Physician Compensation

11

CHAPTER 11

Analyzing compensation by each factor

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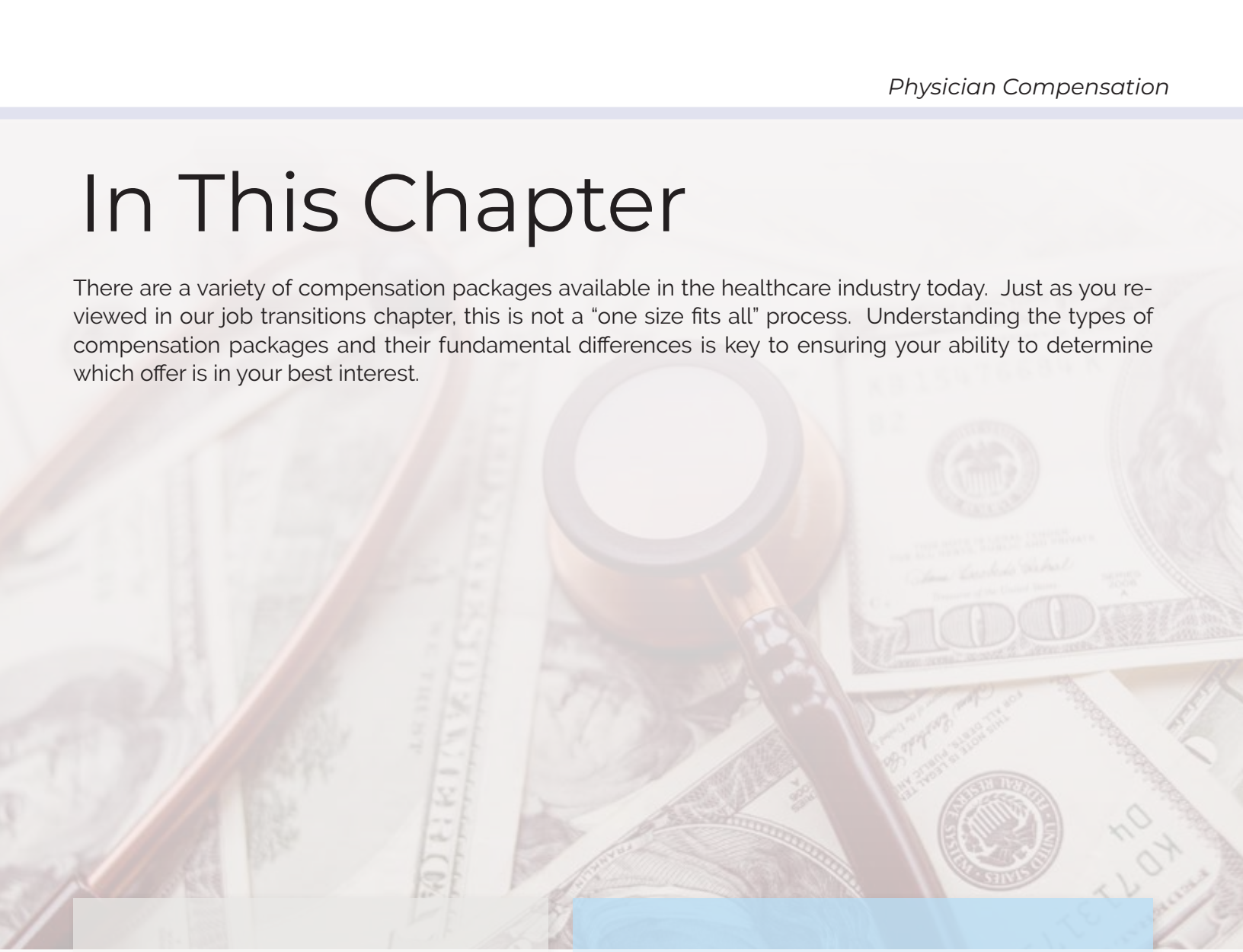
In This Chapter

There are a variety of compensation packages available in the healthcare industry today. Just as you reviewed in our job transitions chapter, this is not a "one size fits all" process. Understanding the types of compensation packages and their fundamental differences is key to ensuring your ability to determine which offer is in your best interest.



OUTLINE

1. Major Factors Impacting a Physician's Salary and Compensation Plan
2. How Employers Determine Starting Salary
3. Additional Compensation Opportunities
4. Taxable Income Considerations
5. Post-Starting Salary Transition
6. Fair Market Value and Commercial Reasonableness Standards
7. Production Models

GOALS

- Learn how employers determine compensation packages.
- Generate questions to ask the employer before making a decision.
- Understand how compensation is impacted by geographic location, demographic classification, practice type, practice ownership, and medical specialty.
- Learn how compensation methods impact a physician's financial bottom line.
- Differentiate between various production-based models.

LET'S GET STARTED

READ:

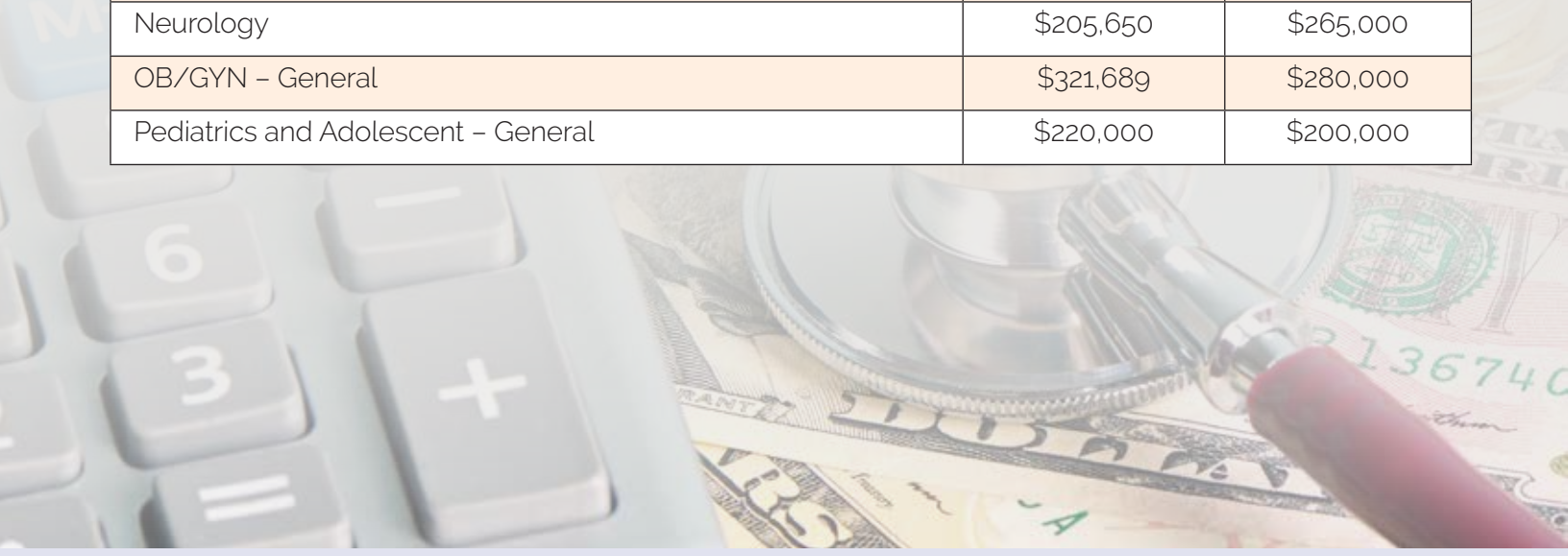
Major Factors Impacting a Physician's Salary and Compensation Plan:

Completing specialized medical training is not the end, it's the beginning of a career as a highly-skilled physician. After years of training and sacrifice, it's time to get paid a fair market wage for your hard work. To know that what you are being offered is indeed fair, it's important to understand how a physician's compensation is determined. There are several important factors, some obvious, some not so obvious, that can impact a physician's salary and overall compensation plan.

Throughout the chapter, we'll provide you with compensation data based on how employers leverage physician compensation data to determine the starting salary and compensation package of a new physician.

Geographic location – Where you choose to practice medicine has a significant impact on your compensation. That holds true for most professions, but especially for physicians. Consider the following starting salary median data reported by American Medical Group Association (AMGA) in their *2019 Medical Group Compensation and Productivity Survey*, for both new residents and experienced providers:

NEW RESIDENT STARTING SALARIES		
Specialty	**Midwest Median**	**National Median**
Anesthesiology	$459,160	$403,000
Emergency Medicine	$417,600	$343,946
Family Medicine	$242,500	$200,000
General Surgery	$397,500	$360,000
Hospitalist – Internal Medicine	$215,745	$252,700
Internal Medicine	$209,797	$210,000
Neurology	$205,650	$265,000
OB/GYN – General	$321,689	$280,000
Pediatrics and Adolescent – General	$220,000	$200,000



AMGA 2019 Medical Group Compensation and Productivity Survey, 2018 data [1]

EXPERIENCED PROVIDER STARTING SALARIES					
Specialty	**Midwest Median**	**South Median**	**East Median**	**West Median**	**National Median**
Anesthesiology	$342,000		$431,813	$340,000	$427,500
Emergency Medicine	$390,749		$317,186	$264,880	$329,540
Family Medicine	$230,000	$170,439	$186,007	$220,000	$220,000
General Surgery	$325,000	$333,990	$375,000	$300,000	$366,350
Hospitalist – Internal Medicine	$299,208	$219,182	$181,456	$229,150	$250,000
Internal Medicine	$199,093	$220,000	$210,000	$220,002	$220,000
Neurology	$300,000	$275,000	$285,000	$262,086	$285,001
OB/GYN – General	$230,006	$310,000	$217,050	$257,500	$282,500
Pediatrics and Adolescent – General	$230,000	$156,875	$213,782	$221,919	$211,968

What's causes such variation in compensation by geographic region? Large metropolitan markets might have a greater demand for physician services driven by a larger patient population, but they also tend to have a greater supply of physicians. However, those same large metropolitan markets can have a higher cost of living (which we'll speak about later). Smaller, rural markets, while they may serve a smaller patient population by comparison, tend to have a much lower supply of physicians and face challenges recruiting and retaining physicians to those markets, all of which tends to increase the market value for physician services to meet the needs of that community.

Take into account, however, these four geographic regions encompass large segments of the country, each with their own composition of rural and metropolitan service markets, and each with their own unique market competition and other dynamics.

Todd Skertich, managing partner of Arlington HealthCare – a physician recruitment firm, states, *"There are several markets within each region and compensation can vary significantly by the size of the community. To give you an idea of how compensation may vary between markets, below is a comparison of two metropolitan markets in different regions.*

A breast surgeon received offers in two different metropolitan areas. The first offer was located near Seattle, Washington while the second offer was near Manhattan. The Seattle position offered $150,000 MORE compared to the offer in Manhattan.

Generally, when comparing a small, medium, or metropolitan area in each of the regions of the US, compensation tends to be higher in the Midwest and Southeast versus the Northeast and West."

Demographic classification (population) – Non-metropolitan areas, typically defined as a population base of less than 50,000, tend to experience higher starting salaries in order to attract qualified physicians to work in such rural markets. Metropolitan markets, by definition, can be further stratified into segments of 50,000-250,000, 250,000-1,000,000, and greater than 1,000,000. These different metropolitan markets can among themselves experience varying degrees of starting salary.

Mr. Skertich, who has helped negotiate more than $500,000,000 in physician compensation over the past 20 years, states, "Each employer interprets the survey data differently based on their region (geographic location), demographic classification (community size), practice type, and several other factors to determine their guaranteed offer to a new physician.

The Demographic Classification (size of community) is a one of the most significant factors with the greatest impact on the starting salary. For example, an interventional cardiologist was offered a position at two different organizations. The first position in Chicago offered a starting salary of $250,000 and a second position located in a mid-sized community located 90 minutes from Chicago offered a starting salary of $500,000.

As another example, a family physician candidate received the three below offers:

	Metropolitan	Medium	Small
Population	2,700,000	150,000	10,600+
Starting Salary	$140,000	$220,000	$245,000
Signing on Bonus	$10,000	$50,000	$30,000
Residency Stipend	$0	$0	$20,000
Total Compensation	$150,000	$270,000	$295,000

The difference between the position located in a metropolitan area and the small community is $145,000 before calculating an additional $25,000 per year in loan repayment as the facility site qualified as an underserved area.

This doesn't mean every family physician located in a small community will receive a first year guarantee of $295,000 or that every position located in a metro area will offer you a total guaranteed compensation of $150,000, but it should provide insight on how guaranteed compensation can differ among community size.

Although, there are exceptions to the rule, generally, "guaranteed" compensation packages are higher the further you are from a metropolitan area and lower as you move closer to a big city."

Practice type – The type of practice you work in will influence how much compensation you might expect to earn. Typical practice types include:

- Single specialty
- Multi-specialty
- Hospital/health system
- Rural health clinic
- Federally Qualified Health Center
- Academic medical center
- Locum tenens

Different practice types allow for varying status as employed, independent, or partner physicians.

Group practices, especially hospital group practices, whether single specialty or multi-specialty, are usually better able to accept and manage financial risk than solo practices. This may be advantageous to weather the ups and downs of the healthcare industry and changing administrations. Group practices have other benefits such as more physicians to spread the workload and share the burden of overhead.

Ready to hang a shingle and go it alone? A solo practice offers very little scheduling flexibility and fewer resources for managing the administrative tasks associated with running a practice.

Hospital-based practices can generate a more predictable income, a regular patient base, and a solid referral network. This can come at the cost of independence and of following policies that you don't have a hand in creating.

Rural health clinics are most often, medically underserved areas and are subject to specific reimbursement as they are funded in part by a government program. They are designed to increase access to primary care services for patients in rural communities. They are considered the essential source of outpatient care, emergency care, and basic lab services in a rural area. Federally Qualified Health Centers, also government programs, are also known as community health centers.

These centers offer more comprehensive services including diagnostic and lab, pharmaceutical, behavioral, oral, primary and specialty care, after-hours care, case management, transportation, and interpretative services. These centers address the care of a population base in rural and urban areas defined as medically underserved areas or Health Professional Shortage Areas (HPSA). Ultimately, physician compensation opportunities in these practice settings will be impacted by a shortage of physician access (theoretically increasing compensation) and financial limitations of the centers (theoretically decreasing compensation).

The mission of an academic medical center (AMC) creates a completely different practice environment. Academic physicians tend to be paid less than non-academic counterparts depending on faculty position within the AMC and their relative scope of responsibility within clinical and research departments. AMCs have not traditionally focused on clinical effort across the faculty, however that is changing as economic pressures increase. AMCs tend to separately define and value protected time for administrative, research, and teaching services apart from clinical services.

Practice ownership – According to a 2019 report by Avalere Health and the Physicians Advocacy Institute, hospitals and health systems employed 25% of the physicians in the United States in 2012. That figure is up to 44% in 2018 (2). Medical practices continue to be acquired at a significant pace. This consolidation is reshaping the healthcare industry.

The reality is that employed physicians and those in private practice face different challenges and risks largely related to reimbursement. A private practice model puts the pressure on physician owners to manage ever-changing rules and requirements and to assume risk associated with commercial and governmental payers. A hospital-employed model shifts most of the risk to the hospital for administrative and regulatory burdens; however, employed physicians can begin to feel like a cog in a wheel merely churning out widgets.

Are you looking for the freedom to own and manage your own practice? Do you want closer relationships with your patients and the ability to establish your own culture? Physician-owned practice may offer less value in the initial set of contract years, but may offer more value in the long term. Independently owned and operated practices can be more efficient and nimbler in making decisions. Higher business risk comes with higher reward. Also, you may have opportunities to invest in other areas such as a medical office building, ambulatory surgery center, and other ancillary services that are not available through hospital-owned practices.

Recently there have been other market disruptors in the arena of physician employment, such as large investor-backed entities such as DaVita and Optum. These groups may offer ownership interest or equity in their practices that may not be available with not-for-profit hospitals and health systems.

Regardless of the practice type, make sure you fully evaluate the practice leadership. Look for practices that are physician led and professionally managed. As the healthcare delivery system is continuing to be reorganized, shared accountability among physicians, hospitals, and payers is critical. Physician-led groups are an integral part of a model of integrated care. A successful practice will engage its physician leaders in areas of clinical quality, system development, and public policy.

Medical specialty – It is no surprise that medical and surgical specialists experience higher levels of compensation than primary care physicians. Primary care is generally defined to include family medicine, internal medicine, general pediatric medicine, general obstetrics and gynecology, and geriatrics.

Consider the "Total Compensation" national median data reported by AMGA:

Physician Specialty (Primary Care)	**Provider Count**	**Median**
Family Medicine	9,366	$260,108
Internal Medicine	7,367	$273,254
Hospitalist – Internal Medicine	5,982	$293,252
Pediatrics and Adolescent – General	4,080	$245,043
Geriatrics	383	$250,000
Urgent Care	1,274	$283,787
Physician Specialty (Specialists)	**Provider Count**	**Median**
Anesthesiology	2,226	$436,404
Cardiology – General	2,071	$519,964
Cardiology – Cath Lab (Invasive Interventional)	992	$613,743
Diagnostic Radiology (MD Non-Interventional)	1,734	$482,599
Emergency Medicine	2,703	$363,201
Gastroenterology	1,638	$527,998
General Surgery	1,950	$431,163
Hematology and Medical Oncology	1,527	$450,502

AMGA 2019 Medical Group Compensation and Productivity Survey, 2018 data (1)

The preceding national survey data reflects established and experienced physicians, indicative of longer-term compensation earning potential. An important distinction here is that these data points are not reflective of merely base salary levels but rather of total cash compensation, which is inclusive of all sources of compensation (base salary, production bonus, quality, call coverage, medical directorship, etc.).

However, for those of you in primary care, don't fret. You are in very high demand and may have a better pathway to work-life balance not afforded to those in specialty practices.

FIELD NOTES

For specialties with a surplus of candidates, like nephrology and sports medicine, employers may adjust the guaranteed compensation down and for specialties who are in high demand with a shortage of candidates, employers will adjust the compensation up.

An employer located in a medium-sized community located 90 minutes from Chicago uses the median as a starting point and then adjusts up or down as they work through each compensation factor.

To demonstrate how guaranteed compensation may be impacted based on one high-demand specialty and one specialty with a surplus of candidates, check out the table below.

Specialty	In Demand	Median	Adjusted Guaranteed Compensation
Psychiatry	HIGH	$295,000	$310,000
Nephrology	LOW	$310,000	$250,000

– Todd Skertich, Managing Partner at Arlington HealthCare Creator & Author of Career and Life Planning Guidebook for Medical Residents

Organizational needs and defined services – What you are asked or expected to do will certainly influence what you earn. We'll touch on some common physician services shortly, but remember there are only so many hours in the day, the week, the month, and the year. Compensation can stack up quickly the more you commit to do. Compliance experts will suggest you can't be in two places doing two different activities at the same time. Also, this "do more, earn more" wheel can quickly lead to physician burnout, which doesn't help anyone.

There are only so many hours in the day, the week, the month, and the year.

READ:

How Employers Determine Starting Salary

Physician Compensation and Production Surveys

So exactly how do healthcare employers determine starting salary and total compensation levels? Hospitals and healthcare systems might use available national or regional physician compensation and production survey data such as that reported by Medical Group Management Association (MGMA), American Medical Group Association (AMGA), and Sullivan Cotter & Associates.

Private groups might set a guaranteed level of compensation with the understanding that the practice is likely to subsidize the new physician for a period of time until their practice builds. Factors that influence your ramp-up time include whether you are new to the practice and whether you are experienced or new to the geographic market or relocating a practice within that market.

Patient demand and how willing your practice colleagues are to share in overall practice volume will also impact how quickly your practice grows. It is common to see guaranteed salary provisions for at least one year and up to three years depending on the market and practice dynamics. Employers are making an investment in you with the intent of full value being realized in the future. Don't forget that starting salary is only part of the overall compensation package for physicians. In the following section, we will talk about some of the other compensation opportunities in which you might participate.

FIELD NOTES

"Worry less about money, and more about the day-to-day details that make life happy. In the end, the poorest physician is richer than 99% of the population. I'm a happy, employed physician and it works well for my career and family because I really took the time to find an employment opportunity that worked for everyone."

– Kelli Webb, MD, Plastic & Reconstructive Surgeon
SIH Medical Group

- **WHEN UTILIZING PHYSICIAN COMPENSATION SURVEYS, VERIFY WHETHER THE DATA SOURCED IS FOR STARTING SALARIES OR TOTAL COMPENSATION.**
- **TOTAL CASH COMPENSATION INCLUDES BASE SALARY, SIGNING BONUS, TAXABLE LOAN REPAYMENT, BONUSES, RELOCATION, AND ANY INCOME CONSIDERED TAXABLE**

READ:

Additional Compensation Opportunities

An employer may offer a variety of upfront or future recruitment incentives that will be treated as taxable income at the time they are paid. These incentives are above and beyond any other physician service provisions to be discussed later in this chapter.

Relocation allowance – If you are relocating to (or sometimes even within) a new market, you can expect to receive a reimbursement of moving expenses. This reimbursement can be a flat stipend, while most of the time it's structured as a maximum allowable amount subject to submission of actual receipts. On average, you can expect this allowance to be around $10,000. While more uncommon, you may also receive a short-term housing/living allowance which is intended to allow you to move to a new market and give you time to find permanent housing.

Residency/fellowship expense stipend – If the recruiting process starts before you finish training, you may be offered a stipend to help offset expenses incurred during your residency or fellowship. This type of stipend may be in the range of $3,000 - $12,000 per month and comes with the commitment that you will commence employment with the employer after your training is completed. Also, the aggregate stipend paid to you during your training may be subject to repayment for early contract termination.

Starting/signing bonus – Employers commonly offer a starting or signing bonus as a recruitment incentive. This one-time cash payment may be paid to you at the time you start employment or the time you commit to an employment relationship. This upfront cash payment can be quite useful in getting settled in a new practice location, for example purchasing a new home. The amount of such a bonus is negotiable and can typically range from $10,000 - $50,000 depending on your clinical specialty and practice situation.

Retention bonus – Another common recruitment incentive is a retention bonus typically payable at the end of each contract year as a mechanism to reward a year of continued service and commitment to the practice. This bonus too is negotiable, and can typically range from $10,000 - $50,000 per year depending on your clinical specialty and practice situation.

Student loan repayment assistance – According to the Association of American Medical Colleges, 75% of medical school students in the class of 2018 graduated with student debt, the average of which was $200,000 (4). Employers may offer assistance to help pay down your debt, often structured as either a one-time lump sum payment or as an ongoing payment over your contract term. If paid up-front, the assistance is typically structured as a loan subject to principal and interest forgiveness over the contract term. This assistance may be paid directly to you or may be paid directly to the loan holders.

Recommended Tool

Negotiating Your Compensation Package.

Negotiating is an art. Push too hard—or unrealistically—and you might lose the opportunity. Don't push hard enough and you might leave thousands of dollars on the table. This Survival Tool will walk you through the negotiation process step by step.

http://md.careers/ST-17

READ:

Physician Service Provisions

Beyond a starting salary and any available recruitment incentives, you may have opportunities to earn additional compensation for a variety of professional services, depending on the practice situation. Not all of these provisions might be available right away, but are common in physician contracts. A reminder that the following compensation opportunities are reflected in the definition of total cash compensation in the national survey data (e.g., AMGA).

Advanced practice provider ("APP") supervision – In a 2019 study by the Association of American Medical Colleges, the nation will experience a shortage of 46,900 – 121,900 physicians by 2032 (5). This looming shortage, which we have seen coming for quite some time, has necessitated the usage of APPs to help bridge the gap in patient access and the delivery of quality healthcare in traditionally underserved markets. However, physicians may not be motivated to fully utilize APPs without compensation for their role in supervision of an APP.

These additional supervision responsibilities require physicians to take on more risk and put forth more effort above and beyond their traditional clinical responsibilities. The need for APP supervision will vary among clinical practices and may be influenced by state requirements. Some questions to consider include: 1) how are APPs clinically integrated into the practice? 2) how is APP production accounted for? 3) is there a separate stipend for APP supervision or is the value included in the base salary and 4) what are the specific split-share or incident-to requirements?

Call coverage – Physician call coverage is almost a core expectation for many clinical specialties and practices. In the past, hospitals might have relied on physicians to provide coverage of emergency departments and other specialty departments without providing compensation to the physicians.

Generally speaking, in today's terms, physicians are unwilling to take on the additional risk and effort associated with call coverage without additional compensation. Although some hospital bylaws may still require some minimum number of uncompensated on-call days, especially for employed specialist physicians, this practice is less common than it was in the past.

Call coverage may be limited to your clinical practice (i.e., your patients), but more than likely will include some form of hospital coverage. An extension of traditional call coverage is the emergence of telemedicine which is being seen with increasing application in behavioral health, neurology, and cardiology.

Call coverage compensation may take many forms such as a daily stipend, an hourly rate, professional fees generated for actual professional services rendered, credit toward productivity compensation, an activation rate, or a subsidy for uninsured or unassigned patients. Compensation for call coverage is fundamentally a function of the burden associated with the call coverage.

Examples of call burden include the size of the physician panel participating in the call rotation (e.g., 1:5), the restricted nature of the coverage, the scope, size, and trauma designation of the facility or facilities being covered, the acuity of patient care associated with the coverage, projected volumes of telephonic consultation and/or activations to present to the hospital, the applicable payer mix and associated risk for reimbursement, and other unique factors relevant to the coverage.

Hospital options for call coverage include employed physicians, independent physicians, APPs, or locum tenens. In cases where there is a shortage of physicians to provide sufficient and often-required levels of 24/7/365 coverage, you may be asked to provide "excess" shift coverage above and beyond a reasonable and customary full-time obligation.

Concurrent coverage of more than one hospital and/or more than one specialty panel will also influence the value of call coverage. There may also be shift differentials for evening, weekend, or holiday coverage. Be careful about comparing call coverage compensation "to your friend down the street who works at XYZ hospital," as physician call coverage is fact specific and your burden is not the same as someone else's, even in the same clinical specialty, across different facilities and in different markets.

Also, be aware call coverage value may be included in a base salary structure and not necessarily paid out per shift. In instances where call coverage is paid on a per-shift basis, there are national surveys such as Sullivan Cotter & Associates and Integrated Healthcare Strategies that report physician specialty call pay data.

Quality initiatives – No doubt you have heard about healthcare's shift from volume-based care to value-based care. It's a long journey, but one that is no less taking form with increasing quality metric-driven incentives designed to improve the quality of care delivered to patients and also result in lower healthcare costs. Implementation of quality incentives in a physician compensation model require trust, transparency, and data validation.

There is no magic number for how much compensation might be put at-risk for such quality incentives, but you might expect anywhere from 5% - 20%. The specific types of metrics will vary among clinical practices and departments. Common metrics might include patient satisfaction, charting, clinical quality scores (e.g., percentage of patients receiving preventative services), or rates of surgical complications or hospital-acquired infections.

The Centers for Medicare and Medicaid has long supported this transition to value-based payment

and continues to create value-based payment models and rural health initiatives, all of which eventually impact how physicians receive compensation whether through direct employment relationships or through practice reimbursement for professional services.

Medical administrative/physician leadership services – Some physicians with appropriate leadership skills may be asked to provide medical administrative or physician leadership services within an organization. Roles are typically individually assigned, and not available to all physicians. An example of medical administrative responsibilities might include designation as a medical director of a hospital department or service line. Examples of physician leadership responsibilities might include designation as a medical group president or a service line/regional executive. Such roles are often part time, however some may be full time as the role requires.

As market players in the healthcare arena continue to evolve, physicians are seen as integral partners contributing to strategy, growth, development, and culture. For example, as health systems increase in size, there has been a corresponding increase in the prevalence of "regional" and "system-wide" medical administrative and physician leadership designations. Similar to call coverage, leadership roles are fact specific and do vary across different facilities and different markets. A title of "medical director" means only what that organization has defined the role to encompass. Job descriptions and scope of responsibility will vary from role to role, even within the same organization. Payment to physicians for such services typically requires detailed time documentation submission and approval.

Before committing to these additional services, make sure to understand the following:

- What are the position qualifications?
- What are the expected duties and to whom do I report?
- What is the expected time commitment?
- Is my clinical practice schedule going to be modified to allow for this time commitment?
- What are the time reporting requirements?
- How will my performance be evaluated?
- How will I be compensated for these services (stipend; hourly)?
- Is there any incentive linked to my performance in this role?
- Are the compensation terms fair market value and commercially reasonable?

Medical administrative services are typically valued lower than clinical services as the value to an organization for physician leadership is economically different than that of direct patient care. Historically you might have observed hospitals and health systems valuing all medical administrative services at a flat rate (e.g., $125-150 per-hour) regardless of the position and the physician's clinical specialty. That approach is disappearing as hospitals and health systems have had to face the reality that a neurosurgeon's and a family physician's time is inherently valued differently in the market. But don't expect full opportunity cost based on your clinical rate of pay to apply to medical administrative services.

The trend is that "clinical" and "non-clinical" rates are coming closer together, but each service has to stand alone from a valuation perspective.

Other opportunities – Depending on the practice setting, you may be asked to participate in research or teaching (e.g., residency programs). Compensation for these services will typically be a function of the time commitment on an hourly rate basis. You may also find additional compensation opportunities arising through third-party, value-based incentive programs such as gain sharing, population health, shared savings, and quality improvement programs. Depending on the nature and funds-flow of these programs, there may be predetermined, pass-through percentages or other distribution methodology applied.

Recommended Tool

Compensation Package Worksheet.

You cannot make a good decision about which offer to accept without gathering all of the facts regarding compensation and comparing them to what you believe is acceptable. This exercise worksheet will help you make an objective evaluation of all the elements involved with the compensation offer.

http://md.careers/E-23

READ:

Post-Starting Salary Transition

At some point, the "guarantee" in a guaranteed base salary might expire and you will find yourself being "at-risk" for a potentially large portion of your compensation. This might occur somewhere after the first contract year or not until your fourth contract year depending on your guaranteed salary provisions and practice ramp-up expectations. Going at-risk for production, typically measured in either wRVUs or net professional collections depending on the applicable compensation model, will require some basic understanding of productivity which we will cover in the next section. Going at-risk also requires some advanced planning and reporting to make sure you're ready to have the safety net taken away.

It is important to understand how compensation earned/paid is treated as taxable income on a W-2, 1099, or Schedule K-1. Make sure to ask the employer and consult your tax advisor for specific guidance.

Fair Market Value and Commercial Reasonableness Standards

Arrangements involving physicians are subject to a number of regulatory restrictions that require compensation for services to be at Fair Market Value ("FMV"). These include the Stark Law, the Anti-Kickback Statute, and tax-exempt organization regulations.

The Stark Law limits the ability of physicians to have a financial relationship with entities that provide certain services to which the physicians are in a position to refer patients. The federal government has provided a list of Designated Health Services ("DHS") subject to the Stark Law. The Stark Law prohibits a provider or his or her immediate family members from referring a government healthcare program patient for any DHS to an entity with which

the provider (or an immediate family member) has a financial relationship, unless an exception applies.

A physician employment arrangement is one of these exceptions if all of the requirements are met. The Stark Law not only prohibits referring physicians from owning an interest in businesses to which they refer, unless an exception applies, but also requires that the compensation paid pursuant to the contractual relationships between referring physicians and entities to which they refer, not exceed FMV, and the arrangement itself must be commercially reasonable.

The term "fair market value" is defined by the various Stark regulations (42 CFR § 411.351) as the value in arm's-length transactions, consistent with the general market value. "General market value" means the compensation that would be included in a services 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 at the time of the services agreement. Usually, the fair market price is the compensation that has been included in bona fide services agreements (e.g., employment) with comparable terms at the time of the agreement, where the compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals. An arrangement is not considered to be at fair market value where a party pays substantially more for the services from a physician-owned entity than it would from a non-physician-owned entity for the same or similar services.

The definition of "fair market value" according to the Anti-Kickback Statute is generally the same as under the Stark Law. Fair market value compensation under the Anti-Kickback Statute is to be reflective of an arm's length transaction and not to be determined in a manner that takes into account the volume or value of any referrals of business between the parties reimbursed under Medicare or Medicaid. The Anti-Kickback Statute makes it a felony to offer, pay, accept, or solicit payment for the referral of, or the arranging for the referral of, items, services, or patients reimbursed by any federal or state healthcare program. The Anti-Kickback Statute has safe harbor provisions that allow for certain business practices, including physician employment arrangements, which would not be treated as violations of the Anti-Kickback Statute under very specific facts and circumstances.

The IRS restrictions on private inurement and private benefit control and regulate acceptable actions of tax-exempt organizations. Internal Revenue Code Section 501(c)(3), which governs tax exempt organizations, does not prohibit transactions with persons in controlling positions as long as the transactions are consummated at arm's-length, in good faith, and are reasonable. However, when the interests of the tax-exempt organizations are sacrificed for the benefit of private interest, tax exemption can be lost because the organization is serving private, not charitable interests.

A hospital or health care organization that is exempt from federal income tax must be operated exclusively for charitable purposes. No part of an exempt organization's net earnings may inure to the benefit of a private shareholder or individual.

The primary purpose of the exempt organization must remain to serve the public interest rather than a private interest. Under IRS regulations concerning excess benefit transactions with respect to services provided, the FMV of services is the amount that would ordinarily be provided for like services by like enterprises (whether taxable or tax-exempt) under like circumstances (i.e., reasonable compensation).

The IRS further defines "fair market value" in Treasury Regulation Section 20.2031-1 as "the price at which the property would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy or to sell and both having reasonable knowledge of relevant facts."

Commercial Reasonableness ("CR") is not as well defined in the laws and regulations, however an agreement will be considered Commercially

Reasonable "if in the absence of referrals, the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician or a family member or group practice of similar scope and specialty even if there were no DHS referral." [69 Federal Register 16093 – March 26, 2004] Also, the compensation arrangement must appear "to be a sensible, prudent business arrangement, from the perspective of the particular parties involved, even in the absence of any potential referrals." [63 Federal Register 1659, 1700 January 9, 1998]

That's a lot of legal jargon and you're thinking to yourself that you're a doctor not a lawyer - but it's critical to understand the ramifications of not adhering to the regulatory guidance for physician relationships. There is significant financial penalty and people have gone to jail for engaging in arrangements that are not legally defensible and involve kickbacks or incentivize referrals. It's incumbent on you to at least have a basic understanding of FMV and CR standards. You should also have competent legal counsel in your corner to help you navigate these regulatory waters.

Valuators of FMV and CR will consider the pertinent facts and circumstances of a services arrangement and utilize published market survey data like those surveys discussed in this chapter as support for FMV and CR ranges of physician services compensation. In deriving such ranges, valuators will consider a variety of benchmark metrics, most commonly including compensation-per-wRVU rate. Other metrics will include compensation-per-FTE, wRVUs-per-FTE, net professional collections-per-FTE, and compensation to collections ratio.

READ:

Production Models

The proverbial other side of the compensation coin is productivity. At some point in your medical career, whether part of a private medical practice or employed by a hospital/health system, you will find yourself measured on your production. Let's review a few common types of production measurement for associated compensation plans.

- **Work Relative Value Units ("wRVUs") –** Without getting too deep into the weeds, a wRVU is simply a component of a Total RVU as determined by The Centers for Medicare & Medicaid Services ("CMS"). A wRVU serves as a practical, transparent, payer-neutral, standard measurement of physician effort. For example, an office/outpatient visit for the evaluation and management of a new patient (CPT code 99203) has a value of 1.42 wRVUs according to the 2019 National Physician Fee Schedule Relative Value File. If you were paid $50.00 per-wRVU according to your compensation model, that patient visit would yield $71.00 of compensation.

CAUTION – *Be mindful of receiving zero wRVU credit for unlisted procedure services or nonbillable services.*

- **Gross Charges –** The full, non-discounted fees charged for all services provided before any contractual, charitable, courtesy, bad debt, or other adjustments are applied is referred to as gross charges. This financial metric considers patient and procedure volumes before considerations of actual payments received, which mitigates concerns among physicians regarding payer mix or other adjustments that might otherwise lead to inequality in distributed compensation. The common practice is to distribute net practice earnings (or a defined compensation pool) based on each physicians' percentage of gross charges.

CAUTION – *Ensure that the fee schedule does not disproportionately reward or penalize certain procedures over others.*

Net Collections – The actual cash received for services rendered is referred to as net collections. This financial performance metric is influenced by payer mix and revenue cycle efficiencies and can be used to calculate physician compensation in a variety of models, including as a percentage of collections. Private practices may also choose to distribute net practice earnings (or a defined compensation pool) based on each physicians' percentage of net collections.

CAUTION – *Payer mix and revenue cycle inefficiencies can materially influence net collections. For example, physicians with a higher Medicare/Medicaid payer mix may be disproportionately penalized under a net collections model compared to physicians with a better payer mix.*

Productivity Pitfalls

As with anything, there are pitfalls to consider and avoid if possible, on a production-based compensation model, including.

- Transitioning from a guaranteed salary too early.
- Not understanding the differences in compensation models (e.g., charges vs. collections vs. wRVU).
- Not understanding how advanced practice provider productivity is accounted for in the compensation plan.

Under a production-based compensation model, here are some best practices to consider:

- Utilize a shadow period leading up to the transition so you understand the mechanics of the new production-based model and its impact on your calculation.
- Determine in advance how material changes in the practice or the services provided will be addressed in the compensation plan.
- Develop a compensation "floor" of which you cannot earn less, regardless of your actual level of productivity.

Qualifying Compensation Questions

Whether your salary is evergreen (rare), or at some point you transition to a production-based salary, you want to ensure you understand the productivity formula or risk taking a pay cut.

Below is a list of questions which will help you measure the income potential and likelihood of maintaining or increasing your compensation during, and as you transition, to a production-based salary.

- Can you walk me through the compensation and productivity structure?
- Is there a productivity formula? If so, how does it work?
- If I do a good job, what is the income potential for:
  - Year 1?
  - Year 2?
  - Year 3?
- What is the total compensation range earned by current physicians?
  - Low?
  - High?
  - Median?
- How have other physicians adapted to a production-based salary?

- If I perform well, what is the income potential for the first, second, and third years?
- Do you anticipate acquiring any new systems that will impact and improve patient flow?
- What is the waiting period for new patients to see a physician in my specialty?
- How busy will I be from day one?
- Will the hospital help market my practice? If so, what is included in the marketing plan?
- What are my responsibilities in building a successful practice?
- How long do you estimate it will take to build a full practice?

You're probably thinking that there have to be instances where production shouldn't be the primary indicator of effort. You're correct!

- **Shift-Based Practices –** Certain physician specialties lend themselves to being more shift-based. In these instances, physicians provide on-site coverage regardless of the patient volume. Examples of these include emergency medicine, hospital medicine, and critical care medicine. These types of physicians are typically not in control of or able to predict the patient volume, the payer mix, or the payer contract associated with those patients. Additionally, the inherent nature of these types of practice settings is to be open and staffed 24/7/365 without regard to the commercial factors of demand as found in non-healthcare industries.

- **Rural Practice Settings –** We discussed in Section I that contributing factors to physician compensation include geographic location and demographic classification. These same factors influence physician productivity. Rural practice settings tend to contribute to higher levels of compensation and recruitment incentives due to supply and demand constraints.

These rural practices tend to provide care to a smaller patient base spread over a wider geographic footprint as compared to practices in large metropolitan markets. Take for instance a medical center located in a rural county consisting of approximately 2,500 people that is located one to two hours from the nearest large town. Physicians practicing in this type of rural setting provide a level of care to the population base that would be otherwise inaccessible without significant travel. In this instance, physician services are at a premium while physician productivity may not be the primary indicator of value.

Other Production Factors:

In any conversation regarding production there are other factors to consider including the application of CPT codes, payment modifiers, the use of internal coding reviews and audits, and comparison to CMS norms. Another influencer on production is the impact from practice recruitment and retention efforts. A physician practice will undoubtedly go through changes with new providers coming and going over the course of time. Understanding the impact and how your compensation plan will handle these changes is critical.

As we discussed earlier, healthcare is transitioning from volume to value. Essentially, payers are increasingly rewarding population health management and moving away from the traditional fee-for-service model of payment. This is aimed at improving quality and reducing the overall cost of healthcare market. CMS has adopted a framework dating back to 2007 to improve patient care, reduce healthcare costs, and improve population health. With the transition to value-based care, a fourth aim related to clinician experience has evolved.

Summary:

As discussed in other chapters, when choosing your next employer, it's important to evaluate all aspects of a position beyond compensation. Finding a well-run practice will help ensure the compensation will be the best it can be in the situation.

Below is a list of questions that will help you evaluate the non-compensation aspects of a position:

- Is the practice or health system stable?

Stable is preferable, but if they are growing, some instability maybe expected.

- What is its business outlook?
- Do they have a plan to expand or are they in a solid niche?
- Is the practice or the system a market leader?
- Are the current physicians busy?
- If so, that's good, but make sure they're not too busy, indicating there could be issues.
- How is the leadership structured?
- Is the practice run by physicians or non-physicians?
- Are there administrative expectations for the physicians?
- What EMR will I have to work with?
- What are the organization's expectations/standards for behavior? And do those expectations/standards involve physician and practice leaders alike?

We've covered a lot of ground with respect to compensation. The fact is it's an important subject, and one that will be present your entire career. Be prepared to weigh compensation among other practice factors discussed in this book. It doesn't always have to be about the money, but you owe it to yourself to be knowledgeable and to protect the biggest investment you've ever made - you.

Chapter Tool Box

The **CHAPTER TOOL BOX** consists of **RECOMMENDED TOOLS** featured throughout the chapter, along with additional resources and recommended links.

These tools will help you gain valuable insight about **Physician Compensation.**

CALCULATING PHYSICIAN PRODUCTIVITY
http://md.careers/E-28

COMPENSATION PACKAGE WORKSHEET
http://md.careers/E-23

NEGOTIATING YOUR COMPENSATION PACKAGE
http://md.careers/ST-17

SAMPLE PHYSICIAN COMPENSATION ANALYSIS
http://md.careers/S-11

Chapter Bibliography

1. American Medical Group Association, "2019 Medical Group Compensation and Productivity Survey," AMGA 2019 Compensation and Productivity Survey. ©2019 AMGA amga.org 2018 Data
2. Avalere Health and the Physicians Advocacy Institute, *Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012-2018*, Published February 2019
3. Association of American Medical Colleges, *Education Debt Manager for Matriculating and Graduating Medical School Students*, Published January 2019
4. Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2017-2032*, Published April 2019

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