EXECUTIVE INSIGHTS

Physician Compensation: The Hidden Challenge to Healthcare Transformation

Throughout the U.S. healthcare provider landscape, fundamental changes are happening at an accelerated pace. This transformation can be attributed to a number of developments, not the least of which are the ways in which healthcare costs are covered, consolidation, and the level at which physicians are compensated.

In today's U.S. healthcare ecosystem, healthcare organization and physician financial incentives are increasingly misaligned. Without addressing these dueling incentives, healthcare provider organizations will struggle to achieve their ambitions when it comes to transforming healthcare.

Without a more deliberate and strategic approach to physician compensation:

- Healthcare provider organizations risk serious misalignment between physician incentives and organizational value drivers
- Physician compensation can quickly become a serious drag on an organization's bottom line and its efforts to implement value-based care (VBC), consuming an outsized share of management and organizational bandwidth and leading to poor recruitment, retention and performance

In this *Executive Insights*, L.E.K. Consulting discusses:

- Six key physician compensation challenges to healthcare transformation trends
- Guiding principles that healthcare provider organizations can use to navigate these six distinct challenges

Physician compensation-related challenges to healthcare transformation

We have noted the following six challenges related to physician compensation:

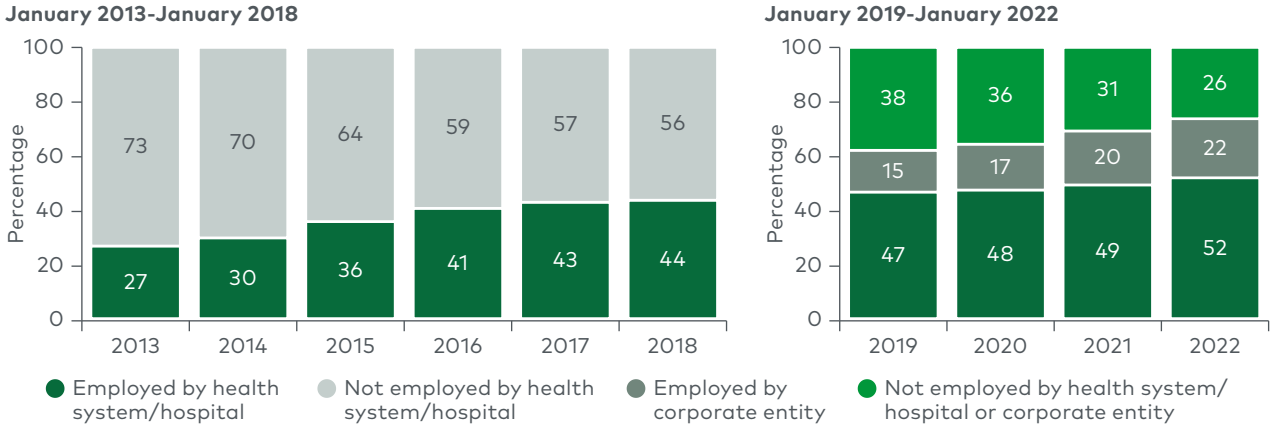
1. **Physician employment models challenge a long-standing entrepreneurial spirit and a mantra of maximizing volume.** Historically, U.S. physicians have operated within a highly fragmented and entrepreneurial landscape. As independent businesses, they took significant financial risk, but had full transparency into and control over their financial performance and had full access to the upside that their businesses generated.

   Consolidated healthcare provider organizations have a more complicated agenda, include physicians from a wider set of geographies who joined the organization at different times and under different terms, and offer less financial autonomy and transparency while transferring more financial risk.

   While physicians may choose to join a larger provider organization (see Figure 1) to reduce their financial risk and access back-office and other forms of support, the associated loss of financial transparency and upside exposure runs counter to long-standing physician experiences and expectations. Given these dynamics, a poorly designed and/or insufficiently managed physician compensation plan can quickly create significant challenges for a consolidated provider organization such as:

   - Recruiting and retention of clinicians
   - Perceptions of unfairness across specialties/geographies
   - Mistrust, given that ensuring data availability and transparency can quickly become a significant drag on management bandwidth and the organization's bottom line

Figure 1
Percentage of US physicians employed by health systems, hospitals or corporate entities



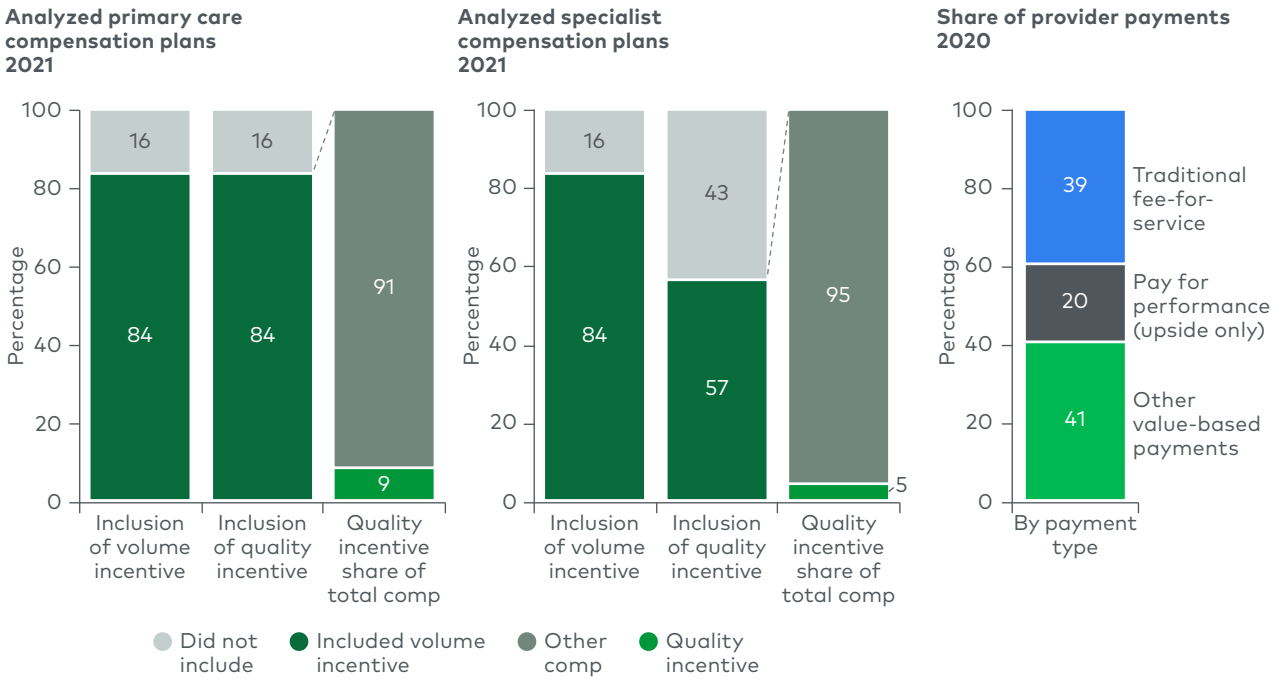
Source: Physicians Advocacy Institute

These challenges should be addressed when considering physician employment models.

2. **Physician compensation has been long tied to production, and resistance to change is high.** Despite growth in value-based contracting, a recent study of health system physician compensation models found that more than 80% of analyzed primary care models and more than 90% of analyzed specialist models included a volume-based incentive payment (see Figure 2).[1] While a similar proportion of primary care compensation plans included some form of quality-based incentive, only ~55% of specialist compensation plans included some form of quality-based payment.[2]

Figure 2

Typical physician compensation plan structure vs. share of provider revenue by payment model



Source: JAMA Health Forum; HCPLAN

When included, quality-based incentive payments only comprised 9% of total compensation for primary care physicians, and 5% of total compensation for specialist physicians,[3] representing a significant disconnect between provider organization revenue (now at ~40% paid via upside/downside contract models)[4] and physician payments, a disconnect that is much more difficult to remedy for specialist physicians relative to primary care.

While a shift to value-based physician incentives is picking up speed, it is increasingly challenging to shift away from well-understood volume-based incentive models. Over 70% of provider organizations are actively hiring physicians,[5] and only 45%-70% (depending on

specialty) of physicians believe their current compensation is fair.[6] Consequently, the risk (and cost) of losing recruits and existing talent to more predictable or widely understood compensation offers is high.

3. **Physician incentives have historically rewarded individual results, not collaboration.** Today, fee-for-service (FFS) based physician compensation plans are typically anchored to individual physician activity. However, consolidated provider groups and those participating in VBC programs require significant collaboration to reduce cost of care and improve outcomes (in some studies, primary care coordination reduced costs by ~$300 per member per month for high-risk patients).[7]

   As different specialties and service lines have unique roles and impacts on overall performance and demand and a range of market-competitive compensation levels, setting both compensation structure and levels during this transition is complex. In addition, the emphasis on teamwork makes physicians understandably hesitant to accept compensation mechanisms that prioritize individual responsibility, or reward, for positive patient outcomes and value. In short, physicians worry that since they don't have control over outcomes individually, that dictates, to some extent, their faith (or lack thereof) that the larger group is able to influence outcomes.

4. **Because healthcare transformation is gradual, there is a serious risk of competing incentives.** The transition to coordinated, value-based healthcare has been very gradual — despite proclamations to the contrary. In many cases, physicians now face opposing incentives to both increase volume (e.g., number of patient visits) and maximize non-revenue-generative value-driving activities (e.g., time spent tracking patient adherence to care plan). In a recent study, 70% of physician organization leaders noted that increasing the volume of services delivered is the top action that primary care and specialist physicians could take to increase their compensation[8] — a statistic seemingly contradictory to industry tailwinds focused on value.

5. **VBC introduces significant time lags between physician actions and ultimate organizational financial outcomes.** Under value-based contracting models, financial payments are tied to patient outcomes rather than physician activities, and there is a considerable (multimonth) lag between physician activity and value-based payment. Given that historical physician compensation models pay for volume/physician actions, healthcare provider organizations need to develop incentive structures that balance near-term rewards for activities that are expected to yield value with longer-term incentive payments that tie to VBC results and financial payments the organization receives.

6. **Very few organizations have "closed the loop" on measurement and reporting of VBC performance, and physician trust of outcomes data is low.** To compensate physicians based on VBC performance, organizations must develop their data and analytics capabilities, identify and focus on the most impactful metrics, and invest significantly in building physician trust in the data.[9] Most healthcare provider organizations have not yet closed the loop on VBC measurement and reporting. This challenge will only increase as healthcare organizations consolidate and become more complex.

Guiding principles to consider

We believe six guiding principles should be taken into consideration to address these challenges (see Table 1).

Table 1
Guiding principles

Key challenges	Guiding principles
1. Physician employment models challenge a long-standing entrepreneurial spirit	**A.** Invest in designing a physician compensation plan that is simple and transparent and shares organizational success **B.** Create physician-led compensation oversight bodies **C.** Build a significant physician compensation team and empower them to invest significant time in education, communication and continuous improvement — do not let molehills become mountains
2. Physician compensation has long been tied to production, and resistance to change is understandably high	**A.** Devise simple and clear long-term value accretion/bonus mechanisms (e.g., equity, long-term incentive plans), and account for the discount physicians will understandably apply in comparing equity/long-term pay with all-cash alternatives **B.** Balance competitive base productivity/salary with these clear and compelling long-term compensation components (e.g., equity for private organizations, long-term incentive plans for systems and public companies)
3. Physician compensation has historically rewarded individual behavior, not collaboration	**A.** Institute long-term reward mechanisms that share a portion of value (or losses) across the organization and across the "team" of providers that interact with a given patient **B.** Educate providers and convey the value of all compensation drivers, especially longer-term value incentives such as equity (for private groups) and incentive plans
4. Because healthcare transformation is gradual, there is a risk of competing incentives	**A.** Reward the right actions (i.e., increased quality and decreased overutilization) for ALL patients — FFS and VBC; it is the right thing to do and pays off in the long term **B.** Make the plan simple and flexible — create simple mechanisms (e.g., percentage of pay tied to VBC) that can increase as the organization's VBC exposure increases
5. VBC introduces significant time lags between physician actions and ultimate organizational financial outcomes	**A.** Devise a compensation plan that balances immediate payment for actions that are expected to drive VBC performance and long-term reward for outcomes **B.** Plan upfront for the cash flow implications of this approach (i.e., payment to physicians before cash receipt for VBC surplus/shared savings)
6. Very few organizations have "closed the loop" on measurement and reporting of VBC performance	**A.** Institute stepwise changes to compensation; in the short term, VBC upside is largely tied to the pool of at-risk dollars or "lives" tied to cost-based outcomes, whereas in the long term, performance increases with proven ability to "bend the cost curve" **B.** Invest in analytical tools in parallel — VBC initiatives are often better analytically proven using backward-looking analysis, but closing the loop on actual performance is critical to dial in your VBC performance over time

Understanding these principles can be crucial to navigating the six key challenges related to physician compensation — and transforming healthcare provider organizations.

For more information, please contact strategy@lek.com.

Endnotes

[1]JAMA Health Forum, Physician Compensation Arrangements and Financial Performance Incentives in US Health Systems. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2788514

[2]Ibid.

[3]Ibid.

[4]HCPLAN, "APM Measurement Effort Results." https://hcp-lan.org/apm-measurement-effort/

[5]MGMA Poll, "Is Your Organization Planning to Hire for New Physician Positions in 2021?" https://www.mgma.com/data/data-stories/market-for-medical-group-physician-hiring-strong-a

[6]Medscape, "Medscape Physician Compensation Report 2021: The Recovery Begins, 2021." https://login.medscape.com/login/sso/getlogin?wcode=102&client=205502&urlCache=aHR0cHM6Ly93d3cubWVkc2NhcGUuY29tL3NsaWRlc2hvdy8yMDIxLWNvbXBlbnNhdGlvbi1vdmVydmlldy02MDEzNzYx&sc=ng&scode=msp

[7]JAMA, "Can Better Care Coordination Lower Health Care Costs?" https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2712173

[8]JAMA Health Forum, "Physician Compensation Arrangements and Financial Performance Incentives in US Health Systems." https://jamanetwork.com/journals/jama-health-forum/fullarticle/2788514

[9]Hallmark Healthcare Solutions, "What Is the Real ROI of Physician Compensation Management Technology?" https://www.ehidc.org/sites/default/files/resources/files/real-roi-physician-compensation-management-technology-whitepaper.pdf

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