

Trends in Physician Compensation Arrangements: Q & A With Todd Mello of HealthCare Appraisers

By Lindsey Dunn

Q: What are some of the biggest trends you're seeing in physician compensation arrangements right now?

Todd Mello: Two of the biggest trends I'm seeing are employment of physicians and compensation that is very closely tied to productivity. Physician employment is definitely on the rise. We're seeing hospitals looking to acquire large physician groups of specialists (particularly cardiology in light of impending significant reductions in reimbursement), and these physicians, when acquired, are entering to employment agreements. When employing physicians, most smart hospitals and other physician employers today now tie compensation to productivity. Furthermore, to the extent the physician practice is being acquired, the compensation contemplated under the subsequent employment model must be modeled in the practice valuation.

Q: How do hospitals and other providers that employ physicians go about determining compensation?

TM: Most seem to have realized that compensation should have appropriate checks and balances for productivity. Thus, they are tying compensation to productivity. In many cases, hospitals are using relative value units related to a physician's work, or work RVUs ("wRVUs"), to determine a physician's productivity. wRVUs are values assigned to each CPT code, which take into account the expected time a physician is required to perform the procedure. For illustrative purposes, a procedure assigned a wRVU value of 2 would involve twice as much physician work/resources as would a procedure assigned a wRVU value of 1. To assess a physician's overall productivity, wRVU values for a given period are summed and then compared to available benchmarks.

wRVUs are considered to be the most objective measure of productivity. If productivity is tied to billed charges, productivity could be easily manipulated by differences in fee schedules. Using net collections also presents the same problem. If a certain physician sees a large number of Medicaid patients, that physician will have less net collections than a physician with privately insured patients, regardless of their productivity. A good example would be an OBGYN who sees unassigned patients in the ER. Because women with insurance typically have an assigned OB, they will not be relying upon the OB covering the ER when they go into labor. Accordingly, the OB covering the ER receives a disproportionate share of uncompensated or undercompensated patients and resulting collections, if any, will be an inaccurate reflection of physician work performed. wRVUs account for these nuances.

Q: How would a hospital or practice use wRVUs to determine compensation?

TM: Commonly, a hospital will analyze a physician's wRVUs for the most recently completed year and set compensation for that physician to be reasonably commensurate with productivity. For example, if a physician had 10,000 wRVUs for the previous year and if that level of work corresponded to the 75th percentile, then hospital could reasonably set a physician's base compensation close to the 75th percentile. Frequently we observe a model in which the hospital would set a minimum wRVU threshold equal to 95 percent of the physician's prior year totals. To the extent actual productivity as measured by wRVUs is less than the 95 percent threshold, then there would be a predetermined reduction in compensation for every wRVU short of the minimum. Similarly, to the extent that productivity exceeds prior year totals, the physician would be eligible to receive incentive compensation for every wRVU in excess of prior year totals. Fewer physician practices use this method than hospitals, but the larger more-sophisticated ones certainly do. Each hospital and practice can determine how exactly they determine productivity using this method. For example, some give credit for administrative time as well. However, a note of caution with RVUs: You have to be a little careful that historical RVUs are calculated using the same scale as the actual RVUs worked in the relevant contract year. The problem is that CMS occasionally changes the RVU amounts assigned to certain common procedures and that could lead to a mismatch between current and historical RVUs, causing a possibility of overpayment.

Q: On-call pay seems to be another hot issue with regard to physician compensation. What trends are you seeing for this type of compensation?

TM: Call pay has been going on for some time, but there has recently been a tremendous increase in call pay throughout the country. Once it starts, you're never going to shut it off. It starts with one specialty in a hospital and then spreads to the others. Historically, the ER was a means of growing a physician's practice. Physicians saw a patient in the ER and then followed up with them in the office at a later date and maybe continue to care for them. Now, though, as reimbursements and professional fees are being squeezed by Medicare and more and more people are uninsured, physicians aren't as willing to wake up at 3 a.m. to treat a patient that they might not be reimbursed for and could possibly sue them if something goes wrong. As a result, more physicians are asking to be compensated for their time. At the same time, the EMTALA law was finalized which required hospitals to ensure that adequate screening and care is provided to patients that present to the ER with emergent conditions.

Q: How is compensation for taking call coverage being determined?

TM: There are several things to take into consideration such as the nature of the specialty and whether or not an urgent presence is required. We look at the type of facility — physicians at trauma facilities are typically going to see patients with greater acuity. We also look at payor mix for the specialty to determine if the physician is likely to be reimbursed or not for seeing the patient. One of the more powerful components of this is call frequency. We look at the number of calls in a time period, the number of calls that actually require the physician to present to the hospital and the number of physicians on the call panel. A physician at a trauma facility with a high call event frequency and a bad payor mix is going to receive a benefit for that.

Some hospitals are using per diems, so physicians are paid a certain amount per day on-call, regardless of whether or not they are called in. Others may use an “activation-fee” approach. Here, physicians may be paid a reduced per diem (or no per diem), and receive payment only when they have to come in to treat a patient. ■

Todd Mello is a founding principal of HealthCare Appraisers and manages the firm's Denver office. Learn more about HealthCare Appraisers.

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