

Employment or Private Practice? What Young Neurosurgeons Need to Know About Compensation Structures

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After they complete their lengthy, arduous residencies, and for many, an additional fellowship, newly trained neurosurgeons are understandably eager to secure their first jobs. One of the first, and most important, career choices neurosurgeons will need to make is whether to choose employment or private practice¹. It is important to understand the long-term impact of pursuing either, but it is not necessarily a clear-cut choice.

Often, many questions arise: How much should I expect to be paid? What do the compensation terms mean? How do I compare different compensation structures? As today's neurosurgeons are practicing in a broader range of positions, they must be aware of the wide-ranging recruitment strategies and compensation structures, which also can take many forms. Understanding all components of both employment and private practice models is critical to making the best decision.

Dissecting the employed compensation model

Increasingly, hospitals and health systems are looking for ways to expand their market footprints by creating better physician-alignment structures. For younger physicians, employment has become the top practice choice. According to the 2018 Medscape Young Physician Compensation Report, 85% of all physicians aged 40 or younger are employed.

Hospitals and health systems typically use the following primary compensation structure components when recruiting new residents and fellows. Other contractual components may be included, depending on the needs of the hospital.

Base salary. Most employed-physician compensation models today include a base salary, or a fixed amount of money paid to a physician by an employer in return for work performed. Base salaries typically do not include benefits, bonuses or other potential compensation from an employer.

To recruit newly trained physicians, hospitals or health systems typically offer a guaranteed base salary for the initial one to two years of employment. This salary is primarily determined through the study of prevailing local market compensation and national compensation surveys conducted by organizations such as the Medical Group Management Association (MGMA), SullivanCotter and Associates, Inc.

productivity is by using work relative value units (wRVUs). A wRVU is a unit of measure that reflects the time, amount of effort and technical ability required to accomplish a particular service or procedure⁴. A production bonus is most often structured by multiplying a pre-determined conversion factor by wRVUs in excess of a pre-determined wRVU threshold.

In addition, quality metric-based bonus structures are becoming increasingly popular with the push toward value-based care. To receive a quality bonus, physicians must achieve targets or thresholds relating to clinical quality, patient satisfaction and/or physician engagement. SullivanCotter's 2017 Physician Compensation and Productivity Survey Report found that the

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(SullivanCotter) and the American Medical Group Association (AMGA). Hospitals and health systems reference these annual surveys as one means to assess whether they are offering a compensation structure that is of fair market value² and commercially reasonable³. The concepts of fair market value and commercial reasonableness are critical to the determination of compensation for an employed physician. We will explore these concepts further in a future Neurosurgery Market Watch article.

Production and quality bonuses. Beyond the base salary compensation, productivity and/or achieving certain quality metrics are key components of employed-physician contracts. The most common way to measure

mean quality incentive payment was 9.8% of a surgical physician's total compensation.

Call-coverage compensation. Call coverage can be another component of compensation, if it's not included in the base salary. But determining the actual value of call pay can be challenging. According to SullivanCotter's 2016 Physician On-Call Pay Survey Report, the median call pay for neurosurgeons ranged from \$62.50 per hour at non-trauma centers, to \$83.33 per hour for trauma coverage at designated trauma centers. Not only can amounts paid for call vary from facility to facility, but amounts can vary depending on what is included in the call service. For

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example, a neurosurgeon may be responsible for inpatient calls or multiple facilities.

Further, call compensation may be impacted by a hospital's medical staff bylaws, which might describe the call requirements for each specialty providing call coverage to the hospital's emergency department. For example, the bylaws might indicate that each physician will provide call coverage pro rata with the other physicians in the call panel at a minimum specified number of days per month.

Understanding private-practice compensation models

The shift away from traditional private practice in all specialties is driven by both healthcare market dynamics, such as declining reimbursement and regulatory pressures, and physician preference. However, many new physicians join private practices seeking more autonomy and control. Private practice compensation structures typically include the following primary components. Other contractual components may be included, depending on the needs of the practice.

Initial-salary contracts. When a neurosurgeon, whether newly trained or already in practice, joins a private practice, the compensation is typically straight salary or a salary with some potential for bonus compensation. This allows the physician to gradually ramp up productivity, while building up his or her patient panel.

Sharing profit/loss. Following the initial contract period, the neurosurgeon might then be offered partnership or ownership. This might involve a single buy-in into the practice or a gradual stepwise contribution until full partnership or ownership is reached. Once the physician contributes the full buy-in amount, the profit/loss is shared in one or more ways:

- Equal share to every physician partner
- Straight productivity-based compensation
- Productivity bonus in addition to an even-standard compensation for each partner

- Cost-center compensation (i.e., a net collections and overhead expenses allocation model)
- Any combination of the above

Many times, partners choose their model depending on the practice environment and the number of physicians in the group. For example, equal pay for every partner could lead to some physicians bearing a larger work load than others, as there is little incentive to enhance productivity on an individual basis. Conversely, in a purely productivity-based compensation model, each partner is highly motivated to increase productivity, possibly creating competition between partners.

Call-coverage compensation. Private practice compensation arrangements might also include the consideration of call coverage. A hospital may contract with a private practice

to provide coverage for its ED patients and its inpatients. The private practice, in turn, passes through all, or a portion of, the daily call rate to the physician for providing coverage.

The decision to seek employment or private practice will no doubt be one of the greatest choices a neurosurgeon makes in her or his career. Both arrangements have pros and cons, but all neurosurgeons should understand the different compensation structures and, ultimately, their ramifications for them personally, professionally and financially. Choosing the right practice type with the right group is important not only for neurosurgeons' income but also for their future success.

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Resources

Deborah L. Benzil, Edie E. Zusman.

Defining the Value of Neurosurgery in the New Healthcare Era, *Neurosurgery*, Volume 80, Issue 4S, 1 April 2017, Pages S23–S27.

The Employed Neurosurgeon: Essential Lessons, *Neurosurgery*, Volume 80, Issue 4S, 1 April 2017, Pages S59–S64.

2018 Medscape Young Physician Compensation Report

2018 MGMA Physician Compensation and Production Survey

2017 SullivanCotter Physician Compensation and Productivity Survey Report

2018 AMGA Medical Group Compensation and Productivity Survey

2016 SullivanCotter Physician On-Call Pay Survey Report

Footnotes

1. For the purpose of this article, the term private practice means either a solo practitioner, or practitioner not employed by a corporate entity, such as a hospital or health system.
2. Fair market value (FMV) is defined as the price at which the property or service would change hands between a willing buyer and a willing seller, neither being under a compulsion to buy or sell and both having reasonable knowledge of the relevant facts (IRS definition).
3. An arrangement that is commercially reasonable appears to be a sensible, prudent business arrangement, from the perspective of the parties involved, even in the absence of any potential referrals (The Department of Health and Human Services definition).
4. Work RVU amounts are based on the resource-based relative value scale (RBRVS), which is used by the Centers for Medicare & Medicaid Services. The Specialty Society RVS Update Committee (RUC) works with national medical specialty societies to provide relative value recommendations to CMS annually. The RUC uses a survey that is issued to qualified healthcare professionals to determine physician work.