Physician employment compensation models
BIGGEST QUESTION

HOW WILL I GET PAID?
BASIC TERMINOLOGY AND CONCEPTS

- “wRVUs”
- Salary Survey Data
- Salary Caps
- Other forms of upfront Compensation
“wRVUs” = work relative value units

- Amount MDC pays for physician services depends upon the number of “relative value units” assigned to each CPT Code

- Service is assigned number of RVUs based on resources used to perform the service which include
  - Physician’s work effort
  - Physician’s practice expenses associated with producing the service
  - Professional liability insurance expense
“wRVUs” = work relative value units

- MDC FFS = RVUs x annual dollar conversion factor
- wRVUs = the number of RVUs assigned to the physician work effort component of the service
Salary Survey Data

- Certain associations and companies conduct annual surveys of physician compensation and productivity

- Commonly used, "government endorsed" surveys
  - MGMA
  - AMGA

- Survey data is (and should be) “specialty specific”
Salary Survey Data

Hospitals and health systems, particularly tax-exempt organizations, use this data for several purposes:

- To assist in setting compensation for employed physicians
- To provide objective legal support and justification for reasonableness and FMV of amounts paid to employed physicians
Salary Survey Data

- Important that Drs. understand
  - How survey data are used (and misused)
  - How to interpret survey data

As they go thru the process
Key Items Surveyed for Physician Compensation and Productivity

- Total annual cash compensation ("TCC")
- Productivity (measured by wRVUs)
- Professional Services collections
- Compensation per wRVU
- Compensation per hour
- Other aspects of physician compensation and productivity (Admin Stipends, Signing Bonus, etc)
Salary Caps

- Relevant mostly to tax-exempt organizations ("TEO’s") like non-profit hospitals or their subsidiaries
- IRS has deemed certain compensation models structurally problematic because they result in impermissible sharing of charitable assets
  - E.g., payment to physicians of unlimited upside (FMV Issues)
    - Akin to shareholder distribution
    - Identical to for-profit private practice
- Penalties for violation
  - Excise taxes levied against hospital management and physicians
  - Loss of tax-exempt status
Salary Caps

- Caps on physician TCC eliminate unlimited upside and protect hospital, management, and physicians from scrutiny.
- Caps also help to ensure reasonableness and FMV of TCC for tax, Stark, anti-kickback law purposes.
- Salary survey data is used to set these caps.
CURRENT MODELS BEING OFFERED TO PHYSICIANS

- Two basic models with variations
  - Base + Bonus
  - Pure Productivity

- Guaranteed total salary is rare
  - Government positions
  - Kaiser, etc.
BASE + BONUS COMPENSATION MODEL

- Guaranteed Base
- Incentive Bonuses
Base Amount

- Benchmarks include:
  - Amount physician currently earning in private practice
  - Third party salary survey benchmark level based on historical productivity
    - E.g., if historical productivity measured by wRVUs was at the 60th percentile on salary surveys, base compensation would be set at the 60th percentile TCC on the same surveys
  - (In private practices) “going rate” in that market for that specialty, or the practice’s historic salary levels
Base Guarantee

- If any guarantee, usually only for 1-2 years (must understand what happens after that)
- Guarantee of base amount sometimes dependent upon physician's maintaining some minimum level of production as measured by professional collections or wRVUs
  - If threshold not met, base is lowered in current or subsequent year
  - Sometimes, there is repayment of the “excess salary” (then not really a guarantee)
Types of bonuses:
- Productivity, as measured by wRVUs or cash collections
- Quality/citizenship, as measured by
  - Patient satisfaction
  - Score on quality metrics (e.g., for primary care physician, number of patients receiving annual flu shots)
  - Charity care
  - ED call
  - Service on committees, etc.
- Share of quality/utilization bonuses paid by third party payors (this is becoming more important to include)
**Bonus**

- Productivity bonus earned only after some minimum productivity level is reached, as measured by wRVUs or cash collections (or level of charges)

- ***Important to plug in actual (projected) numbers for your average production to test the new formula (Health systems have better/lesser payor reimbursements that will affect your revenue and therefore your future compensation)***
Health System might require:

- Physician’s TCC usually (could be) subject to an annual cap (e.g., 90\textsuperscript{th} percentile TCC in salary survey data)
PURE PRODUCTIVITY COMPENSATION MODEL

- wRVU Model (stated conversion factor)

- Revenues Minus Expenses Model (profitability)

- % of Collections Model (or Charges x Collection % x Incentive %)
wRVU Model

- Total annual wRVUs x wRVU conversion rate
  - Important to know your historical productivity and compensation per wRVU to compare
  - Must understand how billing codes and POS might change under Health System
  - Also important to be familiar with the most current salary survey data for your specialty
Advantages of wRVU Model

- Not dependent upon effectiveness of employers’ billing and collection department

- Not dependent upon Payor Mix
  - Important where employer is a hospital with large amount of Medicaid and/or charity care
Disadvantages of wRVU Model

- Private physician practices often do not track wRVUs so difficult to know how much you will earn in such a model
- Doesn’t take into account Slowdowns and Transitions and the negative effects (eg., EMR implementation, new processes/other changes to procedures under the health system)
  - Sometimes possible to negotiate temporary “hold harmless” provision for major change periods
Disadvantages of wRVU Model

- Encourages “every man for himself” behavior with physicians competing for wRVUs rather than sharing patients
  - Can hurt junior physicians with no patient or referral source “following”
  - Could hurt senior physicians when new physician is brought on to grow the practice before there is sufficient volume to support him/her
Revenues Minus Expenses Model

- Individual physician TCC = physician’s share of total allocated practice revenue MINUS physician’s share of total allocated practice expenses
  - Common model in private practice
- Important to understand how revenues and expenses measured and allocated (and how might change)
- Important to have some say over expense decisions
  - Staff costs usually increase under hospital employment because of higher benefit costs and salary grading system – can’t control this
  - Other changes under Health System (corporate allocations)
Advantages and Disadvantages of Revenues Minus Expenses Model

- **Advantages**
  - Depending upon how revenue is allocated, may encourage more group-like behavior
  - Rewards cost efficient physicians

- **Disadvantages**
  - Dependent upon effectiveness of employer’s billing function
  - Dependent upon Payor Mix
  - Dependent upon overhead
    - Physician may have little control over this in hospital employment
    - Physician cannot avoid higher hospital benefit costs
% of Collections Model

- Individual physician TCC = % of professional collections received by the employer for personally performed professional services
  - Common model in private practice
- Stark law prohibits paying % of collections for certain ancillary services (DHS) ordered by the physician
  - Lab
  - X-ray
  - PT
  - DME
Advantages and Disadvantages of % of Collections Model

- **Advantages**
  - Easy to track
  - Rewards highly productive physicians

- **Disadvantages**
  - Dependent upon effective employer’s billing office
  - Dependent upon Payor Mix
  - Encourages “every man for himself” behavior
For physicians performing substantial administrative services, there should be (and usually will be) separate administrative stipend in addition to compensation paid under the above models:

- Usually determined based on hourly rates from Survey Data
- Will likely require you to fill out monthly time logs documenting services and hours
RECOMMENDATIONS

- **Know Your Own Historical Data**
  - wRVUs
    - May need to determine this retroactively if your billing system does not track this
  - TCC (including benefits, allowances, and other directs)
  - Compensation per wRVU
  - Practice overhead (how will this change under the new model)
RECOMMENDATIONS

- Obtain Most Recent Salary and Productivity Survey Data for Your Specialty
  - Get it from Natl Assoc, local consultant or directly from hospital
  - Understand nuances
    - Differences in data based on geographical area
    - Differences in data based on type of group, size of group, past production, years of experience
    - Functions/position (Medical Director, Chief, Department Chair)
RECOMMENDATIONS

• Make sure you completely understand the proposed compensation formula
  
  ○ What factors are within your control and what is not
  ○ How your comp might change under the new formula using your own annual date to test it
RECOMMENDATIONS

- Find out what types of monthly reports you will get to measure your earned bonus and/or productivity compensation
  - There should be no surprises at the end of the year
  - Include list of reports in your Agreement and the timing of when you will receive so you can measure your progress and see where you stand
Talk to other, similarly situated, physicians who have worked under the proposed formula (ask for references for Drs who signed in the last 6 mths, 1 year and 3 to allow you to hear different perspectives)
RECOMMENDATIONS

And last but very important -

- Hire an experienced attorney and/or consultant to advise you
QUESTIONS/COMMENTS