



Compensating Physicians for Executive and Administrative Services



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Introduction

To hit the mark on the “Triple Aim,” hospitals and physicians together must target improvements in quality and efficiency. Leaders must collaborate in new and imaginative ways, integrating business acumen with clinical expertise. To promote such collaboration, hospital leaders are engaging physicians as employees or independent contractors to serve in executive or administrative roles within the hospital organization.

Examples of these roles include the following:

- Chief Medical Officer
- Vice President of Medical Affairs
- Chief Medical Information Officer
- Clinical Service Line Leader
- Member of an executive or operational committee administering a clinical co-management agreement
- Director of a service line institute (e.g., heart and vascular institute)
- Clinical oncology leader for a hospital with a National Cancer Institute designation
- Director of the Institutional Review Board or other research-related administrative role

Determining appropriate compensation for these executive and administrative services performed by physicians to ensure compliance with the fraud and abuse laws is critically important. As the Office of Inspector General stated in a June 2015 Special Fraud Alert:

“Physicians who enter into compensation arrangements such as medical directorships must ensure that those arrangements reflect fair market value for bona fide services the physicians actually provide. Although many compensation arrangements are legitimate, a compensation

arrangement may violate the [A]nti-[K]ickback [S]tatute if even one purpose of the arrangement is to compensate a physician for his or her past or future referrals of [f]ederal health care program business.”¹

According to guidance on Stark regulations, paying a physician the same amount for time spent on clinical work, as for time devoted to administrative services, is appropriate only if both have the same value:

“A fair market value hourly rate may be used to compensate physicians for both administrative and clinical work, provided that the rate paid for clinical work is fair market value for the clinical work performed and the rate paid for administrative work is fair market value for the administrative work performed. We note that the fair market value of administrative services may differ from the fair market value of clinical services.”²

To establish appropriate compensation for a physician in an executive or administrative role, several factors should be considered to determine if the compensation associated with those services is fair market value:

- What key skill sets does the position require?
- Does the position require a physician to perform the duties? If so, does it require a physician of a particular specialty?
- Does the physician have experience filling a similar administrative role?
- What are the time requirements for the requested services?
- What time during the day must the duties be performed?
- Does the position require certifications in addition to board certification in a particular specialty?
- How many physicians in the market meet the position requirements?
- Is the position a requirement for maintaining a hospital’s special certification/designation? (e.g., “Center of Excellence”)
- Is the position required by regulation? (e.g., physician supervision of certain clinical services)

This white paper examines the executive and administrative roles assumed by physicians on behalf of hospitals, and relevant considerations in determining appropriate compensation.

1 https://oig.hhs.gov/compliance/alerts/guidance/Fraud_Alert_Physician_Compensation_06092015.pdf.

2 72 Fed. Reg. 51016 (Sep. 5, 2007).



I. Contract Considerations

The written agreement between the hospital and the physician for the provision of executive or administrative services furnishes the context for the compensation paid to the physician. Key provisions relevant to evaluating the appropriateness of the compensation include:

a. Specification of Duties

Regardless of job title, the specific executive and administrative duties assumed by a physician may vary significantly based on the health system's needs. For example, a physician may be responsible for the following:

- Development and implementation of clinical protocols
- Training and evaluation of clinical staff
- Evaluation of technology needs and solutions
- Outreach to other physicians regarding available services
- Community outreach regarding available services
- Analysis and recommendations regarding performance on quality-based indicators
- Leadership in specific performance-improvement initiatives (design, implementation, evaluation)
- Review of denied claims for opportunities to assist with appeals
- Engagement in physician credentialing issues
- Intervention with disruptive physicians
- Help with positioning the hospital to meet criteria for special certifications
- Assistance in remedying deficiencies noted during licensure and certification surveys
- Identification of opportunities for greater operational efficiencies

Historically, administrative payments to physicians have been scrutinized to ensure the acquired services were legitimate and not a disguised payment in exchange for referrals. Diligence on the part of the hospital in defining a physician's responsibilities in the parties' written agreement and in monitoring performance is critical to defeating any claim of improper payments.

b. Hourly Rate vs. Fixed-Base Compensation

As a general rule, compensation for services requiring the physician to work less than 20 hours per week should be based on an hourly rate. To reduce compliance risk, physicians serving in these roles should be required to prepare and submit timesheets documenting the services provided. Timesheet entries should not be "cut and pasted" from one period to another, as one could infer such entries misrepresent the physician's actual time and effort.

For a position requiring 20 or more hours per week, a physician may be paid a fixed-base compensation. Because 20 or more hours per week is a reasonable dedication of time, some compliance officers have not required hourly reports, but rather other reports reflective of work effort and certain presented deliverables. Nevertheless, if the physician is working less than full-time, the hospital still may require completion and submission of timesheets for verification purposes. Additionally, the compensation may include a provision for benefits expense, as this level of time commitment may preclude the physician from earning a sufficient level of compensation from his or her clinical work to cover benefit costs.

c. At-Risk Compensation

In this transition from volume-based to value-based payments, more hospitals are placing a portion of physician compensation at risk based on achieving pre-determined performance standards to align the physician's interests with those of the hospital. In such an arrangement, the contracted rate represents the total compensation potentially available



(e.g., \$100 per hour). However, a portion of that amount is withheld (e.g., \$5 per hour) and later paid to the physician only if specified goals are achieved.

Alternatively, a hospital may use a bonus structure, especially if the performance standards represent significant “stretch goals.” Here, the bonus represents payment beyond the total compensation for the defined services, as the physician delivered greater value than expected.

The inclusion of an at-risk element of compensation is factored into the determination of fair market compensation. Under such an arrangement, the physician risks not earning all potential compensation, and therefore should reasonably have the opportunity to earn some amount of compensation higher than would otherwise be expected absent the at-risk feature.

The theory behind the higher rate to accommodate for an at-risk element is that the physician will not only have to provide the services, but, to earn the higher rate, will have to provide them well. In providing services well enough to meet the quality target, physicians set themselves apart from their peer group, resulting in the ability to earn a premium for their services, all other things equal. A similar concept is embedded in CMS’ approach to physician reimbursement as reflected in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and its related Merit-Based Incentive Payment System (MIPS).

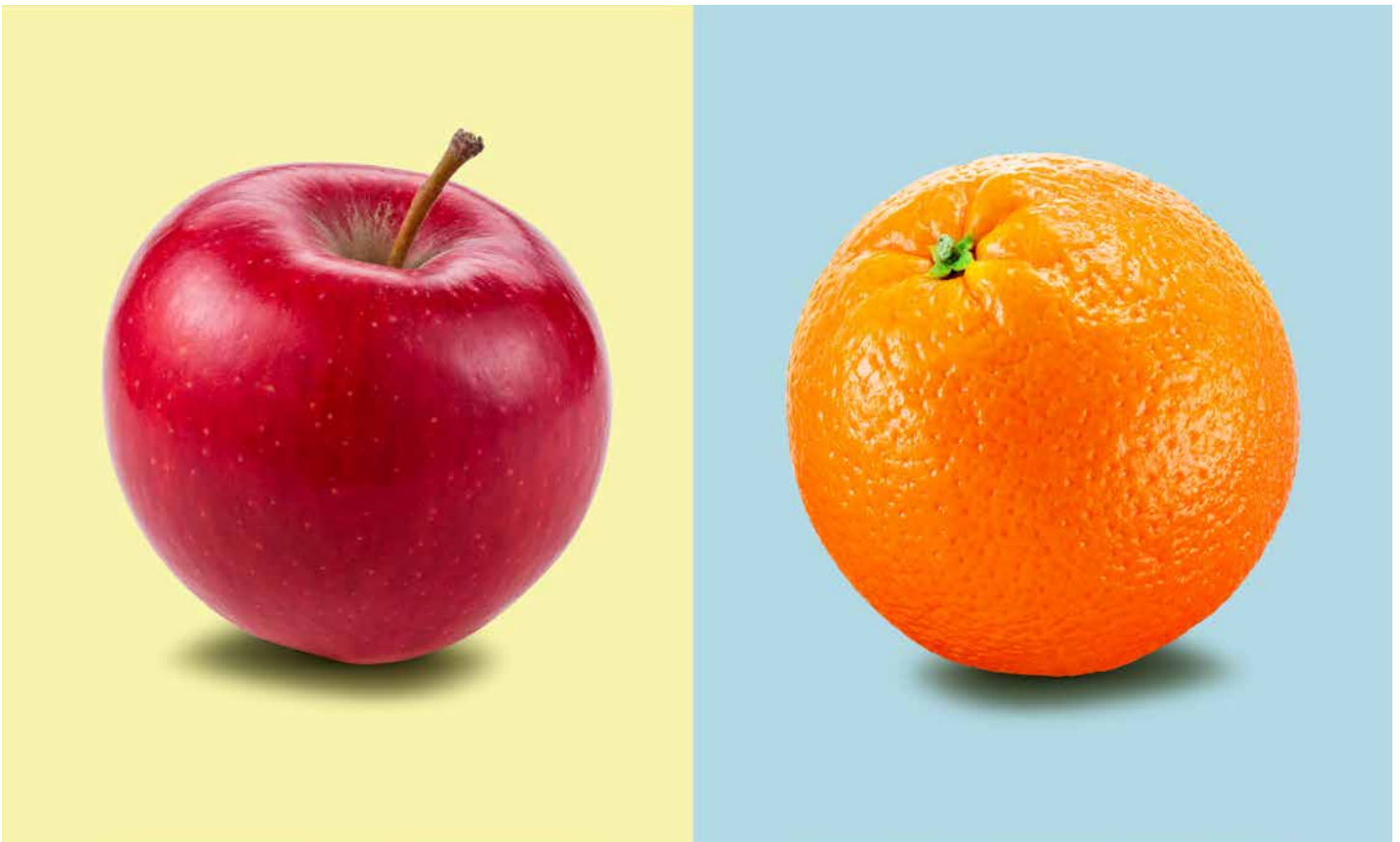
Additionally, depending on how much of the rate is at risk, a physician who did not earn the entire at-risk portion may have jeopardized hours that could’ve been spent in clinical practice and earnings that otherwise would be deemed fair market compensation related to those hours. Achieving the performance targets should require a physician’s additional focus and exceptional skill, thereby justifying a higher rate of pay.

This assumes, of course, that meeting the specified performance standards in fact requires additional effort and/or unique capabilities. If the standards require little-to-no effort or special skill, a higher pay rate could not be justified as the physician is not actually assuming any risk of non-performance. A hospital, therefore, should be able to defend the selected standards as bringing unique value to the organization.

d. “Double Dipping”

Finally, when compensating the physician on an hourly or fixed-salary basis, the agreement for services should state that the physician is prohibited from providing and billing for professional (i.e., clinical) services during the time he or she is providing administrative services. This prohibition ensures there is no double dipping, whereby the physician is paid twice for the same hour of time, an occurrence that would certainly elevate the regulatory risk of the agreement and likely create the perception of an Anti-Kickback violation. An exception to this theory occurs when a physician compensated for call coverage services is allowed to bill for services actually rendered. This is a common practice in the industry and is, therefore, contemplated and embedded in the establishment of call coverage compensation rates.

Additionally, a situation in which a physician providing clinical services is simultaneously compensated for contracted administrative duties could result in an effective rate of compensation outside the bounds of fair market value. The hypothetical employer, or buyer of services, would not likely pay an employee who is running a side business instead of doing his or her job during normal business hours. The employer receives no services in such a situation, and therefore, is not going to compensate the employee.



II. Validating Compensation

The most reliable method for validating physician compensation for executive and administrative roles is to analyze various market indications of compensation levels paid for similar executive or administrative positions. The key issue in applying this approach is the comparability of the subject arrangement to the market data for similar arrangements.

A number of industry benchmark sources are available, including the following:

- American Medical Group Association (AMGA): *AMGA Medical Group Executive and Leadership Compensation Survey*
- *AMGA Medical Group Compensation and Financial Survey*
- Sullivan Cotter and Associates (SCA): *Physician Compensation and Productivity Survey*
- Hospital & Healthcare Compensation Service (HHCS): *Physician Salary & Benefits Report*
- Medical Group Management Association (MGMA): *Medical Directorship and On-Call Compensation Survey and Management Compensation Survey*
- Integrated Healthcare Strategies (IHS): *Medical Director Survey*

Some of the surveys listed provide data on a limited range of administrative positions. For example, the HHCS and IHS surveys primarily provide hospital-related medical directorships data. The MGMA medical directorship survey data represents a mixture of hospital and medical group directorship positions. The new *AMGA Medical Group Executive and Leadership Compensation Survey* includes the following physician-filled positions:

- Chief executive officer (CEO)/president–physician
- CMO
- Chair: primary care/medical specialties or surgical specialties
- Medical director: primary care, medical specialty, or surgical specialty
- Director: medical education or quality management/performance improvement

Physician recruiting and search firms are other possible sources of administrative compensation benchmarks.

Additionally, administrative agreements may include duties that require clinical knowledge to effectively perform them. In this instance, it is appropriate to consider a clinical rate for the clinical duties, as well as an administrative rate for the administrative duties (consistent with the Stark guidance referenced earlier) to determine which benchmark data is more relevant in specific circumstances.

Note that some surveys (including those previously listed) inherently include some clinical data in the administrative data because it is not always easy to separate the two. Clinical compensation benchmarks can also be found in the following industry sources (again, not an exhaustive list):

- MGMA: *DataDive Provider Compensation Survey*
- Towers Watson: *Healthcare Clinical and Professional Compensation Survey Report*

When determining physician executive/administrative compensation, it is important to use as many sources as can reasonably be expected to provide insight into the fair market value for the physician's services. Use of multiple sources helps to: 1) balance any anomalies contained in the reported results due to such things as small sample size, and 2) give the broadest representation of services to ensure the market benchmarks evaluated are as close as possible to the bundle of administrative services undergoing valuation.



It is critical when selecting administrative compensation benchmarks to bear in mind the expertise needed for the position, rather than the expertise the physician currently has. For example, if determining compensation for a chief medical information officer, it is important to isolate similar physician executive positions that could provide a proxy for fair market compensation. If the physician who will fill the position happens to be a neurosurgeon, that fact does not necessitate the use of benchmark data specific to neurosurgery administrative positions, as the position may not require the expertise of a neurosurgeon.

Other factors to weigh when evaluating compensation for administrative positions are the size of the organization and the scope of the administrative position. For example, the position of CMO for a 500-bed hospital is different than for a 75-bed hospital, as is having responsibility for a system as opposed to a single facility.

Generally speaking, larger organizations or broader scope positions result in responsibilities that are more complex and are generally more highly compensated, all else equal. Some of the survey benchmarks present data specific to the size of the organization, in terms of bed size or revenue base, to assist in determining the appropriate benchmark data to use.

Finally, one should consider the cost of living for the geographic region where the services are delivered. Unlike clinical services, where the impact of the cost of living may not be apparent due to the impact of the payer mix, administrative compensation is more heavily influenced by cost of living. The Council for Community and Economic Research (C2ER) produces a quarterly report that reflects costs of living for Metropolitan Statistical Areas (MSA) across the U.S. This information is available online for a nominal fee at www.coli.org.

In addition to the market approach, other methods for validating physician compensation include the income and the cost approach, but neither is well-suited to compensation for executive and administrative services. Because there typically is no revenue or net earnings stream directly associated with, or attributable to, these positions, the income approach is not generally applicable. However, one might be able to conceive a theoretical income approach that attempts to assess an organization's net earnings with, and without, a given administrative/executive position. Such an approach may not be practical and would definitely be subject to significant levels of assumptions.

There are two methods for considering the cost approach for this type of analysis.

One method is to analyze market indications of costs for comparable positions; however, application of this method would be dependent upon the market approach. The second is to evaluate the historical costs paid for the position (if it had been previously filled by another physician or professional, or if the physician had served in a similar position for another organization), to determine the historical compensation associated with the similar position.

However, for the historical compensation approach to be meaningful, one would need to undertake a thorough analysis of the responsibilities and market conditions that were present when the historical compensation was paid. Both methods would be dependent upon the principle of substitution. In essence, one would be identifying the costs associated with a substitute provider of the limited service, based on the substitute's past costs.



III. “Stacking” Issues

Stacking of responsibilities comes into play particularly when evaluating a part-time physician administrative position. A stacking analysis involves the process of accumulating all the disparate components of compensation paid to a physician and ensuring that: 1) there is no overlap of duties and compensation, e.g., the physician is not paid twice for the same block of time or the same set of services, and 2) the totality of the compensation package is still fair market value and commercially reasonable, given the totality of services provided under the arrangement. Thus, stacking does not come into play when evaluating a full-time administrative role (assuming there are no other separate agreements with the same physician).

Stacking can become a problem when a physician serves in multiple administrative roles for the same, or closely related, service line(s). Stacking can also become a consideration for the hospital when it has multiple facilities in a narrow geographic area, and it replicates the administrative position at each location. When this occurs, the relevant stacking issue revolves around whether it is commercially reasonable for the hospital to replicate the service at each location.

If a stacking analysis becomes necessary, it is important for an appraiser to ensure that the stacked compensation components are matched as closely as possible to the types of compensation included in the benchmark data used in making the comparison. For example, when stacking a medical directorship with clinical compensation (such as when a physician is employed in clinical practice and also serves as a medical director—a common occurrence), the relevant industry information analyzed in the valuation should include both clinical and administrative compensation.

The definition of compensation in the various clinical compensation industry surveys indicates that direct compensation *may* include compensation related to medical directorships. Unfortunately, the definition applies to the entire survey, not to a specific specialty. Therefore, there is no way to know if the clinical compensation benchmark already incorporates medical director compensation.

One can reasonably draw a couple of conclusions: 1) it is highly unlikely that *all* survey respondents in any given specialty have medical directorships; and, 2) when the survey demographics are comprised of larger physician practices, it is unlikely that all physicians in the group, much less every responding group, had medical directorships. Therefore, the representation of medical directorship compensation in the survey data is questionable. It is a judgment call whether the medical directorship compensation should be included with clinical compensation in evaluating whether the stacked agreement is still within fair market value and is commercially reasonable.



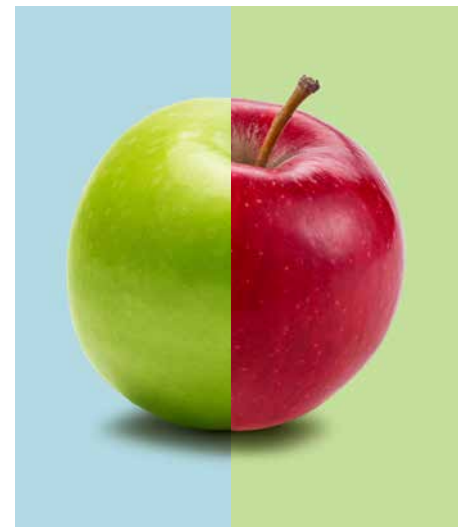
When evaluating the physician's administrative responsibilities, it is also important to evaluate the time required of the physician to perform those duties relative to his or her clinical, or other, responsibilities. This evaluation is particularly relevant within the context of commercial reasonableness. For example, is it reasonable for a physician who produces clinically at the 90th percentile to also be able and available to serve in an administrative capacity for 10 to 15 hours per week? If so, the hospital should be comfortable representing that the physician typically works well in excess of a typical 40-hour work week.

In the context of stacking, the highly productive clinician is likely to have high compensation before consideration of the additional administrative duties. The totality of the compensation package may therefore rise to the level outside the bounds of fair market value and commercially reasonable compensation when additional administrative compensation is layered on, depending, of course, on the facts and circumstances of the specific arrangement.

Conclusion

A number of resources are available to assist in determining fair market value compensation for both full-time and part-time physician administrative positions. The most important criteria for evaluation include:

- What skills are necessary to perform the duties?
- Do the duties overlap with any other responsibilities of the physician?
- Do the duties overlap with any other agreements the hospital has in place with other physicians?
- Are the time requirements of the position reasonable, relative to the other clinical/administrative responsibilities of the physician?



How PYA Can Help:

PYA's valuation experts provide well over a thousand fair market value compensation opinions annually for a wide range of financial arrangements entered into by physicians, hospitals, health systems, and other healthcare entities. Such review is often used to help ensure that compensation arrangements comply with the Stark Law and the Anti-Kickback Statute, including their commercial reasonableness requirements, and any other regulations governing transactions in the healthcare industry.

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