Designing a Flexible Compensation System

Genie G. Blough, M.B.A., F.A.C.M.P.E.

Shena J. Scott, M.B.A., F.A.C.M.P.E.

As a follow-up to the topic of "Creative Scheduling to Retain Staff in a Tight Market" presented at the ASA Conference on Practice Management in 2003, and again as a breakout in 2007, a frequently asked question is *which physician compensation system works best to provide this flexibility?* With more women entering the anesthesiology workforce, different priorities for work/life balance in both genders of the younger generation, and the "workhorse" baby boomers approaching retirement age, groups around the country increasingly face the dilemma of structuring a part-time work program that benefits the group and the individuals. Yet, as recently as 2007, 19 percent of groups reported that it was "too difficult to manage in the schedule," 23 percent reported that it was "too difficult to decide reimbursement," 26 percent reported "group resistance to the idea of some working less" and another 11 percent cited the catch-all "it's just too complicated." The authors believe that part of the reason for this could be that nearly 60 percent of groups (up from 55 percent in 2003) report an equal share compensation system.

While an equal share system presents many advantages for anesthesiology practices primarily its simplicity and the camaraderie fostered in a system where people share call and case responsibility it is a difficult platform from which to create opportunities for people to work less (or more). Under an equal share system, the concept of the "job share" (where three physicians share two positions, four share three, etc.) or a simple "salaried non-call position" are really the only options that do not require creating a separate system. Devising a separate system just to accommodate one or two individuals is a difficult and time-consuming endeavor. But what about the physician who is willing to take his/her share of call but simply wants more vacation? Or the one who is willing to take less vacation to work fewer hours during the week? Or the one who wants to do both? Accommodating these types of positions is accomplished much more easily through a blended compensation system that compensates the physicians based upon their actual work.

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There are many different ways to achieve this objective, the extreme (and polar opposite of equal share) being total productivity. Under this system, the physician is paid based on the revenue generated for the cases that s/he performs. Anesthesiologists do not typically fare well under this system, as most facilities require they "take all comers." Since commercial payers typically reimburse significantly better than Medicare, two physicians could perform the same type of case for two different patients and be paid very differently for doing similar work. In addition, "self pay" patients, who

Genie G. Blough, M.B.A., F.A.C.M.P.E., is Principal, G, Blough Associates, LLC, Mobile, Alabama.

Shena J. Scott, M.B.A., F.A.C.M.P.E., is Executive Director, Brevard Anesthesia Services, PA, Melbourne, Florida.

are potentially "no pays," can often result in a physician not receiving any compensation for his/her services.

In between these two extremes, however, are various compensation systems that neutralize the impact of payer type but still compensate based upon cases or time the physician works. The most common types of these systems are based upon units (base and time, which allows extra reimbursement for complexity of the case), case minutes (which does not differentiate between case type but does encourage anesthesiologists to move cases along because, if they are not "billing minutes," they are not earning for themselves), and time-based (rewards based upon how long the physician is required to be in the hospital regardless of case efficiency or complexity). Most of these systems also include a "base" value paid for being on call in addition to pay for time worked; many also differentiate between time of day and weekend hours. Other popular choices include blended versions of the three types listed above and systems that work one way (e.g., equal share) during "peak hours" and move to some iteration of one of the above "after hours."

What is the best type of system for your group? Like many things, the answer depends upon the make-up of your group, where you practice and what types of cases you perform. Some key considerations include:

1) In what type of setting do you work care team, physician-only or a blend? If the practice is "physician-only," a unit or case minute system may be easier to implement than if you work in a care team or blended setting. If you work in a care team setting but the medical direction ratios tend to be consistent, a unit or case minute system may be easier to implement than if some cases are done with anesthetists and others are personally performed by physicians. In that scenario, you should implement a "neutralizer" so that the physician medically directing four cases did not earn four times as much "credit" as a physician working a complex case as a solo provider. The group might have to differentiate between the types of responsibilities physicians have to perform to ensure that everyone is comfortable with the valuations. It is also critical that everyone has equal access to perform all types of cases in all types of settings. If the group cannot agree to provide equal access to all cases, a "time-based" system may be the more equitable choice to create more harmony within the group.

2) How many facilities does your group cover? In general, the fewer facilities you cover, the greater your flexibility in selecting a system, especially when the facilities operate at similar intensity levels. If varying intensity levels exist among your facilities, physicians

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ASA, the American Medical Association (AMA) and more than 70 other organizations are conducting a comprehensive multispecialty survey of America's physician practices. The results will be used to positively influence national decision-makers to ensure accurate and fair representation for all physicians and patients, and to articulate the challenges of running a practice that provides expert patient care while operating a sustainable business. Of particular importance is the section of the study pertaining to practice expenses and the amounts that are attributable to you. The Centers for Medicare & Medicaid Services has indicated it will use the results of this study to help determine physician payment. The survey firm dmrkynetec will contact randomly selected physicians and practice managers to collect responses. All responses will remain confidential.

Please alert your staff regarding your willingness to participate in this survey and the importance of accepting incoming calls, faxes or e-mails from dmrkynetec. A postcard will be mailed to the entire physician sample in June and is one indication that you have been selected to participate. (To see a copy of the card, please click on www.asahq.org/news/PPI_Survey-pstcrd.pdf.)

As of June 6, only 43 percent of anesthesiologists selected to participate have completed this survey.

If you have been selected to participate in this important effort and have any questions about this survey, please call toll-free at (877) 816-8940 and ask to speak with one of dmrkynetec's executive interviewers about the 2008 Physician Practice Information Survey.

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might view a "time-based" system as highly unfair without a weighting system based on the hours (e.g., one hour medically directing 1:4 at the level 1 trauma center is valued at 1.5 times an hour in MRI or at the two-room GI facility). In that scenario, you might be much better off to have a minutes or unit system as long as you can neutralize for multiple minutes of units earned by medically directing physicians in a blended group.

3) How efficient are the facilities you cover? If the facilities run fairly efficiently with few "gaps" in the schedule, providing the added incentive to move things along could be a positive. If there is much inefficiency outside the physicians' control, however, a time-based system may be more appropriate.

There are many factors to consider in devising a compensation system that meets your needs. It takes a lot of forethought and analysis of the factors mentioned here and of others that are specific to your situation. Changing the physician compensation system is one of the largest undertakings a group will ever do. In addition to the challenges of designing the ideal system are the group dynamics and governance issues. Individual members or factions within the group may resist change. The authors recommend that a group test any new system for a minimum of six months before the conversion in an effort to sort out any potential "bugs" and develop "rules" to ensure fairness. For example, do you treat labor epidurals as placement time, the entire time it is running or with a flat fee? If you are on a case minute system, do you need some "special rules" to accommodate situations where the physician is "up and down" all night but does not actually earn a lot of minutes? Every group is different and should tailor its system to fit its needs. In speaking with groups around the country, the authors universally hear that groups who "make this leap" are generally very happy they have done so. In the process, they have essentially created a perfect vehicle to allow individuals the flexibility to work at the level they desire and alter that level should lifestyle choices change over time.

Once you have created a system based upon the type and amount of hours worked, the transition to part-time work or slow down work has essentially been accomplished. Some additional considerations include defining who constitutes a "full-time shareholder" and whether those who work something less should maintain their shareholder status and/or voting rights. In addition, groups should determine how to allocate benefits and fixed costs when people work differing amounts (see May 2003 "Practice Management" column from for this discussion; March 2003 for associated survey results).

But the hardest part is usually figuring out the money. Groups who have gone through this process and devised a system that meets all of their needs are usually many steps ahead in this process. People can move up or down the income/lifestyle spectrum as their own personal needs dictate. Critics of these systems argue that you trade one set of headaches for another: people fight over money instead of time. While this may indeed be true, at least these systems provide flexibility, something that is becoming increasingly important in the current environment. Three critical elements to help diffuse "fighting over money" with these systems are: 1) having a neutral "gatekeeper" with no personal vested interest overseeing the system (hint: this should not be one of the physicians); 2) there must be a mechanism for ensuring an equal opportunity to a share of the pie for those who want it (hint: scheduling is key here); and 3) the group must willingly adjust the system as loopholes are identified.

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Many people object to the idea of these systems because they perceive them as expensive to administer. Even if the group had to hire a separate person to administer the system, the cost would most likely be in the $2,000-3,000 per physician per year range, as only the larger groups would require a full-time position. Obviously, the cost for recruiting and physician turnover is much higher than this one salary. Flexible systems can allow groups to recruit and retain valued physicians who simply want to work less (or more!) and are willing to adjust their incomes accordingly. Most importantly, they can allow all physicians to feel that they have more control over their own destiny, thereby improving job satisfaction, a factor that many consider priceless in today's challenging health care environment.