

FEATURE STORY

Healthcare CFOs and other leaders should consider market characteristics, base salaries and incentives, and the structure of the compensation package when developing a physician compensation plan.

AT A GLANCE

Healthcare CFOs should ask three critical questions in determining the right approach to physician compensation:

- > How will market characteristics influence physician compensation?
- > To what extent should base salaries and incentives be used to compensate physicians?
- > How should the organization's physician compensation package be structured?

Healthcare reform is a game changer for hospitals and health systems, with new rules and new objectives for participants. Any organization that is serious about competing in an era of reform should routinely check in with its star players—its physicians—to find out what they want and to understand their backgrounds and experiences, why they joined the organization, what motivates them to stay in the game, and what they view as obstacles to winning performance.

A game-winning strategy for hospitals and health systems should include compensation structures that engage physicians in the mission of the health system and enable them to work toward goals that support the mission, vision, and goals of the organization. Developing a meaningful compensation structure—encompassing salary, incentives, and benefits—involves taking an in-depth look at the organization's culture, mission, and underlying philosophy and considering their value in relation to each of these areas.

The expectations of employed physician groups may vary from group to group. Some groups will be expected to cover their expenses, while others will be expected to generate a positive margin. Some will contribute in ways that go beyond their financial ROI. The best way to arrive at a meaningful physician compensation structure is to consider these and other issues and to seek ways to reward physicians based on outcomes that are rooted in the organization's strategic mission.

For example, physicians can be key contributors in developing protocols and identifying standard approaches that improve quality of care and outcomes and streamline costs. At some organizations, physicians assist in evaluating

how much the organization spends on equipment for various specialties and help to narrow selection or the use of a particular item. Physicians also can bring value to a system by participating in discussions related to revenue for their specialties and by working with the hospital or health system in negotiating discounts from vendors.

The key to achieving the system's overarching objectives—both short- and long-term—with the support of its physicians is to identify the behaviors that will be compensated and to compensate those behaviors within a program that has the flexibility to respond to changes in revenue models.

There are three critical questions healthcare CFOs and other leaders should ask when developing a physician compensation plan.

The first critical question to consider is, *How will market characteristics influence physician compensation?* How an organization defines the market when considering pay levels is a key component of an organization's compensation philosophy—and is a topic that deserves continuous debate.

When defining the physician market, the following factors should be carefully examined:

> Geographic pay issues

Accessing Market Data for Physician Specialties

Specialty pay for physicians varies widely. Knowing which surveys to use, how to use them, and how survey participants were selected are critical steps in developing appropriate and contextualized market data.

The exhibit below features market data for a number of physician specialties and subspecialties from the Medical Group Management Association and Hay Group.

Physician Specialty	2011 MGMA Survey—Total Cash Compensation	2011 Hay Group Survey—Total Cash Compensation
Endocrinology/Metabolism	\$212,529	\$197,563
Family Practice (without OB)	\$186,048	\$170,643
Hospitalist: Internal Medicine	\$221,338	\$208,175
Internal Medicine: General	\$203,044	\$177,125
Neurology	\$250,075	\$249,625
Obstetrics/Gynecology: General	\$286,871	\$254,333
Orthopedic Surgery: General	\$526,398	\$400,000
Pediatrics: General	\$195,266	\$177,456
Surgery: General	\$343,999	\$312,868
Hematology/Oncology	\$375,000	\$326,500
Nephrology	\$280,613	\$253,000
Cardiology: Invasive	\$550,000	\$491,036
Cardiology: Invasive-Interventional	\$586,765	\$465,850
Cardiology: Noninvasive	\$459,168	\$401,759

- > Pay by specialty level (see the sidebar on page 71)
- > Salary versus total cash (i.e., incentives)
- > On-call pay practices
- > Special benefits (e.g., supplemental retirement, long-term disability)

Another point to consider is whether the organization should take private practice pay into consideration.

There are trade-offs involved in reducing the burden of a physician who leaves private practice for a hospital. The benefits for physicians include reduced personal risk, less time spent running the business and more time for patients, fewer business development pressures, and the deferment of malpractice insurance costs to the employer. However, some physicians may not be happy with this change. Some may lament the loss of control and autonomy they previously enjoyed in private practice. Compensation structures also will be vastly different as they move away from a "reap what you sow" model to one of salaries and incentives.

Different personality types will view compensation changes differently. Some will feel a sense of comfort in a base salary-plus-incentives model, while others may yearn for the capitalistic approach of private practice. The physician total reward philosophy is a critical factor, because it will influence the message that the organization wants to send to physicians. For example, if the hospital were attempting to replicate private practice compensation levels, physicians would not be likely to respond the same way as they would if the hospital were establishing compensation that recognizes differences in how physicians will function within a larger healthcare provider compared with private practice.

A large, multispecialty physician practice in the southwestern United States was wrestling with these issues as it debated how to compensate both new and existing physicians. In reviewing the organization's current compensation program, health system leaders discussed how market data should be used to create context: Should leaders

focus on regional market data, or did the practice's significance warrant a review of national data related to compensation?

The physician practice determined that the answer depended on the specialty, to ensure that physicians were paid competitively against any group that attempted to tap its talent pool. The most heated exchanges came when the CEO pushed to drive incentives higher than any market data would support in an effort to heighten the emphasis on pay for performance. In the end, the group's human resources professionals convinced the CEO to keep incentives within market data for the time being, but they agreed to revisit this issue periodically according to changes in the market. The physician practice also built flexibility into its incentive plan that would allow the group to shift metrics and weighting for incentive payouts. This flexibility allowed the group to make changes to the incentive plan annually based on changing payment structures, available talent, and retention strategies.

A physician compensation program also should address physician productivity. For example, let's assume that the current year's base salary is rooted in last year's production, with part of the incentive based on production that exceeds expectations, but that over the year, something beyond the physicians' control happens that causes production to drop 10 percent. Maybe a large employer in the area shuts down and employees are either laid off or transferred to another region. Any time an organization experiences such an event, it will need to address the situation with its physicians in a timely manner—and its compensation program should be built in such a way that adjustments can be made when volumes are lower than anticipated. Everyone should know the rules of the game from the start.

Sometimes the physicians themselves will want to make a change that will require an adjustment to their compensation agreement. Some may want to slow down—perhaps their children are out of college and their mortgages and student loans have been paid off, and the incentives that were effective five years earlier are less so today. The

compensation program should be flexible enough to deal with changing personal circumstances as well as changing economic circumstances. When there are planned production drops, everyone should understand how pay will change as well.

For example, compensation programs typically adjust base salary levels to correspond with decreases in production. For planned drops in production, this adjustment typically occurs over a period of years, with the physician and the employer understanding the reasons. The incentive portion of the program may not necessarily change, but the amount earned by the physician as an incentive could be affected by a change in production, depending on the incentive performance measures that are used.

There also are personal circumstances that could affect production, such as family illness or divorce. The organization's program and processes should be designed to address changes in reality, changes in physicians' interests, and changes in their levels of engagement. For example, a typical approach is to retain current compensation levels (no midyear adjustments to base salary) with a specific process in place to ensure the right conversations occur at the appropriate time to get to the root of the issue.

Conversely, the compensation program should not be a disincentive to production. Monitoring market compensation and market production data is critical to ensuring that pay levels for production outcomes are consistent with the objectives of the compensation philosophy and design of the program.

The second critical question leaders should ask is, *To what extent should base salaries and incentives be used to compensate physicians?* Currently, even for physicians who are employed by health systems, there is very little variable component of compensation beyond base salary. For a typical healthcare senior executive (e.g., a CFO), the annual incentive is around 20 to 30 percent of base salary, while physicians are usually

compensated at 10 to 15 percent of base salary, according to Hay Group 2011 Healthcare Survey data.

Until recently, incentives weren't factored into physician compensation programs, mostly because the revenue model was based on production, with little emphasis on any other behaviors or outcomes. But today, measures such as patient satisfaction, quality, coding, and citizenship are easier to track and compare on a relative basis. This helps organizations flesh out their pay philosophy and provide both a base salary and an incentive as part of the cash compensation components of the program.

Bear in mind that the potential elements of compensation are not only cash and benefits, but also intangible benefits that come with working at a hospital or health system. For physicians, these benefits could mean anything from a flexible work schedule to opportunities for research, pro bono projects, conference presentations, independent contracting, or other work in the community. The organization's leaders should sit down with physicians and ask what is important to them, and then use their feedback in developing a compensation program.

Five action steps can help in determining the extent to which base salaries and incentives will be used to compensate physicians:

- > Develop a working committee that comprises both physicians and nonphysician leaders.
- > Show the committee data that include base salary and incentive numbers as well as how the incentives are structured.
- > Review and discuss several approaches regarding how these elements will be mixed.
- > Model one or more approaches with real-life examples.
- > Integrate the results through discussions with the other physicians.

An integrated delivery system (IDS) in the Great Lakes region built a formal physician compensation philosophy with a new multispecialty physician group from scratch. The IDS sought to determine how physicians should be paid and what metrics should be used in determining

compensation. To create a sense of fairness with existing physicians in the hospital and a primary care group, the IDS also needed to allow for transparency while ensuring that its program could withstand scrutiny.

The IDS assembled a collaborative committee of departmentally credible physician leaders, practitioners, and system financial and operational leaders. By involving key influencers who had established trust with peers and subordinates, the organization could communicate progress and results more effectively.

An IDS in the southeastern United States built up its employed physician population over the years primarily through practice acquisition and had negotiated a wide range of compensation and structural relationships between these practices and the system. The organization recently underwent a process similar to the one described above to develop a common compensation plan framework to be used in the future for employing physicians.

The incentive portion of the plan framework focuses on achieving outcomes that support the IDS's quality goals and the financial goals of the employed physicians groups. This arrangement recognizes the impact that the physicians have on more than just revenue. Incentive measures include interaction with other physicians within the group and with patients (as measured through patient satisfaction scores). Because these incentive measures were new to the group, getting physicians to participate in developing and communicating the framework was critical to designing it. Since the compensation program was developed in 2010, quality of care and financial results have improved and communication among physicians and between physicians and patients has been enhanced.

The third critical question is, *How should the organization's physician compensation package be structured?* Just as salary levels provided by hospitals and physician groups differ, benefits provided in private practice are typically not the

same as those paid by hospitals. There are a number of variables to consider.

There is a range of options for retirement benefits in the private practice space depending on factors such as how the health system wants the retirement plan to work, the percentage of current compensation that should be directed toward retirement, the make-up of the rest of the staff, and the tax rules that apply to the organization's retirement plans. Hospitals, on the other hand, typically do not have a great deal of flexibility in developing retirement plans for physicians. In more and more hospitals across the country, SERPs are being used to augment retirement plans. Fundamentally, SERPs are designed to supplement what the physician is expected to receive from the basic hospital plan and through Social Security.

As mentioned, tying annual incentives to the success of a department or the entire organization is essential—at least for a portion of the annual incentive. However, when designing pay components, hospitals often do not build in long-term measures that complement and support their strategic plan. LTIs can be hugely beneficial to the organization and to the individual if the full board supports the decision, the right leaders are chosen to have LTIs, the goals are structured strategically, and the rewards are significant.

Group disability insurance plans vary, but most offer a modified "own occupation" definition of disability. This provides protection in the event that an illness or injury prevents the physician from working in his or her own occupation. It is imperative that appropriate policies be purchased in these disability plans so that, if an accident occurs that prevents physicians from performing their duties in their current roles, they can be compensated accordingly. In some situations, especially for physician leaders, an individual long-term disability plan may be warranted, depending on payout caps in a group plan.