MEDICAL BUSINESS ADVISORS, LLC

Physician employment compensation models

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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)

Bonus

- 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)

Annual Cap

Health System might require:

- Physician's TCC usually (could be) subject to an annual cap (e.g., 90th 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

ADMINISTRATIVE STIPENDS

- 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

RECOMMENDATIONS

- **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**

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QUESTIONS/COMMENTS