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.