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HEALTHCARE MANAGEMENT ADVISORS

Beyond Benchmarks: Five Considerations in Structuring Physician Compensation Arrangements

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Healthcare system executives are well aware that physician employment agreements must be consistent with Stark and Anti-Kickback legislation requiring that they not pay more than fair market value (FMV) for any services provided or received. However, quantitative benchmarking is only part of the story. As regulatory scrutiny continues to increase, it is imperative that certain practical safeguards are put in place to ensure the agreement as a whole meets both FMV and commercial reasonableness standards, both quantitatively and qualitatively. Here are five important considerations:

1. COMMERCIAL REASONABLENESS

As evidenced by numerous recent settlements (as described further in "Recent Settlements Suggest Need for Greater Caution Around Physician Deals"), the concept of commercial reasonableness is at the forefront of regulators' minds. Not only must payments made to physicians for a particular service be made at FMV, but the service being provided must "make business sense" (be necessary and support the hospital or health system's mission) in the absence of referrals to the system. Regularly reviewing and assessing the applicability of a position can provide management with insight regarding the services that continue to generate a benefit for the organization. Without justification for the services being rendered, the FMV of the payment is a moot point.

2. DOCUMENTATION OF AS&T (OR HOURLY) POSITIONS

Hospitals and health systems often opt to compensate a physician at an hourly rate for administrative positions. This frequently occurs for part-time positions or when the responsibilities of the physician may change over the term of the agreement (for example, when starting a new department or service line). To conform to regulatory requirements,

it's important to complete an analysis that determines whether the hourly rate itself is consistent with FMV for the physician and position in question.

Once that is done, it's essential to make sure that the organization has safeguards in place to document actual effort spent per the contract requirement. Documentation protects both the hospital and the physician by providing a record of the tasks completed and the effort expended.

3. MAKING INCENTIVE THRESHOLDS REASONABLE

Incentive compensation (productivity-based, and now, often quality-based) is becoming an increasingly significant component of total physician compensation. With the changes in payment vehicles and the shift toward quality-based care, collections are more at risk than they were under fee-for-service. To achieve and maintain financial stability, healthcare entities are shifting some of the risk to employed physicians.

Given the changing landscape of the healthcare industry, physician compensation models will continue to evolve to incorporate value-based elements.

It's critical to select appropriate productivity and quality thresholds at which physicians will obtain incentive payments. If the thresholds are set too low, the compensation is often not truly at risk. If the thresholds are set too high, they are unlikely to ever be achieved. Finding an attainable yet challenging threshold for productivity or quality is key to successful incentive compensation.

4. DEFINING CALL AND EXCESS COVERAGE OBLIGATIONS

For many hospital-based specialties, a baseline level of call coverage has become an expected part of clinical responsibilities, and is covered by an employed physicians' base pay. Therefore, the physician compensation amounts reported by commonly used compensation surveys may already implicitly include a payment for call coverage. When using compensation surveys to determine FMV, it is important to compare the physicians' anticipated call coverage burden to that of other physicians in the marketplace.

An employment agreement should outline the level of call responsibility that is included in the physician's clinical services requirements for each specialty, as well as any additional call coverage (excess call) for which a physician can receive call compensation, subject to FMV.

Some physicians do not want to take on or share in the burden of call coverage while others rely on the additional income that call coverage brings. If individual physicians are allowed to decline call coverage or take on additional hours of coverage, the physician's base compensation should be adjusted accordingly.

5. CONSISTENCY ACROSS THE ENTIRE ORGANIZATION

Given the changing landscape of the healthcare industry, physician compensation models will continue to evolve to incorporate value-based elements. As these value-based compensation plans become more commonplace, it will be important to be consistent in incorporating value-based metrics in compensation models for employed physicians in the organization. Some variations may be necessary, but exceptions should be limited, to produce a defined set of organization-wide goals and expectations. Ultimately, this will ensure that improved quality and value are at the forefront of each physician's mind.

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