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Setting doctor compensation is both art and science

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Valuation professionals are frequently retained to help clients evaluate whether physician compensation agreements adhere to statutory requirements, as evidenced by documentation of the services to be exchanged and the expected financial flows.

The relationship between services and compensation has historically been evaluated in terms of the fair market value definition provided by CMS in the regulations relating to the federal physician anti-referral statute, commonly referred to as Stark. It defines fair market value as "the value in arm's length transactions, consistent with the general market value."

"General market value" means the price that an asset would bring, as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party.

Estimates of this general market value provide a range within which compensation may be deemed fair and not an inducement for one party to generate business referrals for the other.

Imagine a hospital administrator with a team of three full-time cardiothoracic surgeons. Salary surveys and the surgeons themselves suggest that their compensation increases have not kept pace with those of other medical specialties.

The hospital administrator in this scenario recognizes the need for full-time cardiac surgical coverage. Such coverage not only contributes to better quality and continuity of care, but also encourages the growing, aging population to consider the hospital as a viable choice for other emergent and non-emergent needs.

To maintain a robust, high-volume interventional cardiac care program, an interventional cardiologist requires backup. Without full-time surgical backup, patients may experience delays in care or may be transferred – along with their revenue streams – to other hospitals.

Notwithstanding certain market pressures limiting the growth of cardiothoracic surgeon salaries, most experienced practitioners have grown accustomed to their decades-long pre-eminent status in patient care, which has historically commanded pre-eminent salaries. Although hospital administrators often argue that technological developments and market forces are pushing salaries down, such claims can fall on deaf ears.

Information and misinformation complicate the fact-based analyses needed to evaluate compensation arrangements for fairness. Physicians may find local or national anecdotal comparison points to argue that the bar has been raised for their specialty's "fair" compensation. Although such market data points may be relevant, the fair market value estimation should involve broader analysis of additional factors to provide assistance for clients' informed business decisions.

Analysis performed by valuation professionals has generally involved at least one of three approaches. In the market approach, fair market value is determined based on what similarly situated buyers are paying in the relevant business market. Compensation arrangements entered into by local employers of physicians provide a reference point for evaluating fair market value.

In the cost approach, the replacement cost of the asset, such as the cost to recruit a new specialist for the service area, influences the fair market value of that asset. With the income approach, in the physician employment context, actual personal professional revenues and personal ancillary revenues generated by the physician provide an income-based factor in determining fair market value.

These three approaches provide a basis for evaluation for the hypothetical institution.

In many instances, there are opportunities for cardiothoracic surgeons to start new cardiology programs at other institutions. Such pursuits may provide salaries comparable to those paid by their current hospital employers.

Academic opportunities with reduced schedules, research facilities and staff support, as well as the ability to shift burdensome on-call duties and certain clinical tasks to interns and residents, may be attractive alternatives. There also may be reports of local or national competing hospitals offering more lucrative compensation for key specialists.

When such specialists hint that they might opt for other employment opportunities, hospitals like the hypothetical institution in this situation are placed in a challenging position. It may be difficult to distinguish "market noise" from relevant market data. Fact-based analysis should go beyond anecdotal reports.

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When considering entering a compensation arrangement with a physician, facilities should closely evaluate that arrangement for commercial reasonableness. The challenge is to pay specialists enough to retain them, provided that their compensation can be demonstrated to fall within fair market value and commercial reasonableness limitations. It is important to distinguish between isolated data points, such as market noise, and genuine movement of the market.

In an employment relationship, the physician's direct professional services revenues – the financial inflows associated with the physician's medical services – and ancillary revenues – traditionally, the supplies and tests ordered by the physician and his associates – provide a generally allowable benefit.

If the hospital can collect enough direct and ancillary revenues from a physician to meet or exceed his compensation, the arrangement appears to be commercially reasonable. However, if this directly attributable revenue does not cover the physician's salary, it makes sense to analyze the relationship more carefully for commercial reasonableness.

A hospital might begin to consider subsidizing the relationship with portions of its technical-component revenue. Without careful fact-based analysis, compensation arrangements may creep quietly from a commercial reasonable allocation of professional and ancillary revenues to one that might not make business sense.

When employers begin to pay compensation beyond the direct professional and ancillary service revenues attributable to such physicians, market compensation begins to spiral upward. Markets appear to reach a point at which participants are justifying their compensation arrangements based largely on claims that "everyone else is doing it." In the long-term, these arrangements are unlikely to break even. ■

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