Healthcare Compensation Plans: Current Challenges and Novel Approaches

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SUMMARY

The US healthcare sector differs from others, particularly with regard to how its workforce is compensated. In healthcare's third-party payer system, the consumer (i.e., the patient) typically is not the one paying for the service. Moreover, the payment for a given service is negotiated by the provider and the third-party payer before the patient ever seeks care—and the payment for the same service may differ among payers and patients. To further complicate matters, myriad overlapping federal, state, and local statutes and regulations govern how providers interact with patients and each other. The challenges with compensating physicians have been amplified by the healthcare workforce shortage that was looming even before the onset of the COVID-19 pandemic. In light of these various forces in the healthcare industry, this article reviews the current ways healthcare providers are compensated and the challenges with those compensation plans. Potential approaches to remedy those challenges are described, both broadly and with specific real-world examples related to primary care and surgical specialties. Lessons learned from these approaches include ways that healthcare organizations may measure the success of a compensation plan.

The US healthcare sector differs from others, particularly in the way its workforce is compensated. In our third-party payer system for healthcare, the consumer receiving the service (i.e., the patient) typically is not the one paying for the service. Furthermore, the payment for a given service is negotiated by the provider and the third-party payer before the patient ever seeks care, and the payment for the same service may differ among payers and patients.

In addition to the differences in how healthcare services are reimbursed and

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The author declares no conflicts of interest.

DOI: 10.1097/HAP.0000000000000141

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compensated, myriad overlapping federal, state, and local statutes and regulations govern how providers interact with patients and each other. For example, fraud and abuse laws put upper bounds on compensation for providers who perform the services that organizations charge payers. The challenges of healthcare compensation plans are made more complex because organizations are limited in how much they can compensate a provider.

Before diving into the current challenges surrounding healthcare compensation plans, and potential approaches to meeting these challenges, it is important to understand how we got here. Even before the COVID-19 pandemic, a healthcare workforce shortage loomed as more baby boomers aged and required more healthcare services. At the same time, the physician population was projected to decline as a result of an imbalance between the number of physicians aging into retirement and new physicians entering the practice of medicine (Association of American Medical Colleges 2020). This analysis was conducted before the pandemic, which has spurred additional, unexpected physician retirements and decisions to leave the practice of medicine (Stewart 2020).

Likewise, the nursing workforce is expected to experience a critical shortage resulting from replacement of retiring registered nurses (RNs) and those who are simply moving on to a different occupation (US Bureau of Labor Statistics [BLS] 2021). In all, the BLS estimates that 1.1 million new RNs are needed to avoid a nursing shortage (American Nurses Association n.d.). In addition to RNs, BLS projects growth in the need for numerous other nursing roles including licensed practical nurses, nurse anesthetists, nurse practitioners, and nurse midwives (Behring 2021).

As with other sectors, the levels of supply and demand for the same resource have an impact on the price paid for the resource. The supply of and demand for healthcare providers, and the services they provide, are not immune from this economic concept.

The Shift from Volume to Value

Despite the narrative that the US healthcare delivery system is in the middle of a transition from volume-based reimbursement to value-based reimbursement, most physicians are still compensated on a productivity (volume-based) basis that rewards those who provide more services, most commonly measured by work relative value units (wRVUs). In fact, a 2022 *JAMA* study found that 68.2 percent of compensation models for primary care physician organizations and 73.7 percent of compensation models for specialty physician organizations were volume-based (Reid, Tom, and Ross 2022). Similarly, nurses and other nonprovider practitioners are largely compensated based on hourly rates.

Identification of Compensation Challenges

While physician compensation models have been slow to shift from volume to value, the pandemic has accelerated the pace for organizations that are considering the next generation of provider compensation plans. Certainly, the challenges with provider compensation plans differ by provider type (and even by specialty). For example, with all the additional measures put in place to combat the spread of COVID-19, the ceiling of physician productivity (i.e., the amount of time to devote to patient care—and producing wRVUs) has been decreased. This is leaving physicians with less control over their productivity along with their resulting compensation, which was the original motivation for such plans.

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For nurses, the discrepancy in pay rates between employed nurses and travel nurses has been a significant cause of concern, with travel nurses earning up to five times the hourly rate (plus various stipends) of employed nurses. This has led to a vicious cycle where nurses are leaving their hospital of employment and joining a travel agency, leaving hospitals short-staffed and forcing them to hire travel nurses to combat those shortages.

Potential Approaches to Compensation Challenges

After consideration of the current provider compensation landscape, and a review of the accompanying challenges, the contemplation of any potential approaches to resolve these challenges must be made within regulatory restrictions such as the Stark Law, which prohibits physician self-referrals, and the Anti-Kickback Statute, which prohibits the exchange of remuneration to induce or reward patient referrals. These laws include numerous exceptions to protect certain business arrangements that are unlikely to result in fraud or abuse, most of which require an employer to pay no more than fair market value, setting a sort of ceiling on provider compensation.

At its highest level, compensation comprises two elements: cash and other benefits that may be monetary or nonmonetary. Any compensation approach should address both elements and use them to align organization and provider goals and consequently incentivize or disincentivize certain activities.

Further, in consideration of potential tactics, it is important to consider near-term and long-term approaches. Near-term approaches—those addressed during the pandemic—have included hospitals (and other employer organizations) seeking to simply incentivize providers to continue employment and care of patients with hazard pay. These measures were made possible through temporary regulatory waivers and relaxations. However, these waivers will sunset at the conclusion of the public health emergency; consequently, near-term approaches need to be revised to ensure compliance with laws and regulations. The ending of these waivers (and any necessary compensation plan restructuring to regain compliance) provides an opportunity for organizations to determine what longer-term approaches may best incentivize their aligned providers to meet the organization's goals.

Obviously, there is no one-size-fits-all plan. The behaviors and metrics that organizations wish to incentivize (and the resulting compensation plan) will likely differ between health systems and critical access hospitals, and in urban versus rural locations. And while it is understandable that a productivity-based compensation model works in the current volume-based reimbursement environment, the design of a compensation plan should correspond to the organization's strategic, long-term priorities, not just those of third-party payers (Gallani et al. 2021).

Compensation plans also should allow providers to control their measured performance and improve upon it (Blumenthal et al. 2013). Trending alternative (i.e., to pure productivity-based) provider compensation models that have been implemented include payment for, or consideration, of:

- provision of indirect care (e.g., care coordination),
- patient panel care (primarily for primary care providers),
- managed care efficiency,
- group citizenship,

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- patient satisfaction, and,
- group/service line profitability (Fibuch and Ahmed 2018).

Because practice patterns vary, behavior and compensation incentives typically vary between primary care providers and specialists/surgeons. Specific examples of provider compensation approaches that include one or more of these elements are provided here for primary care physicians and surgical specialists.

Novel Approach for Primary Care

Physician recruitment and retention is a priority for most organizations and across most physician specialties. However, primary care specialties (e.g., family medicine, internal medicine, nurse practitioner) are the most recruited providers by healthcare organizations. Therefore, many alternative primary care compensation model designs include elements that (1) assist in the recruitment of new primary care providers (PCPs) to their organization and (2) incentivize both new hires and their already-employed PCPs to see more patients and retain their patient panel. As many healthcare organizations consider offering their own Medicare Advantage plan and becoming a "payvider," compensation models that incentivize care coordination over a defined, and growing, patient panel allow the organization to not only deliver cost-effective healthcare but also control the care their members receive.

This type of compensation model includes consideration of visit volume across age cohorts, patient panel size, and patient attrition rates. The compensation model also includes consideration of "high-touch" care, with more frequent contact between PCPs and patients. Evidence shows that increased care ultimately results in healthier patients and a 28 percent reduction in costs (e.g., reduced emergency room visits and hospitalizations) (Ghany et al. 2018).

This primary care–based approach includes compensation consisting of a (relatively small) base salary plus certain incentive payments for retention of a patient panel of a certain size and additional incentive payments based on the number of visits. For example, for physicians who are new to the organization and area, a panel size of 700 or more in the first year results in bonus compensation of 5 percent of their base compensation. In years 2 and 3, the PCP must maintain a minimum patient panel of more than 700, with 20 percent and 30 percent growth in panel size, respectively, to receive a bonus of 5 percent and 10 percent of their base compensation, respectively. The PCPs who are employed for 3 years or more are paid an escalating bonus amount (5 percent–12 percent of base compensation) depending on (1) the overall patient panel size and (2) the amount of the increase in patient panel size over the annual period. Additional incentives are paid to PCPs who can retain at least 90 percent of their patient panel from the previous year and to PCPs who see at least 90 percent of their patients within 7 days of an appointment request.

The compensation amounts and panel size thresholds for this specific, real-world example are based upon market-specific variables such as socioeconomic factors, population density, and patient population acuity.

Novel Approach for Surgical Specialties

Orthopedic surgeons also are highly sought-after specialists. While the preceding primary care example illustrates an employer/employee alignment model approach, many organizations have other physician alignment models such as joint ventures and provider service agreements.

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To date, I have not seen many clients enter into nonvolume-based compensation arrangements with their surgical specialists, but I have seen organizations link a greater proportion of their specialist compensation to value. Shifting more compensation to at-risk, where a physician does not receive compensation if they do not achieve a given metric, allows an organization to increase the ceiling on a provider's compensation.

I am also seeing organizations accompany flat-pay arrangements with a stack of performance metrics for which a group of physicians is held accountable. As described in the following example, this compensation approach involves a healthcare organization entering into a provider services agreement (PSA) with a large specialty orthopedic practice.

In designing the PSA compensation model, the organization seeks to incentivize high-quality orthopedic care. Its compensation model pays a small, fixed amount to the group per full-time equivalent (FTE) physician and an additional small, fixed amount per FTE advanced practice clinician, plus certain incentives based on a schedule of various quality metrics. As with an à la carte menu, the practice receives more money for more of the metrics that it meets or surpasses. Many of the metrics are based on Medicare and other payer performance and quality metrics. They include:

- alignment of skilled nursing facility utilization post diagnosis related groups (DRGs) 469 and 470 with national benchmarks and in conjunction with the Centers for Medicare & Medicaid Services Bundled Payments for Care Improvement program and Comprehensive Care for Joint Replacement (CJR) program (with the goal of achieving the 25th percentile for discharge disposition to post-acute care);
- development and use of clinical protocols, including a demand-matching tool (with the goal of using the demand-matching tool at least 75 percent of the time);
- development and implementation of evidence-based protocols for the transition of patients through post-acute care facilities and/or for the presurgical optimization of patients in the CJR bundles (with the goal of creating at least three clinical protocols);
- development and presentation of a community lecture series to increase awareness of the orthopedic services and continuing medical education lectures to staff, physicians, and the community (with the goal of developing and presenting at least eight 45-minute presentations);
- partnership with the organization to create new programs with school districts or new programs within existing partnerships (with the goal of implementing new programs in five or more school districts);
- development and implementation of evidence-based treatment guidelines for musculoskeletal conditions (with the goal of developing and implementing at least three evidence-based treatment guidelines for conditions related to hand, forearm, and wrist care); and
- creation of additional programs—or improvement in existing programs—to increase patient access for orthopedics (with the goal of creating at least three programs).

The achievement of each of these performance metrics results in a certain maximum payment amount to the group, while

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partial achievement results in a payment of a percentage of the maximum payout.

Considerations for Other Benefits

As a result of the increased competition for provider services, as well as efforts to care for and retain providers, compensation approaches today are including a broader range of benefits to enhance the noncompensation elements of employment plans, including:

- more mental health days,
- more programs to encourage employee wellness,
- more (free) training to move workers into in-demand occupations, and
- allowing more employees to work remotely.

Lessons Learned, Moving Forward

In designing, establishing, and maintaining novel compensation approaches, healthcare organizations have learned two valuable lessons:

1. **Provider buy-in is essential.** Otherwise, the redesign may result in an outcome that is the opposite of what is desired (i.e., losing providers). Buy-in is most often achieved with a compensation committee comprising physicians of various specialties (quality metrics and compensation incentives may need to be tailored to each individual specialty) to make any changes to the plan.
2. **The model must be flexible and transparent.** Compensation plans need to be revised frequently once the model is in place and the organization and employees have experienced it. This process is particularly important in plans with various quality metrics, as those metrics may change over time to reflect the latest care effectiveness protocols and reimbursement requirements.

Measurable Outcomes of Initiatives

In determining whether these various novel compensation design approaches are deemed successful, organizations must track objective, measurable metrics, including:

- employee retention,
- employee job satisfaction,
- patient satisfaction scores,
- quality of care (as determined by payers or internal benchmarks), and
- meeting value-based reimbursement metrics set by payers.

These metrics must be continuously evaluated, and new metrics also must be considered for addition to this list.

Also, organizations may monitor trends in provider productivity and compensation to ensure there is no more than a 20 percent variance (positive or negative) in the respective industry normative benchmark percentiles for productivity and compensation. Significant deviation from those benchmarks and percentiles may result in legal issues or overpaying providers (Gee 2022).

Conclusion

When the United Nations was being formed after World War II, Winston Churchill famously said, "Never let a good crisis go to waste." Over the past couple of years, healthcare organizations have been in the middle of the COVID-19 pandemic, and that crisis has been occurring in the midst of the shift from volume-based to value-based reimbursement. However, this ultimate stress test, with its resulting staffing shortages and financial hardships, has highlighted the

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things that must be changed. For those who choose to take advantage of the opportunity, now may be the perfect time to explore wholesale changes to provider compensation agreements.

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