Understanding the Basics

Physician compensation models may vary considerably in their structure and weighting of individual components, and are expected to evolve in the coming years in concert with health reform-associated payment changes. However, there are a few basic arrangements on which most compensation methods, outside the solo practice environment, are based today. Below are brief summaries of physician compensation models and their perceived upsides and downsides.

Salary with Production and/or Quality Bonus: Hospital/Health System Employed or Private Practice

The salary-only model once common in academic centers, government practice settings, and some health maintenance organizations remains prevalent in some settings but is gradually giving way to structures that combine a base salary with a bonus based on the physician's productivity, performance on quality metrics, or increasingly both.

In the hospital or practice setting, physicians' production-associated compensation will be based on either net collections, gross billings, patient encounters, or relative value units (RVUs), a unit of measure that reflects the time, effort intensity, and technical skills required to perform a particular service or procedure. RVUs are classified as either total RVUs or work RVUs, with the latter more commonly used in compensation models. A perception of RVUs is that they're not affected by a practice's charges or collections, which means that two physicians performing the same service generate the same number of RVUs. (RVU schedules are published by Medicare.)

"One way for physicians to figure this out and compare practice production-compensation models is to familiarize themselves with national surveys that pinpoint median RVUs, and [request] concrete examples of what has happened in that particular practice," advised Tommy Bohannon, senior director of recruiting and development training at MHA. Many practices using production-intensive models ultimately require the physicians to convert to compensation based on their individual productivity, usually a year or two into practice.

Quality metrics-based bonus structures is a fast-evolving area that is becoming more complex as care and outcomes data becomes more available. Currently the factors commonly measured, individually or combined are administrative responsibility, patient satisfaction, community outreach, peer review, service quality, and seniority. Today, quality bonuses range from 5 to 20 percent of base salary.

Regardless of the mix of production and quality metrics, most practices use models that ensure the entire income isn't at risk based on physician performance, Mr. Bohannon explained. "A common arrangement would be that the physician receives a salary each quarter based on the number of RVUs generated in the previous quarter. They might be paid 80 percent of that sum, with the other 20 percent withheld in case you're less productive next quarter," he said.

Income or Collections Guarantees

Income- or collections-guarantee arrangements have been fairly common compensation models in medical groups for many years, but are decreasing in use because of regulatory concerns and as some physicians become increasingly reluctant to take on the risk of running a practice and generating revenues.

In income-guarantee arrangements, the hospital or employing practice typically provides an income for the first one to two years, based on monthly income from or collections for billed services. In essence, it's a subsidy while the physician develops a patient base and builds the practice. At the end of the subsidy period, any sum not paid back to the hospital or group is converted to a promissory note and forgiven over time.

The catch is that these agreements typically require the physician to remain in the community throughout the loan forgiveness period, which could amount to several years.

Triangle or Practice Support Agreements

Triangle agreements occur when a hospital helps a local group recruit a needed physician and subsidizes the group, which in turn pays the physician. Triangle agreements have become more popular in recent

years for three reasons: they are more compliant with the Stark laws that govern referrals, reduce a group's financial outlay, and enable it to take a loss while the physician builds a revenue stream.

Like the income guarantee, the triangle agreement involves a forgivable loan from the hospital and a stipulation to remain in the community — not necessarily the practice — for a certain period of time. Therein lies a potential downside; if the community cannot generate enough patient or procedure volume for the physician's practice, the physician may not wish to remain there.

"I always encourage both the relocating physician and potential employers to think about the worst-case scenario with these agreements, to have a plan for how that might play out and be addressed," Mr. Cebulka advises. "The physician needs to feel that there's a demand for the service they provide, because a patient base in need is what makes a practice." A potential downside for the group is that it must share its financial data with the hospital providing the subsidy for up to five years.

Incubator

One of the newest compensation methodologies to develop, incubator models are another iteration of the triangle agreement, in which the three parties (the hospital, the group, and the physician) devise an arrangement to bring the doctor to the community. The physician typically is compensated on a salary plus–bonus plan, and may work as either a solo practitioner or within an existing group's practice. The idea is that the physician will eventually generate enough revenues to repay the hospital's outlay.

However, in the incubator model the physician is initially employed by the hospital, not the group, with the expectation that sometime in the future the doctor will either join the group or incorporate as a private practitioner.

In incubator agreements, the physician is not required to remain in the community for any period of time, which may be viewed as a downside for the hospital. The plus for the physician and the group is that both have time to evaluate whether the relationship and practice are a good fit.

Resources

"Executive Summary: Physician Recruiting Financial Models"
This recent publication, produced by Merritt Hawkins & Associates, offers a detailed overview of prevailing physician compensation models. It's accessible at www.merritthawkins.com.

"Pathways for Physician Success Under Healthcare Payment and Delivery Reforms"
Published by the AMA in June 2010, this document provides a thorough review of the forces shaping medical services payment reform and how these developments may affect physician compensation. Available at no cost to members, an executive summary of the document can be accessed at http://www.ama-assn.org/ama1/pub/upload/mm/399/payment-pathways-summary.pdf.

"MGMA Physician Compensation and Production Survey: 2010 Report Based on 2009 Data"
Although this Medical Group Management Association (MGMA) survey report focuses primarily on physician earning trends, national and regional, the production section offers a helpful view on a medical groups' relative structuring of compensation components. Available for review in libraries or for purchase at www.mgma.com/store/productdetails.aspx?id=38994.

"Report on Medical School Faculty Salaries 2008–2009"
This Association of American Medical Colleges report is a potentially valuable resource for physicians pursuing academic opportunities that involve primarily teaching and research, and some or no clinical duties. The report offers details on prevailing salary ranges and income breakdowns for teaching, patient care, or research. It can be purchased at www.aamc.org/publications.

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