



Negotiating a Compensation Plan

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Compensation does not equal just salary alone. Any offered compensation plan usually includes base salary, bonuses (if any) at signing and for performance, incentives and benefits related to health, disability, etc. and retirement benefits. Graduating vascular fellows and residents focus mostly on the first year salary rather than the total compensation package for comparison with other job offers¹. Little attention is given to perks beyond salary or the terms after the first year. This is an understandable mistake.

Graduates are burdened by debt, have many items on their “wish list” and are itching to enjoy the benefits of years of hard work. Potential partnership, assistance with debt, moving expenses, vacation time, sick time, continuing medical education reimbursement, any buy-in and retirement benefits and the vesting period are often ignored. The dollar amount gained or lost in these clauses in an employment agreement will likely far exceed the additional first year salary. In general, non-cash benefits such as insurances and retirement account for 12-13% of cash benefits for all specialties.

This practice memo briefly describes how to design a compensation plan, pros and cons of various incentives, financial drivers in formulas, and recent trends in compensation formulas in private practices and hospital employed vascular surgeons, as well as a few negotiation tips.

Compensation Plan Design

The ideal compensation plan is fair, easily understood, market competitive, legally compliant, fiscally viable, has a well-defined productivity focus, and is aligned with the group or hospital’s overall strategic plan. As a practical matter, few plans match the ideal plan.

Therefore, how should a compensation plan be devised? First, the group must determine what behaviors are to be rewarded. Most plans are heavily weighted towards clinical productivity, as they should be. Should teaching, outreach to other communities, research (if relevant), patient satisfaction score, patient outcome, leadership role or administrative position also be rewarded? If the answer is yes, how much value should they be assigned?

If the vascular surgeon is in a multi-specialty group or hospital employed, at what level are incentives applied? Is it solely based upon individual productivity, specialty, or global group/hospital profitability? Finally, if funds are

sequestered to reward productivity, how much is this in relation to the fixed, base salary? In general, productivity threshold for behavioral change has to exceed 20% of base salary for physicians to feel incentivized.

Individualistic Versus Group Practice Incentives

Individualistic compensation plans are easy to administer since the physician keeps all revenues minus expenses that they generate. The expectation and responsibility is clear and intuitive. However, individualistic compensation plans may promote internal competition within a group, undermine group objectives, as well as the possibility of “churning” where volume becomes paramount.

Common Compensation Formulas

A typical academic compensation plan consists of a base guaranteed salary based upon market-based benchmarks and academic rank. Productivity incentives also have been seen in recent employment contracts. This salary is then supplemented by additional stipends for directorships, teaching positions, or service efforts. Private practice compensation formulas can be found in numerous variations. Most plans involve a base salary, which can be anywhere from 0-70% of total compensation, plus productivity-based compensation.

Signing Bonuses

According to the 2012 Merritt Hawkins Review of Physician Recruiting Incentives, the percentage of recruiting contracts containing signing bonuses increased from 46% in 2004-2005 to 80% in 2011-2012¹¹. The average bonus in 2011-2012 for all recruited physicians was \$23,338.

Hospital Employed Vascular Surgeons

The revenue to compensation ratio of 6:1 for general surgeons is probably the most comparable for vascular surgeons. Despite this, hospitals are unlikely to repeat the mistake they made in the 1990s by not linking physician compensation to productivity. Under the new reforms, vascular surgeons employed by hospitals will have various other incentives tied to their compensation and may be able to negotiate co-management agreements. The co-management agreements will pay a fixed fee plus variable incentives tied to efficiency and value-based care. It is important for surgeons to understand that employing hospitals are bound by Stark and Anti-kickback Laws, as well as required to abide by rules for tax-exempt organizations. Compensation must be “reasonable” and consistent with fair market value.

A current trend seen by academic hospitals is to offer productivity incentives in faculty compensation plans. Unfortunately, incentives are usually only tied to clinical productivity and not to teaching or research duties. This causes confusion for faculty as it creates a mismatch between their employment agreements and promotion and tenure requirements.

Financial Drivers Used in Compensation

Formulas

The trend has largely shifted to either Work Related Value Units (WRVUs) or net revenues minus expenses. WRVUs are now standardized, easy to measure, and account for the time and skill in caring for patients but this measuring system (which needs accurate and detailed coding) does not reflect the payer mix and the benchmarks can be confusing. Net revenues (minus expenses) reflect the existing market forces and payer mix but may introduce a disincentive to take care of the uninsured or poorly reimbursed health insured patients. A 2010 report by the Medical Group Management Association showed that twice as many physicians (61%) were now using RVU based production as a productivity metric compared to a previous survey they conducted a few years ago. A 2010 SVS member survey revealed that >85% of respondents used collections (revenue) as one metric of productivity measure and WRVUs in about 60% of practices.

Recent Trends

Although quality of care and patient satisfaction are always mentioned as incentives, the fact remains that salary plus production based upon volume of care is still being offered to 74% of recruits as reported by Merritt Hawkins. Furthermore, only <10% of bonuses are tied to something other than procedural volume. Debt forgiveness is beginning to be included more frequently in employment contracts for new graduates. Housing allowances to offset losses tied to sale of a residence upon relocation also have occurred in recent negotiations.

Benchmarks

The AAMC and the University Health System Consortium initiated the Faculty Practice Solutions Center to collect data and surveys. For academic surgeons this benchmark provides data arranged by rank and specialty. The Medical Group Management Association represents 22,500 members and 280,000 physicians (primarily in private practice). Compensation surveys can give the vascular surgeon compensation data based upon geography. The American Medical Group Management Association primarily represents medical groups (two-thirds of its membership) and health care systems that are associated with 113,000 physicians. Numerous other organizations and consulting firms such as SullivanCotter, Merritt Hawkins, and Modern Healthcare generate compensation data.

Negotiating Compensation

Employment contracts typically feature no more than a few paragraphs of content related to compensation. In complicated situations there may be a separate appendix or attachment related to compensation. The base salary, or guaranteed part of the salary, is listed on an annual basis. Productivity, if relevant, is then spelled out. Non-cash compensation (benefits) such as pension, various insurances, and any reimbursement for meetings and educational material are enumerated.

The salary and joining bonus is negotiable whereas the pension contributions may be less negotiable. The benchmarks mentioned are important for negotiation purposes but supply and demand factors are probably more critical for new surgeons. Additional effort to review the demand of additional vascular surgeons in a specific city may be valuable, especially if several groups or health systems are competing to add a recently trained surgeon with new or advanced skills.

Conclusions

No compensation model is perfect. With accountable care organizations on the horizon, the way in which groups and hospitals measure and incentivize productivity will change to include more than clinical productivity (RVUs or WRVUs). An important aspect for new vascular surgeons joining practices or hospitals is to ensure that the compensation formula is based upon the benchmark that best fits the type of practice they are inⁱⁱⁱ. It also is important to remember that almost every facet of a compensation formula is negotiable.

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ⁱSatiani B. Physician Compensation: Models, methods and philosophies. In *The Smarter Physician. Volume 2. Conquering Your Practice's Billing and Reimbursement*; Ed: Satiani. B. Medical Group Management Association. Englewood, CO. 2007.

ⁱⁱMerritt Hawkins "2012 Review of Physician Recruiting Incentives," <http://www.merritthawkins.com/>

ⁱⁱⁱSatiani B. Use, misuse, and underuse of work relative value units in a vascular surgery practice. *J Vasc Surg* 2012; 56:2

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Article Date: Monday, October 1, 2012

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Tags: Manage My Practice

Article Type: Article