physician compensation arrangements will play an important role in driving value in the current environment of reform.

GROWING INTEREST IN PHYSICIAN PAY

Many factors contribute to physician compensation's becoming a "bigger dot" on the governance radar screen. Payments to physicians are a substantial percentage of overall health care spending, second only to inpatient care. Recent data from the Sullivan Cotter and Associates' physician compensation and productivity survey also show notable increases from 2005 to 2010 in total cash compensation for some specialties: more than 20 percent for pediatrics and 15 percent for internal medicine. These trends have contributed to requirements for hospitals to disclose highly compensated physicians on their IRS 990 forms. Regulatory enforcement activities also have resulted in substantial financial settlements related to improper physician compensation arrangements.

Under current reform scenarios, hospital employment of physicians is expected to increase between 10 and 25 percent over the next five years. That means hospitals can expect to make substantial investments in acquiring physician practices to provide continuity of care in line with revamped reimbursement incentives. Hospitals that employ physicians should be planning for patient-focused, population-based care and risk sharing. They also should be developing the infrastructure to establish metrics on physician performance, including clinical outcomes, efficiency and patient satisfaction, to ensure they are prepared for changes to reimbursement and to demonstrate accountability for the agreed amount of compensation.

If properly structured and executed, employing physicians will result in a range of benefits for hospitals, including physician support of strategic clinical integration objectives. Physician employment also provides organizations with opportunities to design approaches to compensation and incentives that support emerging reimbursement structures, and to tailor these approaches to the specific needs of the organization and the culture of the medical staff.

There are several compelling reasons for physicians to want to be employed by hospitals: growing practice expenses; limited access to capital; regulatory compliance burdens; malpractice insurance expense; the time and cost to develop information systems; and ever-increasing practice management requirements. Also fueling this trend are declines in overall reimbursement and younger physicians who want a balanced lifestyle that does not include owning and operating their own practices.

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THE LONGER-TERM PICTURE

In the near term, hospital revenue from employed physicians is expected to increase; however, the longer-term picture is not as rosy. A 2008 Health Care Advisory Board survey on physician employment trends predicted the mean percentage of total hospital net revenue from employed physicians would increase from 16 to 35 percent between 2000 and 2012. However, declining medical school enrollment and an aging physician workforce mean there will be fewer physicians in the market over time. According to a report published by the Association of American Medical Colleges, it is projected that there will be a shortage of nearly 125,000 physicians by 2025. Data from the Medical Group Management Association also suggest that disparities are widening between total cash compensation to physicians and collections for personally provided physician services.

The physician labor market is highly competitive. This has led to a number of unique pay practices for physicians, including sign-on and retention bonuses. According to the Sullivan Cotter survey, 57 percent of health care organizations in 2010 provided sign-on bonuses to physicians they recruited, compared with 47 percent in 2008. Retention bonuses were used by 11 percent of health care organizations in 2010. From a regulatory perspective, such payments must be considered part of the total compensation package for determining the reasonableness and fair market value of the compensation paid for physician services. This means that board members must be familiar with and educated on all aspects of physician compensation arrangements.

Reform will increase these challenges. Hospitals likely will receive less reimbursement for each unit of care they provide as their costs continue to rise. The basis for reimbursement also will move away from volume of services delivered toward clinical outcomes, a shift for which many providers are still preparing.

While the majority of physician employers use productivity-based incentives for clinical services, SullivanCotter data from 2010 indicate that more than half are incorporating quality- and patient satisfaction-based incentives. Organizations also are exploring how to tie physician performance to key strategic objectives to ensure that physician behavior supports organizational priorities.

The legislative and regulatory climate are adding to the complexity of compliance. Enforcement actions are focusing on the ability to demonstrate that compensation arrangements are based on FMV and commercial reasonableness standards. For example, a number of recent settlements under the False Claims Act were based on physician compensation arrangement violations under the Stark law. The

Sample Guiding Principles for Physician Compensation

The physician compensation program is intended to support the achievement of the health system's mission and strategic goals and objectives. These goals will be achieved by attracting and retaining high-quality physicians. To support these efforts, the physician compensation program is designed to be responsive to variations in the market based on:

- specialty area
- position level
- supply and demand
- practice requirements
- practice environment
- service line

All employed physicians will have a base salary, which is intended to provide stable and predictable income levels. The base salary is for the provision of clinical services and participation on the health system's committees and in other key initiatives.

Base salaries will vary based on the physician's:

- specialty area
- position responsibilities (administrative, clinical and academic)
- performance
- skill set
- total cash compensation plan

Physicians may be eligible for incentive compensation. The incentive compensation plan will vary by service line and practice environment. However, all incentive plans are based on predetermined metrics consistent with the overall compensation being reasonable to the goals achieved. The incentive plans are designed to recognize and reward variance in physician:

- productivity for personally provided services
- predetermined quality metrics
- patient satisfaction

Physicians who meet employment criteria are eligible to participate in employee benefits programs. Physician-specific benefits consistent with market practices and supportive of the physician's practice may be offered.

The physician compensation program at the health system will comply with all state and federal regulatory requirements, including those related to reasonable and fair market value compensation.

Guidelines for ensuring fair market value have been developed and adopted by the health system's compensation committee.

The compensation program will be reviewed annually and, if appropriate, adjusted to ensure alignment with the health system's initiatives.

The health system's compensation committee will review and approve policies and provide oversight.

IMAGE FROM ISTOCKPHOTO

Stark, antikickback and tax-exempt laws all focus on FMV (including the Stark and antikickback safe harbors for employed physician arrangements). In addition, increasing numbers of whistleblowers are bringing potentially noncompliant hospital-physician arrangements to the government's attention.

Although waivers are under consideration to allow flexibility in developing new approaches to compensation for such delivery models as accountable care organizations, scrutiny remains high. The role of the board and its compensation committee, with an emphasis on the independence of both committee members and the hospital's compensation consultant, will play an important part in demonstrating the reasonableness of compensation. The use of quality-based incentives, payment for efficiency and shared savings, and other evolving methods will need to be examined carefully as the regulatory landscape evolves.

FAIR MARKET VALUE

To effectively oversee physician compensation arrangements, hospital boards need a thorough understanding of FMV and commercial reasonableness requirements.

Broadly, FMV refers to the value arrived at through arms-length transactions, consistent with general market value. In the health care context, a fair market price for services is generally based on bona fide, comparable service agreements, where the compensation has not taken into account the volume or value of anticipated or actual referrals by the referring physician.

Regulators have not provided firm guidance on what constitutes FMV. However, regulations implementing the Stark legislation have suggested that referring to "multiple, objective, independently published salary surveys" in determining FMV is a prudent practice. The American Medical Group Association, MGMA, Towers Watson, the Hay Group and Sullivan Cotter are among several organizations that provide commercially available survey data. In selecting which data to use, hospitals and boards should be aware that each survey represents different segments of the physician labor market, reports on varying elements of total compensation for physicians, and has its own inherent sampling bias.

Health care organizations are developing criteria for identifying which physician compensation arrangements require board-level review and approval. For example, some require board approval for all physician compensation arrangements exceeding a specified percentile of the market; others may use a dollar threshold. It is prudent for the board to review compensation levels for physicians in key leadership positions as well as all practice acquisitions.

One area with which boards may not be familiar is compensation arrangements for physician on-call payment. According to SullivanCotter, on-call pay represents an increasing and significant level of expense for health care organizations. On-call pay arrangements also can pose a regulatory compliance risk if they are not properly designed. The Office of Inspector General issued two helpful opinions on key variables that should be considered when reviewing on-call pay arrangements. Variables include the frequency of call, the likelihood of being called in, the payments received when called in and the total compensation for the services provided.

Hospitals and boards should understand that significant fines and penalties, including exclusion from participation in Medicare and Medicaid programs, can result if regulatory requirements are not met. A hospital also must consider the damage to its reputation and the cost of addressing investigations, prosecutions and resolution of noncompliance.

While FMV applies to the level of compensation for physician services, commercial reasonableness applies to broader business issues related to the arrangement. The following factors typically are taken into account in determining whether a compensation arrangement meets the commercial reasonableness standard.

- Services covered by the arrangement are essential to operating the organization or addressing unmet community need and are fully defined in a job description or similar document.
- There is a sound business reason or need to pay for the services, and they require performance by a licensed physician and, if applicable, a physician from a specific specialty.
- The number of physicians assigned to perform the services is appropriate.
- The physician is actually providing the designated services as indicated by documentation of work, time logs or records, and periodic performance reviews.

Boards should note that review and approval of factors in determining FMV and commercial reasonableness related to specific compensation arrangements by an entire disinterested board or committee is strong protection if the review is conducted in a manner that qualifies for the rebuttable presumption of reasonableness. For tax-exempt hospitals, there is rebuttable presumption of reasonableness if certain procedures are followed, which require board approval

Compensation Questions for Boards

1. Who has oversight of physician compensation?
2. What arrangements are covered by the oversight process?
3. What is our hospital's physician compensation philosophy?
4. Does compensation comply with fair market value and commercial reasonableness requirements?
5. How do we monitor or audit compliance with statutes, regulations and our philosophy?
6. How will physician compensation change in our organization?

of the compensation arrangement in advance, excluding anyone who has a conflict of interest, reliance on appropriate comparability data, and adequate and concurrent documentation of the decision. For more on this issue go to www.aha.org/aha/content/2008/pdf/08ExecCompPrimer.pdf.

WHAT BOARDS CAN DO

Boards can take a number of steps to ensure they are well-prepared to oversee physician pay arrangements.

1. **Continue education.** Use board meeting education sessions or time at a leadership retreat to update the board on physician compensation trends, the board's compliance responsibilities, and the structures and processes boards should have in place to avoid oversight pitfalls.

2. **Ensure proper oversight.** Consider establishing a committee of disinterested board members—that is, trustees free from bias or self-interest—to oversee physician compensation. In deciding whether to assign this responsibility to an existing committee, such as the executive or compensation committee, or to establish a new committee, boards should consider such factors as the volume of physician-compensation arrangements for review, trustee skill sets, potential conflicts of interest, and the level of external pressure on or scrutiny of committee activities.

3. **Develop processes and guiding documentation.** These can include a set of principles or a philosophy statement regarding physician compensation (see Sample Guiding Principles for Physician Compensation, page 16). Boards also can establish preapproved ranges or thresholds and parameters for defining reasonable compensation, and then review and approve deviations from these parameters on an individual basis. The review process should follow an established schedule, such as an annual review of physician leadership positions, a quarterly review of a set number of contracts and of periodic requests such as new hires or newly acquired practices, and an annual or biannual review of compensation arrangements for employed physicians.

4. **Determine which arrangements will be reviewed.** The board will need to review and approve an overall plan for compensation as well as develop policies for deciding which arrangements require review by a board committee. For example, a board might choose to review all department chair positions, any pay arrangement that exceeds a certain dollar threshold, all arrangements exceeding a percentile of the market, or compensation for any physician who has a family member in a key leadership position.

5. **Conduct a program audit.** At least annually, the board should ensure that the hospital reviews its physician compensation program and procedures to make sure they are consistent with its overall philosophy and guiding principles.

Questions boards should ask include: Does our organization conduct an FMV review of our physician compensation arrangements? Do we understand where we may be at risk? Risks include pay misaligned with productivity; lack of documentation to support the current position on compensation; lack of documented job duties for such positions as medical director; concurrent pay for clinical and administrative duties or on-call pay arrangements that could be construed as double payments for services; and failure to use multiple, commercially available labor-market surveys as sources for comparison data.

Boards should look for approaches that ensure that payment is consistent with productivity, quality and any other variables used to compensate physicians.

6. **Get engaged with transactions early.** The board committee responsible for physician compensation should be involved from the outset of a transaction to review key issues and risks and make sure the proposed arrangement is consistent with FMV and substantiated by an appropriate business case. The committee also should see that documentation is comprehensive enough to support regulatory and tax-exempt compliance.

7. **Test models that align hospital reimbursement for services with compensation.** Boards should look for approaches that ensure that payment is consistent with productivity, quality and any other variables used to compensate physicians.

8. **Update the board.** The full board should be informed about the compensation committee's agenda and actions and should be briefed on high-risk issues or unusual activity that could impact the organization.

Compensation Questions for Boards, page 17, lists several questions boards should ask to ensure a thorough understanding of physician compensation issues and oversight.

CONCLUSION

As hospitals and physicians align more closely under new models of care delivery, boards must expand their responsibility for overseeing compensation arrangements beyond review of hospital executive compensation to include physician compensation. Boards that know how to oversee these arrangements appropriately to ensure fair, market-based compensation that complies with legislative and regulatory requirements not only will help their organizations avoid risk, but also will support the level of hospital-physician integration that will drive success under health care reform. T

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