Physician Compensation:

Designing the "Best-Fit" Plan

BY MATTHEW R. STURM, MBA

Physician compensation is a fundamental element of employing oncologists; yet, compensation planning can be a challenging and politically divisive process, especially as the number and diversity of stakeholders increase. For healthcare systems or multispecialty groups, understanding the nuances of the oncology care delivery model is of key importance. For example, administrators must understand how programmatic features—such as clinical research, multidisciplinary care, and the presence or absence of a patient navigation program—impact oncologists.

All physician practice groups (single specialty, multispecialty, and health system-employed) must consider not only their desired outcomes from the compensation plan and the culture that the plan will foster, but also how the plan will align with the evolving healthcare landscape and payment models (e.g., accountable care organizations, bundled payments, value-based reimbursement). This article presents a framework to evaluate and redesign compensation plans for oncologists.

The Importance of a Compensation Plan

A physician practice group's compensation plan speaks volumes about an organization's culture—whether a healthcare system or an independent medical group. Paychecks are often viewed as a reflection of the value a group places on a physician's contribution. Moreover, the compensation plan—intentionally or not—serves as a beacon for the behaviors and activities that the group values (e.g., clinical productivity, research, multidisciplinary care, adherence to clinical pathways). Therefore, for the long-term success of the organization, the compensation plan must be thoughtfully designed to foster the desired group culture. This plan is especially important for oncology practices, where numerous factors affect group success; these elements should be carefully incorporated into the compensation plan in a balanced manner.

Not surprisingly, altering the compensation formula is a risky enterprise because income will be redistributed in ways that are sure to upset at least some members of the practice. Everyone will have legitimate arguments for why he or she should earn more; many will question the data, process, and outcome; and no one will be completely satisfied with the results. Throughout the compensation planning process, the needs and interests of the practice as a whole must be balanced with those of individual oncologists. As Figure 1 (below) shows, opportunities exist to reach an acceptable compromise, despite disparate preferences.

The objective of a compensation planning project is to develop a plan that both rewards desired activities and incorporates the group's unique characteristics, ideologies, and strategic goals. Many oncology practices use a three-phase approach to compensation planning: Assessment, Design, and Implementation.

Internal Assessment

Start the planning process with a detailed assessment of your current physician compensation plan. Look at the oncologists' performance compared to internal and external benchmarks. The process will ultimately result in the development of plan redesign goals that will guide efforts in the Design phase.

The internal assessment consists of a review of relative group compensation performance and a questionnaire for, or a series of interviews with, the oncologists.

Group Data. Use an analysis of current compensation and production data from the oncologists to assess the impact of the current compensation plan in terms of the group's goals. This analysis may include graphs of compensation and production data for all oncologists (by specialty) in the practice.

Figure 1. Physician Compensation Outcomes

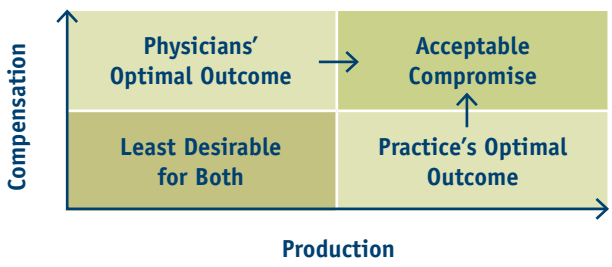


Table 1. Common Service Incentive Bonus Structures

CATEGORY	EXAMPLES
Quality	–American College of Surgeons (ACoS) quality indicators –American College of Radiology (ACR) and American Society for Therapeutic Radiology and Oncology (ASTRO) accreditation –Reporting of select Physician Quality Reporting System variables –Participation in multidisciplinary clinics –Adherence to established clinical pathways –Standardization of drug regimens and purchasing
Operations	–Standardization of clinical processes and/or forms –Improvements in select operational metrics
Patient Satisfaction	–Survey participation and achievement (e.g., Press Ganey Associates, Inc.) –Availability of appointments
Service Line Development	–Participation in tumor boards –Development of CME programs –Outreach visits to referring physicians –Participation in hospital leadership roles
Financial	–Clinical market share or volume growth –Cost-savings bonuses –Device or supply standardization

Review the data for key trends, issues, and concerns. Then answer these two questions.

- Are there significant outliers above or below the trendline? If so, identify why?
- What is the shape of the compensation per work RVU to work RVU trendline? A flat line indicates no incremental incentives for production. A line with a positive slope indicates incremental incentives for production. A line with a negative slope indicates incremental disincentives for production. Ideally, the trendline will have a positive slope.

As noted above, the market is evolving toward new, less production-driven physician payment models. So, evaluate the characteristics of your current physician compensation plan. Specifically, look at what percentage of an oncologist's compensation is tied to nonproduction-based measures, such as:

- Group citizenship (e.g., governance participation, committee participation, peer review, specific work group outcomes, staff surveys)
- Quality
- Multidisciplinary care
- Adherence to clinical pathways
- Outreach efforts
- Participation in clinical research.

Compare your findings to market trends. In 2012, it is appropriate for oncology practices to target allocating 10 to 20 percent of physician compensation using nonproduction-based measures.

Physician Input. During the initial assessment phase, the practice may ask for input from the oncologists (via survey or interview) on compensation plan design. The objective is to identify the practice's goals for the plan and areas of satisfaction and/or dissatisfaction with the current plan, as well as to get feedback on potential modifications (e.g., incentives for multidisciplinary care and/or compliance with clinical pathways).

External Assessment

During the external assessment, the practice may compare its compensation and production data to national and regional benchmarks such as those available from MGMA (Medical Group Management Association), AMGA (American Medical Group Association), and other surveys. Potential questions include:

- Is the practice's production in line with the benchmarks? If not, why?
- Is the practice's compensation in line with the benchmarks? If not, why?
- Are there any specialties that vary significantly from the benchmarks? If so, why?

continued on page 32

The objective of a compensation planning project is to develop a plan that both rewards desired activities and incorporates the group's unique characteristics, ideologies, and strategic goals.

UNIQUE ISSUES FOR HEALTHCARE SYSTEMS

In addition to the general compensation considerations discussed in this article, healthcare systems employing oncologists face some unique issues.

Infusion Suite Services

Medical oncology practices that heavily use non-physician providers for the management of infusion services will need to consider how productivity and expense will impact their compensation model. In particular, non-physician productivity will impact overall compensation, as under an employment model if infusion services are transitioned to a hospital-based billing model (in which infusion therapy is a designated health service), physicians will no longer receive credit for this revenue or RVU production. Depending on the magnitude of non-physician activity, it may be important to structure an arrangement that allows for physicians' continued management of infusion services.

Increasingly, hospitals are opting to create agreements that compensate physicians for management of the infusion suite. Several options are available, depending on the particulars of an arrangement. Many opt for a fixed-fee stipend that compensates physicians for services related to infusion suite management. Others incorporate a payment per work RVU premium that reflects incremental compensation associated with management services. An alternate but similar approach to this last option is addition of a work RVU credit for clinical services that correlates to infusion management activity. Regardless of the approach, to ensure that the program is compliant with the Stark Law and Anti-Kickback Statute, hospitals need to be cautious in developing their preferred methodology to ensure that payment is in no way tied to hospital-based volume growth. As such, legal review is advisable when designing such a compensation model.

Service Incentives

Hospitals generally recognize that production-driven plans will need to evolve to reflect changing practice patterns, economics, and the rising emphasis on non-productivity performance indicators. However, some hospitals are reluctant to get too far ahead of reimbursement changes. Production-based compensation plans (typically measured in work RVUs) continue to be the favored methodology for hospitals, and they often use productivity tiers that disproportionately reward high producers and provide strong incentives for high levels of production. These plans reflect the current economics of physician payment, which is still based almost entirely on clinical work measures.

Although hospitals typically incorporate some type of performance or quality bonus into their compensation models, the measures are often not based on stretch goals (e.g., performance goals that require a significant change or improvement) because defining, valuing, tracking, and measuring outcomes can prove difficult. Yet, doing so can be very helpful to executing service line strategies; as such, more institutions are starting to incorporate these incentives and make them a larger portion of total compensation (see Table 1, left, for examples).

Use of service incentives, such as those identified in Table 2 (page 32), in physician compensation models is an emerging trend that will continue to grow, particularly in light of ongoing healthcare reform efforts that emphasize patient outcomes and episode-based care.

Surgical Oncology Call Coverage Restrictions

With increasing subspecialization of surgical oncologists, many physicians are no longer clinically or personally willing to cover general surgery call. If the hospital's current emergency department (ED) call coverage arrangement or medical staff bylaws require the physicians to take call, the healthcare system may consider providing additional funding to compensate general surgeons for surgical oncology call. It may also be in the hospital's interest to eliminate any of the surgical oncologists' ED call coverage duties to allow them more time to focus on oncology service line advancement.

Table 2. Potential Oncology Compensation Incentives

INCENTIVE	PERFORMANCE METRICS	FREQUENCY
Work Effort	Charges, net revenues, RVUs, panel size, visit and encounters, and office hours and availability	High
Quality	Healthcare Effectiveness Data and Information Set (HEDIS) Indicators and readmission and infection rates	Moderate and Growing
Medical Management	Inpatient stays per thousand, ambulatory visits per thousand, and selective utilization rates (e.g., ER visits, MRIs)	Low
Patient Satisfaction and/or Provider Satisfaction	Satisfaction surveys, complaints and compliments, and panel retention	Low
Group Citizenship	Review, specific work group outcomes, and staff surveys	Medium

continued from page 30

Goals & Objectives

Based on oncologist feedback, draft a set of goals and objectives for the revised compensation plan, addressing such issues as:

- How the compensation plan will compare with market trends.
- Behaviors the plan will encourage (e.g., clinical productivity, research, multidisciplinary care, adherence to clinical pathways).
- The acceptable level of administrative burden to operate the plan.
- How the plan will be used as a recruiting and retention tool.
- How the plan will enable the practice to prepare for new payment models.

With assessment of the current compensation plan completed and goals for the revised plan determined the design phase begins. This process typically involves two parts: developing a conceptual method and testing the method.

The Conceptual Method

In developing and selecting a conceptual method, the goal is to design a compensation method that addresses:

- The practice's goals and objectives
- Any inequity issues identified in the assessment phase.

As mentioned previously, oncology practices today have a unique opportunity to begin developing a compensation model that will propel the practice into the future of evolving payment models. Historically, production measures have dominated most oncology compensation plans. Today, however, many oncology groups are rebalancing their incentives between production and quality. This effort has been aided by the adoption of electronic health records (EHRs) and the increasing availability of reportable information. Thus, many oncology practices are beginning to reserve 10 to 20 percent of the total dollars earmarked for incentive payments in the compensation plan for quality initiatives.

Organizations can choose from many different performance metrics to incentivize oncologists. Table 2 (at left) summarizes the pros and cons of the most common incentives, as well as the frequency of their use.

The primary performance indicators used to calculate the incentive portion of a physician's compensation, as identified by respondents in ECG's 2010 compensation and production survey, which included 63 provider organizations, representing 6,847 physicians in 64 specialties, is illustrated in Figure 2 (below).

As illustrated in Table 1, work RVUs remain the most common productivity payment metric today, in large part because they focus on the professional work of the physician, which correlates with current payment models. However, for the first time in ECG's 12-year survey history, quality was noted as a key performance indicator. See Table 3 (at right) for a comparison of typical productivity metrics and their advantages and disadvantages.

The amount of variability within a compensation system will determine the range of income potential for the oncologists, as the five compensation systems shown in Figure 3 demonstrate (at right).

As mentioned above, incentive payments for oncologists may be tied to a combination of production- and nonproduction-based measures. Thus, a practice must decide both what incentive metrics to use and what percentage of compensation will be at risk for the oncologists. Options include the following models.

Figure 2. Compensation Incentive Performance Measures

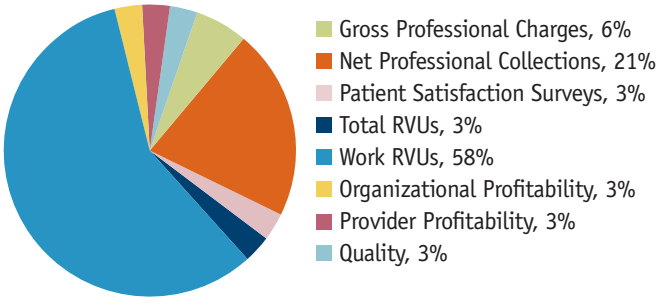


Table 3. Potential Oncology Compensation Incentives

VARIABLE	ADVANTAGES	DISADVANTAGES
RVUs	–Most accurate measure of physician effort –Payer-blind –Consistent comparison of physician productivity	–Divorced from the economics of the practice –Many do not understand proposed changes to the RVU system –Some do not believe that RVUs are a true indicator of productivity
Collections	–Direct measure of cash inflow –Aligned with financial strategy	–Affected by payer mix and effectiveness of billing and collections office –Likely will disadvantage medical oncologists employed by hospitals, as chemotherapy is a designated health service and therefore cannot be credited to the physician
Gross Charges	–Aligned with financial strategy	–Influenced by fee schedules, which can vary widely and are not necessarily representative of productivity or reimbursement –Likely will disadvantage medical oncologists employed by hospitals, as chemotherapy is a designated health service and therefore cannot be credited to the physician
Visits and Patient Encounters	–Direct measure of cash inflow –Aligned with financial strategy	–Not meaningful for procedural specialties –No consideration of acuity or length of visit

Figure 3. Range of Oncology Compensation Models

Base Salary. The salary model (Figure 4a, page 34) is uncommon except for newly-recruited oncologists. This model provides the same level of income regardless of a physician's performance, and therefore, offers little incentive to maintain or increase performance. However, in select cases, such as when the practice asks oncologists to participate in activities that may otherwise inhibit their income-generating ability, the salary model may be warranted. In such instances, the use of a salary should be kept only to the applicable time engaged in the activity, and every effort should be made to transition the payment model to one based on quantifiable performance measures.

Base Salary with Incentive. This model (Figure 4b, page 34) limits an oncologist's downside risk by placing a floor on compensation levels and providing additional income for performance above the threshold. Setting the base salary is critically important in determining the meaningfulness of the incentive. The base salary with incentive model tends to underpay high performers and overpay lower performers because the base salary limits variability within the model.

Flat Incentive. This model (Figure 4c, page 34) includes no base compensation; thus, earnings depend entirely on performance compared to the metrics set out in the compensation plan. Typically, performance is tracked relative to a 12-month rolling period so that income levels are fairly predictable. This model offers a much stronger incentive for performance with much greater compensation available to higher performers.

Tiered Incentive. This model (Figure 4d, page 34) provides oncologists with significant incentive to maintain or increase performance. The tiered incentive model exposes lower-performing physicians to considerable downside income risk.

Tiered Incentive Plus Bonus. Similar to the tiered model, the tiered incentive plus bonus model (Figure 4e, page 34) includes an additional incentive to reach the thresholds. This model is more commonly used when performance is clustered below desired levels. The bonus provides added encouragement to push beyond current levels of performance.

Testing the Conceptual Method

Once a conceptual method is agreed on, develop a financial model to test the model's impact on physician income levels using historic data. This step will not only help to understand the implications of the method but also later help to "sell" the method to the practice. Testing the method typically involves the following tasks:

- ***Quantifying the Variables.*** Assign values to the compensation drivers (e.g., determine the amount to be paid for each work RVU and compensation for achieving various quality or group citizenship metrics).
- ***Developing Financial Projections.*** After determining the values of the model variables, test the financial impact of the new compensation plan on the oncologists using data from the most recently ended fiscal year.
- ***Revising the Model.*** Based on feedback from the practice, revise the model. This process is iterative. Several revisions may be needed to develop a plan that captures the goals of the practice.

Addressing Complications

Many factors complicate the design and administration of a physician compensation plan. The plan should effectively address the following issues in a manner that reflects the practice's culture:

- ***Ancillary or Outside Revenue.*** How will this revenue be allocated among group members (e.g., equal shares, based on use, based on ownership)?
- ***Capitation Revenue.*** How are capitation revenues distributed among the practice? How are incentives weighted for productivity versus efficiency?
- ***Part-Time Providers.*** How does the plan handle part-time providers? Is their productivity "normalized"?
- ***Shared Practices.*** Do physicians in a shared practice share the compensation, or are they each treated as a part-time physician?
- ***Midlevel Production.*** Does midlevel provider (e.g., NP or ARNP) production count toward a physician's productivity?

COMPENSATION MODELS

Figure 4a. Base Salary Model

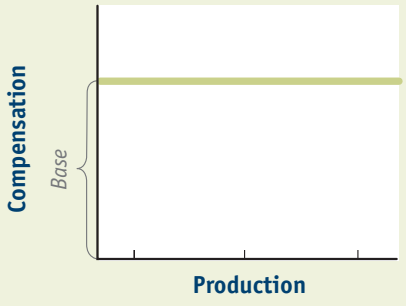


Figure 4b. Base Salary with Incentive Model

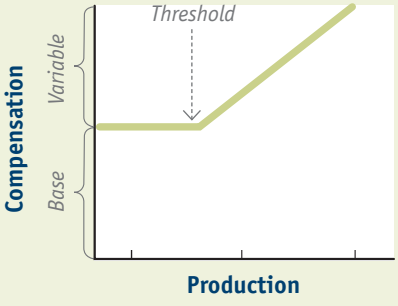


Figure 4c. Flat Incentive Model

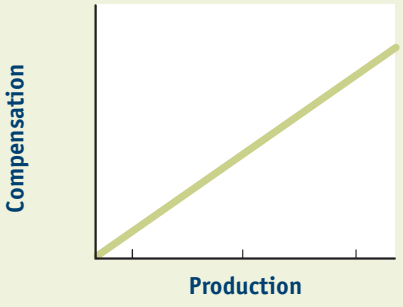


Figure 4d. Tiered Incentive Model

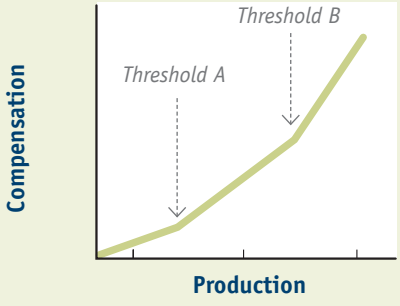
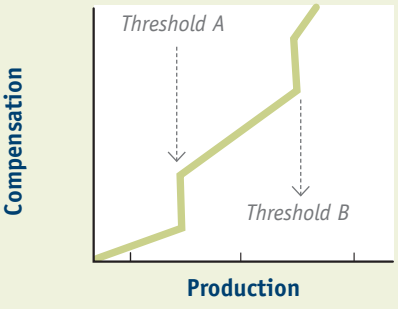


Figure 4e. Tiered Incentive Plus Bonus Model



- ***New Physicians.*** Will the practice provide income guarantees? If so, for how long?
- ***Plan Draws and Reconciliations.*** Over what period does the plan "draw" from, and when is the draw reconciled with actual production?
- ***Nonclinical Duties.*** How will physicians be compensated for nonclinical duties (e.g., practice management responsibilities, outreach staffing, clinical research)?
- ***Expense Management.*** How will physicians be incentivized to manage expenses in their clinic?

Implementing the Plan

With the proposed new compensation plan agreed to by the practice, planning for the transition from the existing plan to the new one will begin. Typically, this process involves careful documentation of the details of the agreed-upon plan, development of necessary tools and processes to administer the plan, and possibly a period of "shadow" reporting (i.e., tracking and reporting a physician's performance under the new model prior to implementation).

Below are some keys to successful compensation plan design for an oncology practice. These specific tactics may help organizations avoid difficult situations.

- ***Physician Direction.*** Recruit opinion leaders to assist in the design of the compensation plan.
- ***Market Relevance.*** Pay competitive income for competitive work effort.
- ***Flexibility.*** Adopt a compensation plan that flexes with the market annually.
- ***Transition.*** Compensation plan design must include analysis of the impact transition to the new structure, and may require temporary income protection.

> Once a conceptual method is agreed on, develop a financial model to test the model's impact on physician income levels using historic data. This step will not only help to understand the implications of the method but also later help to "sell" the method to the practice.

- ***Communication.*** Communicate fully and frequently to all physicians.
- ***Simplicity and Objectivity.*** Establish understandable, objective, and measurable incentives.
- ***Alignment of Incentives.*** Align physician and organization incentives.
- ***Respect for Culture.*** Respect the differences in the decision-making process and organizational style within the oncology practice.
- ***Resistance to Making Special Deals.*** Once the planning process is complete, stay true to the decisions that were made during the process. OI

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