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Compensation Is Major Issue When Anesthesia Groups Merge

Hospital acquisition wave will force many groups into difficult pay negotiations

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Following the passage of the Patient Protection and Affordable Care Act in March, hospital merger and acquisition activity nearly tripled in the second quarter of 2010. Many experts predict merger activity will heat up even further, as hospitals deal with the aftermath of health care reform.

How will this wave of hospital mergers affect anesthesia groups? Many practices will be pushed into "forced marriages" as newly created health systems seek to consolidate anesthesia services under a single contract. Anesthesia groups will face a slew of problems as they work through all the details involved in a merger. The biggest challenge, however, will be agreeing on a new compensation plan.

Two Groups, Two Cultures

Consider the following scenario: West Valley Hospital is a mid-sized community hospital with a good payer mix and an active labor and delivery service. The hospital is served by a 10-member anesthesiology group that uses a pure "equal sharing" compensation plan—individual income is essentially one-tenth of the practice's net revenue. Members of the group share daily cases, call duty and administrative work on an equal basis, and they participate actively on hospital committees.

East Valley Hospital is a large, tertiary medical center with a wide variation in surgical case acuity. Its patient base is composed of a broad mix of both government payers and high-end commercial insurers. The hospital's 16-member anesthesia group uses a "strict productivity" compensation plan—patient revenues enter into 16 individual accounts corresponding to each physician.

The East Valley group is diverse in members' personal priorities. Two anesthesiologists near retirement are working reduced schedules with no call. Five younger members are willing to take more call and less vacation. On a daily basis, the best assignments are rooms with short cases, rapid turnover, low level of complexity and good payer mix. In general, the physicians vie for the most desirable cases and participate only reluctantly in administrative and committee work.

The compensation plan of each group suits its unique situation and culture.

The "lump and divide" approach of the West Valley anesthesiologists allows them to focus on group goals. Although the incentive for individual productivity is weak, physician output generally matches the hospital's needs.

The East Valley group's individualistic approach allows the group to accommodate a broad range of members' goals. Although competition for case assignments does lead to friction—both internally and with surgeons—the compensation plan helps the group recognize individual effort within a context of widely varying case acuity and reimbursement.

Difficulties arise, however, when the two hospitals announce their plan to merge. For the anesthesiologists, a merger represents challenges and opportunities. On one hand, the new health system administrators intend to offer one exclusive anesthesia contract, putting the two anesthesia groups under strong pressure to combine operations. Anesthesiologists' active participation on initiatives for operating room improvements and other nonreimbursable leadership activities also will be expected.

On the other hand, the system administrators are determined to build up the surgical services line. Plans include developing a new four-room ambulatory surgery center to accommodate orthopedic surgeons and ear, nose and throat specialists moving into the area. This is a potentially lucrative opportunity for the anesthesiologists. Yet under the new system, the ambulatory surgery center will need to be staffed with the most seasoned anesthesiologists during the start-up phase. These physicians will face an uneven caseload for six months or longer.

Overall, the new combined anesthesia group will need to meet a wide variety of clinical and leadership expectations, while accommodating a large group of physicians with an array of personal priorities. It is a problem that most merging anesthesia groups confront in one form or another. The underlying challenge is to create a compensation plan that encourages group-oriented behavior while at the same time accommodating individual goals and needs.

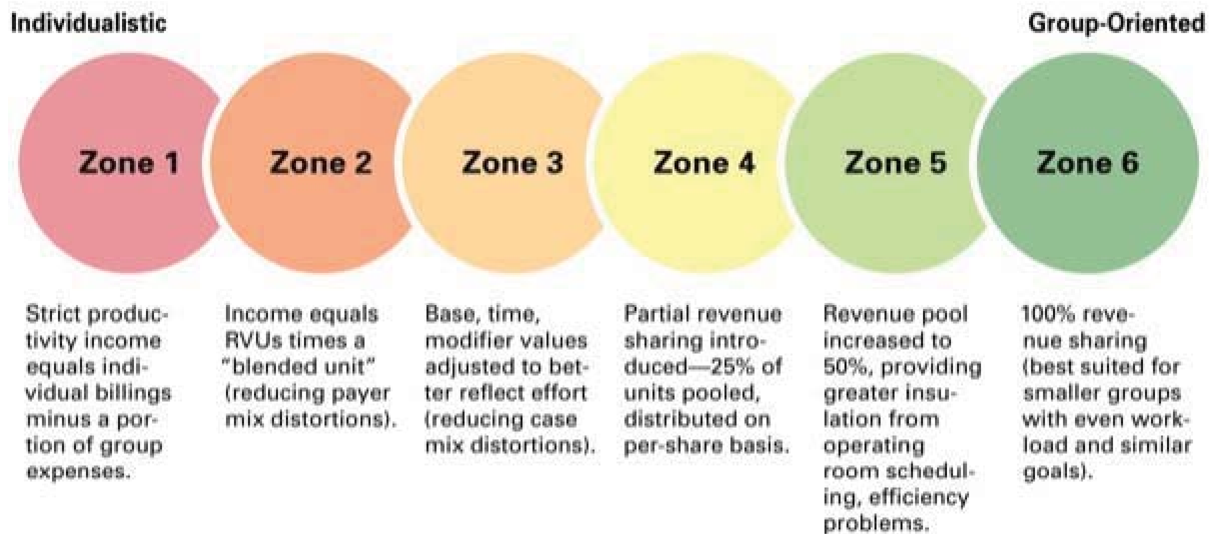

Figure. The anesthesia compensation spectrum. Compensation plan design can help merging anesthesia groups find the right balance between individualistic and group-oriented incentives.

Table 1. "Smoothing Down" RVG Units To Calculate Income

RVG Units (for billing payers)	Compensation Units (for calculating income)
3 to 5	2
6 to 10	4
11 or more	7

RVG, relative value guide

Techniques for Bridging the Gap

How can one compensation plan meet these objectives? Many merging practices have been able to find a workable middle ground between strict productivity and equal sharing (Figure), by using the following three advanced pay plan techniques:

1. Blended payer. Under strict productivity compensation, a diverse payer mix can lead to pay inequalities and friction over room assignments. The solution is to create a "blended payer." For a given period, divide total group reimbursement by total work units for all physicians. The result is the practice's average

reimbursement per unit. Physician compensation equals individual relative value units, or RVUs, multiplied by this blended payer value. The blended payer technique maintains the incentive for maximizing work units, while shifting payer risk from the individual to the group.

2. Relative Value Guide (RVG) transformation. Most individualistic compensation plans use RVG units to measure productivity. The problem is that RVGs—as well as standard modifiers and even time units—do not always reflect true case complexity and work effort. This can compromise pay fairness. In practice, groups end up rotating assignments to equalize physician access to the best cases, instead of matching cases with the most qualified anesthesiologists.

One solution is to "smooth down" RVG units for the purpose of calculating individual income. Table 1 shows a possible approach. In addition, it often makes sense to increase personal credit for evening and night work by adjusting time unit values, as shown in Table 2.

Modifier values also can be used to improve pay equity. For example, groups can compensate physicians for postoperative nerve blocks by creating a modifier schedule for catheter insertion and maintenance. Another option is to assign personal credit for invasive line monitoring (Table 3).

Table 2. Adjusting Time Unit Values

Shift	Time Units per Hour
0700 to 1800	4
1800 to 2400	5
2400 to 0700	6

These and other value transformations can ameliorate the disparities that arise from differences in case mix and more accurately reflect individual effort. RVG transformations are also helpful when accounting for personal physician services versus supervised care.

3. Partial revenue sharing. Under a pure productivity compensation plan, individual income is vulnerable to schedule problems in the operating room—cancelled cases, schedule gaps and generally light rooms. The solution is to introduce an element of revenue sharing into pay. Pool a percentage of all individual units and redistribute them to physicians on a quarterly basis. A 25% revenue pool is a modest but substantial move toward risk sharing. Increasing the percentage amplifies the effect.

Table 3. Personal Credit for Invasive Line Monitoring

Line	Modifier Value
Arterial	1
Central venous	2
Pulmonary	3

This technique reduces individual exposure to problems with scheduling and efficiency. It also ensures partial compensation for nonclinical activities such as involvement on hospital, medical staff or departmental committees. In addition, because revenue sharing reduces the tight coupling between room assignment and compensation, it frees the clinical director to assign cases purely on the basis of case requirements and physician skill sets.

East Meets West

Used together, these three compensation techniques can be powerful tools for facilitating a merger of anesthesia groups. The techniques not only help physicians come to an agreement on pay, but also enable the new combined group to target a wide range of organizational goals.

Returning to the scenario described above, advanced compensation techniques allowed the West Valley and East Valley anesthesia practices to design a combined-group pay plan that achieves several key objectives.

First, a blended payer unit enables members to cover cases in any setting without concern for payer mix; reduced personal credit for RVG base values decreases competition for high-RVG cases. The plan addresses variations in obstetrical caseload by assigning a flat-rate unit value for labor epidurals and creating personal credit for "captive time" on the labor floor. Also, it

provides a temporary personal credit for anesthesiologists who cover the new ambulatory surgery center during its light start-up period. Finally, a new 25% revenue-sharing pool rewards members for group-oriented activities.

Taken together, the features of this compensation plan allow the combined group to cover a range of locations and shifts and meet call coverage expectations. The plan also maintains productivity aspects that facilitate members in different stages of their careers, enabling motivated physicians to increase their incomes and physicians approaching retirement to scale back their workload.

Versatile Tools

These compensation plan techniques are helpful when anesthesia groups merge for any reason—to share costs, meet service demands, negotiate with payers, etc.

As health care reform continues to produce rapid change in the hospital industry, rational compensation planning will be an important tool for helping anesthesiologists meet a variety of personal and organizational goals, including optimizing clinical performance and customer service.

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