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HIGHLY COMPENSATED PHYSICIANS AND COMPLIANCE: CONSIDERING THE COMPLEXITIES

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The Bureau of Labor Statistics recently reported that job prospects for physicians are outpacing other occupations despite market pressures that would generally appear to have a negative effect on their opportunities.[1] National physician compensation surveys show a rise in physician compensation in most medical and surgical specialties.[2] Given this reality, health systems trying to continuously improve services to their patients are fiercely competing for top physician talent in their service area. However, top physician talent often comes at a high price and can reach levels well above the 90th percentile based on national compensation surveys.

So, how much is too much when reviewing a physician's compensation agreement? This is a question that compliance officers and valuation analysts ask themselves almost daily. What analyses should be performed? How does this compensation compare to their peers? What are key factors that need to be considered to mitigate risk? These questions and others become even more challenging when they pertain to a physician who is highly compensated. As the compliance officer goes through the review process, there are key areas that should be considered when determining if the agreement meets fair market value (FMV) requirements. Below are some complexities to consider.

Document exceptionality

Scenario: *Dr. Smith is understood to be a renowned neurosurgeon with a focus in the subspecialty of movement disorders. He is said to have impeccable training and has developed various revolutionary surgical techniques to improve mobility in patients with Parkinson's Disease.*

Dr. Smith's employment agreement has now come across your desk, and the compensation terms require further due diligence to ensure that it meets FMV requirements. What are your next steps?

As all compliance officers are aware, appropriate documentation is an effective and necessary tool in ensuring compliance. The same can be said for determining FMV. In the case of a highly compensated physician, documentation typically will fall under two distinct categories: (1) workload measures, and/or (2) skill set and qualifications.

The highly compensated physician may be compensated based on

workload in excess of norms for their specialty. Workload can include the physician's clinical production in terms of Work Relative Value Units (wRVUs), professional collections, administrative hours, emergency room (ER) call coverage shifts, research activity, etc. A wRVU is an objective means of measuring a physician's professional work. It is one of the three components that sum to a total Relative Value Unit (RVU) used by Medicare to determine reimbursement by procedure (i.e., CPT code). The three components are:

- **Physician work RVU —** The physician's experience, skill, training, and intensity required to provide a given service;
- **Practice expense RVU —** The cost of maintaining a practice, such as rent, equipment, supplies, and nonphysician staff costs; and
- **Malpractice RVUs —** Payments for professional liability expenses.[3]

Performing the necessary due diligence on each of these workload measures is necessary to substantiate a high compensation and is even more critical under an acquisition scenario, given the need to rely on the reporting accuracy of the physician's practice. The proper scrutiny involves a review of the actual production reports for potential issues that include, but are not limited to, coding practice, level of service utilization, wRVUs unadjusted by modifiers, and Advanced Practice Provider (APP) billing procedures. There are cases when this may not be possible, and the FMV analysis should reflect this additional risk.

Other supporting documents may include administrative time sheets, ER call calendars, didactic teaching schedules, and interviews. Gathering this information will enable you to more accurately isolate the value from each of these potentially stackable services and determine if the total compensation package appropriately reflects the work being performed..

In terms of skill set and qualifications, it is important to establish clear measures in order to have the support necessary to justify the level of compensation. Having a process that validates the physician's credentials based on various criteria requires research, objective measures, and uniform application. Examples of criteria that can be used are: (1) medical school attended, (2) fellowship training and/or certifications, (3) peer-reviewed publications, (4) national speaking engagements, (5) media coverage, and (6) academic appointments. We would recommend that this process be performed for all physicians within your system to further support the distinction from the norm for the uniquely skilled and highly compensated physician.

Outline duties and requirements in the agreement

Scenario: *Dr. Jones is a family physician who is extremely productive and known to be a key figure in the health system. He participates in numerous administrative meetings and is well respected by all of the medical staff for his contributions. He holds a medical directorship position, and he is compensated $30,000 per year for that role. As you review his agreement, which is up for renewal, you recognize that there are no specific duties outlined in the agreement for the medical directorship compensation.*

When considering the FMV range for a specific agreement, the analysis is inseparable from the structure of the compensation terms. The same is true for physicians at compensation levels near median and for physicians that exceed the 90th percentile for compensation. One key factor that can affect the value is the degree of specificity with which the physician's duties and requirements are delineated in the compensation agreement.

Physician agreements vary from system to system, based on clarity, complexity, and level of detail when outlining requirements and compensation. The FMV process is specific to the terms outlined in each subject agreement. In order to quantify the FMV range of compensation on the basis of each term, clarity in the compensation agreement will facilitate a more accurate analysis.

For example, below are two versions of contract terms associated with the administrative services provided by Dr. Jones in the scenario above.

Option A: Physician shall be compensated $30,000 per year for the provision of administrative services as medical director of Family Medicine Services.

Option B: Physician shall provide administrative services as medical director of Family Medicine Services and be compensated at a rate of $150 per hour, documented by time sheets, up to 200 hours per year, for a maximum of $30,000 per year.

The terms under Option A can theoretically be paid to the physician who only worked 30 hours in the year, resulting in an effective hourly rate of $1,000 per hour, well over FMV. Although there is evidence that Dr. Jones provides a significant amount of administrative services to the system, compensating physicians for undocumented services should be avoided. Subject agreements that compensate physicians a stipend for broadly defined administrative services

Table 1: Dr. Adams' proposed compensation terms under two different options

	Option A — Low Base	Option B — High Base
Proposed base guarantee	$500,000 per year	$1,000,000 per year
Physician wRVUs	7,500 wRVUs (~30th percentile)	7,500 wRVUs (~30th percentile)
Call coverage (60 shifts per year)	$90,000 per year ($1,500 per 24-hour shift)	$90,000 per year ($1,500 per 24-hour shift)
Administrative services (240 hours per year)	$60,000 per year (240 hours x $250/hour = $60,000)	$60,000 per year (240 hours x $250/hour = $60,000)
Total physician compensation	**$650,000 per year (below 25th percentile)**	**$1,150,000 per year (~75th percentile)**
MGMA Benchmarking & Ratio Analysis*		
	Option A — Low Base	**Option B — High Base**
Base compensation per wRVU	$66.67 per wRVU (below 25th percentile)	$133.33 per wRVU (~85th percentile)
Total compensation per wRVU	**$86.67 per wRVU (~50th percentile)**	**$153.33 per wRVU (105% of the 90th percentile)**

** Medical Group Management Association[4]*

without the explicit number of hours required are a compliance risk. The absence of a minimum number of required hours may result in the effective hourly rate exceeding FMV.

This is just one example of the risk associated with not fully documenting the necessary requirements for particular compensatory services. Adding compensation from other services without specific requirements in the subject agreement potentially places the entire compensation outside of FMV.

Minimize guaranteed compensation

Scenario: *Dr. Adams is a neurosurgeon who is relocating to your health system's service area. He was previously employed by another health system and, as such, you have very little production data for your review. Dr. Adams is able to provide minimal documentation; however, in his interview with you, he states that he was producing at approximately 150% of the 90th percentile and has done so for many years.*

How do you structure the compensation terms for Dr. Adams as a new recruit into your health system, while mitigating risk to the system and ensuring compliance?

Overall risk to the health system is reduced with subject agreements that have terms that minimize the guaranteed portion of the physician's total compensation (assuming all components of compensation are at FMV). This structure is not meant to reduce the total potential compensation to the physician, but to ensure that a high level of compensation is only achieved when the physician's production level and/or workload is in excess of the base. This can be illustrated by the example in Table 1.

This illustration demonstrates how Option B, with the high base guarantee, carries the greatest risk of the physician's compensation being outside of FMV. Total compensation falls at the 75th percentile; however, the effective wRVU conversion rate of $153.33 per wRVU falls well above the 90th percentile. This is a function of the low wRVUs produced relative to the high base guarantee in the subject agreement. The potential risk is directly related to the degree of discrepancy between the production level achieved and the base compensation. Although employers may have non-production work to offset lower production levels, it becomes a harder argument to support when attempting to compensate for additional non-production services (i.e., administrative services). The risk of being out of compliance from an FMV perspective is greater when more compensation is guaranteed to the physician and/or less is contractually required of them. (Note: Table 1 is for illustrative purposes only, and the figures are presumed to be within FMV.)

Using advanced practice providers

Scenario: *Dr. Wells is a highly productive orthopedic physician in the community and is also very highly compensated for her specialty. A local health system is interested in acquiring her practice. She currently*

employs three advanced practice providers (APPs), who will all be hired by the acquiring system.

As the compliance officer for the health system, you are considering the level of compensation for Dr. Wells and wondering if her use of APPs affects the survey benchmark review to determine FMV. Are there considerations that need to be addressed?

The answer is: Yes, however, the effect of the APPs depends. As APPs become even more integrated into the healthcare system, their use has been increasing and, as a result, will extend into services that have historically been handled solely by physicians. APPs are being used more and more, whether it be in a primary care office, medical sub-specialty, or surgical practice. APPs are most often hired in order to extend the services of a practice and/or physician. In doing so, any potential impact to the physician compensation for these services should be considered. Below are two possible considerations.

Consideration 1: Are the APPs generating a significant amount of professional collections and/or wRVUs from professional services that they personally perform? The FMV analysis should consider the extent to which the APP increases the work capacity of a physician. For example, there are two orthopedic physicians in your system that produce 12,000 wRVUs annually; however, one has an APP and uses them concurrently for taking patient histories, ordering X-rays, performing procedures, and documenting visits. Under this scenario, the APP is not generating wRVUs on their own, but instead their work product is being captured under the physician's total wRVUs. The APP is also being used for post-op follow-up visits where the total wRVUs for the surgery (inclusive of post-op visits during global period) performed by the physician are being credited to the physician. Side by side, each physician generates the same number of wRVUs; however, one has an APP and one does not. In this case, the use of an APP's professional services to extend the physician's capacity should be considered in determining the physician compensation value.

Consideration 2: Dr. Wells is asking for APP supervision compensation to be stacked on to her base guarantee. As the compliance officer, it is important that you determine: (1) the degree to which the physician is providing supervision, and (2) the compensation terms for supervisory payments. First, the supervisory services should be documented. The most preferable method is either through time sheets or through the number of charts reviewed. Many of these supervisory services are paid in the form of a monthly stipend to the physician with little documentation. The ability to document the work performed for the compensation received minimizes the risk of overpayment in terms of FMV.

Second, supervisory payments can be structured to be paid in addition to a base guarantee or reconciled against the base guarantee. It is recommended, especially for highly compensated physicians, that supervisory compensation be reconciled against any form of base guarantee. For example, Dr. Wells has terms that pay her the greater of (1) a base guarantee, or (2) the sum of the product of wRVUs times a conversion rate plus supervisory payments. This structure accomplishes two key items: (1) the physician is foregoing clinical production in order to provide supervisory services, and (2) the physician needs to produce a minimum number of wRVUs in order to receive full compensation for the supervisory services performed. By reconciling against the base, the term ensures that the physician produces enough wRVUs/professional collections consistent with her base guarantee and avoids any potential double dipping or overlap of compensation.

Use of survey benchmarking analyses

Scenario: *Dr. Todd is an employed general surgeon within a hospital that your health system just recently acquired. You are reviewing his employment agreement, which you inherited, and notice that the physician is highly productive at over the 90th percentile. The prior system approved all clinical compensation terms with compensation per wRVU rates at the median for the specialty. You recall a webinar by a valuation expert that warned against using median in all cases. What are your next steps?*

Understanding the national physician compensation surveys is key to using them appropriately. Most systems use the MGMA survey, but numerous other surveys are available, including the American Medical Group Association (AMGA); Sullivan, Cotter and Associates Inc. (SCA); Willis Towers Watson Data Services; as well as specialty-specific surveys that exist for neurosurgery, transplant surgery, and interventional neurology, to name a few. Using more than one survey will lend greater validity to the analysis and provide greater

support for the argument in determining the FMV range.

Many topics surround the appropriate use of survey data, but we limit our discussion to the relationship between the physician's level of wRVU production and their wRVU conversion rate. As the example above describes, Dr. Todd has historically been paid at a compensation-per-wRVU rate at the median, despite his highly productive practice. Is this reasonable? Figure 1 is a graph of General Surgery Compensation and Compensation per wRVU at different production levels. The data in the figure is based on the physician compensation reported for physicians producing at particular wRVU levels.

Figure 1 demonstrates that as compensation increased from $363,109 in the first quartile to $596,661 in the fourth quartile, the increase did not correspond directly to wRVU production since the compensation per wRVU ratio decreased from $95.96 to $55.58 between the quartiles.

Overall compensation tends to increase for more productive physicians, but per-unit compensation does not. The amount of non-production earnings (e.g., directorships, call coverage, research) can increase the wRVU rate, especially at the lower levels of production. The same is true of a physician newly recruited to a system who has a base guarantee but has yet to produce at the expected levels. Both scenarios have an upward impact on the median compensation per wRVU reported in the surveys and, as a result, compensating all physicians regardless of level of production at the median compensation per wRVU rate can result in a value that is potentially outside of FMV.

Reconcile stacking compensation against the base guarantee

Scenario: *Dr. Green is an interventional cardiologist who is compensated above the 90th percentile. His production levels are at approximately the 25th percentile. However, he provides 240 days of call coverage to the hospital, furnishes directorship services for the cardiology service line, and oversees research activities.*

Highly compensated physicians typically receive compensation from multiple earning streams in addition to a clinical base guarantee. Multiple earning streams may include call compensation, medical directorship, APP supervision, research compensation, and graduate medical education services. Typically, two methods are used to compensate these multiple earning streams. One is referred to as "stacking," which refers to adding compensation from the various earning streams on top of a base guarantee. A second option is reconciling the multiple earning streams against the base.

Let's use the example of Dr. Green to illustrate the difference in Table 2.

As can be seen through this analysis, the total compensation can vary significantly depending on whether additional earning streams are stacked or reconciled against the base guarantee. When reviewing the resultant total compensation ratios, the stacked version carries the greatest risk of being outside of compliance. Compensation per wRVU ratios benchmark much higher in Option A when compared to Option B where all earning streams are reconciled against the base. Under the stacking method (Option A), compliance risk decreases as wRVU production increases to the level that supports the base guarantee. In other words, the physician needs to produce enough wRVUs to support their base guarantee before they can be compensated for additional services (e.g., call compensation) in excess of the base guarantee. (Note: The example in Table 2 is for illustrative purposed only. Each of the compensation terms in isolation (i.e., base, call compensation, and administrative rate) is presumed to be within FMV. The hypothetical analysis

Figure 1: MGMA Compensation and Comp:wRVU by quartile of production for General Surgery

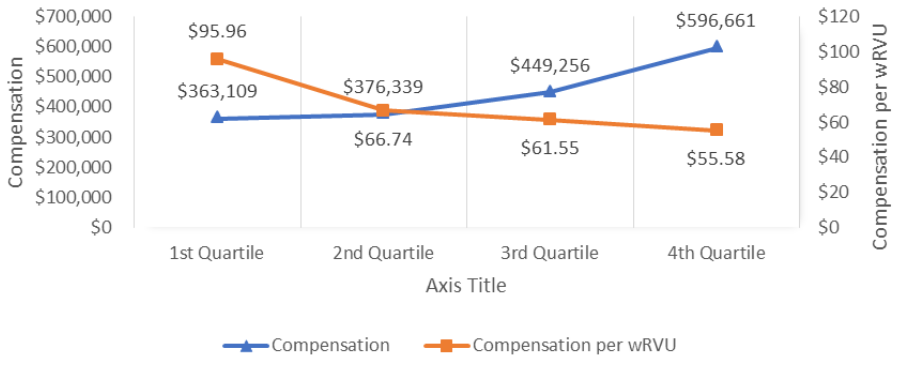

Table 2: Stacked compensation terms versus reconciled against the base.

	Option A — Stacked		**Calculation**
Proposed base guarantee	$550,000 per year (~25th percentile)	A	$550,000
Physician wRVUs bonus ($55 per wRVU in excess of 9,000)	5,000 wRVUs per year (below 25th percentile)	B	$0
Call coverage (60 shifts per year)	$240,000 per year ($1,000 per 24-hour shift)	C	$240,000
Administrative services ($250 per hour)	$60,000 per year (240 hrs x $250/hr = $60,000)	D	$60,000
Research services ($250 per hour)	$15,000 per year (60 hrs x $250/hr = $15,000)	E	$15,000
Total annual physician compensation (A+B+C+D+E)			**$865,000 (~78th percentile)**
	Option B — Reconciled		**Calculation**
Proposed base guarantee	$550,000 per year (~25th percentile)	A	$550,000
Physician wRVUs bonus ($55 per wRVU)	5,000 wRVUs per year (below 25th percentile)	B	$275,000
Call coverage (60 shifts per year)	$240,000 per year ($1,200 per 24-hour shift)	C	$240,000
Administrative services ($250 per hour)	$60,000 per year (240 hrs x $250/hr = $60,000)	D	$60,000
Research services ($250 per hour)	$15,000 per year (60 hrs x $250/hr = $15,000)	E	$15,000
Total annual physician compensation (Greater of A or sum of B+C+D+E)			**$590,000 (~34th Percentile)**

reviews the total compensation and demonstrates the potential compliance risk associated with either stacking compensation terms or reconciling.)

Summary considerations

Successfully navigating through the many potential compliance risks when structuring the employment agreement for a highly compensated physician can be done with careful consideration of the facts, detailed documentation of terms and requirements, and accurate use of national benchmarking surveys. Ultimately, know when you need to ask for outside help and expertise. Valuation firms with appropriate credentials and experience in healthcare valuation services can be a useful resource. CT

Endnotes

1. *Bureau of Labor Statistics, U.S. Department of Labor, "Physicians and Surgeons,"* Occupational Outlook Handbook, https://bit.ly/348Olo4.
2. Medical Group Management Association (MGMA), *MGMA DataDive Provider Compensation Data*, 2019, https://bit.ly/2Jxv4oB
3. State of Alaska Department of Labor and Workforce Development, *Introduction to Relative Value Units and How Medicare Reimbursement is Calculated*, https://bit.ly/2NlJedw.
4. MGMA, *MGMA DataDive Provider Compensation Data*.

Takeaways

- Document and be consistent across your review of each physician agreement. Perform the necessary due diligence to avoid a problem in the future.
- The requirements and duties associated with all compensated services need to be detailed, clear, and quantifiable in each agreement.
- Use APPs appropriately and compensate the physician in accordance with the work they personally perform.
- Know the national surveys and how to use them before relying on them to support a highly compensated physician.
- Minimize the guaranteed portion of the agreement and compensate based on performance. Reconciling multiple earning streams against the base guarantee reduces the compliance risk.

Highly compensated physicians and compliance: Considering the complexities

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