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Jessica L. Bailey-Wheaton, Esq., Editor
Todd A. Zigrang MBA, MHA, CVA, ASA, FACHE, Publisher

Study: Most Physician Compensation Plans Still Productivity-Based

A study conducted by the RAND Corporation and published in the January 2022 issue of the Journal of the American Medical Association (JAMA) seeking to determine whether health systems primarily incentivize volume or value in their physician compensation models found that almost all physicians are still compensated through a volume-based model that rewards productivity over the value of care provided.

The most recent iteration of healthcare reform, formalized in the 2010 *Patient Protection and Affordable Care Act* (ACA), signaled the shift to both *value-based care* (VBC), i.e., the goal of improving a patient's outcomes and the quality of care, and *value-based reimbursement* (VBR), how health systems and payors financially incentivize physicians to practice VBC over volume-based care.[1] Volume-based care has been, and still is, the default method of care and payment model in the U.S. because it incentivizes healthcare providers to treat more patients in order to achieve higher revenue.[2] The problem with volume-based care is that it largely disregards a patient's health outcomes and the quality of care received. As a result, volume-based care and volume-based payment models are increasingly under scrutiny and the Centers for Medicare & Medicaid Services (CMS) is leading the charge with their goal of shifting all Medicare beneficiaries to be treated by a provider in a VBC model by 2030.[3]

In the article's introduction, the RAND researchers noted that since the ACA's passage, physician hires and the size of health systems have increased.[4] They also noted that the majority of physician payment models were still based on volume-based care in 2019 (the end date of the study's survey).[5] This result, nine years after the ACA was passed, led RAND researchers to investigate how physicians are compensated and why VBR has been slow to be embraced.[6]

In determining why VBR has been slow to be incorporated, RAND researchers collected data, conducted interviews, and ran surveys from November 2017 through July 2019.[7] The researchers collected information from 31 physician organizations (POs) among 22 non-profit health systems across four states (California, Minnesota, Washington, and Wisconsin).[8] These 31 POs were comprised of 27 medical groups and 4 independent practice associations; all but one had compensation plans for both primary care providers (PCPs) and specialists.[9]

The two-year study indicated that VBC practices were the easiest and quickest way for physicians to increase their compensation.[10] 26 of the 31 primary care PO compensation models incentivized the volume of services in their base compensation, as did 28 of the 30 specialist PO compensation models.[11] Further, of the 26 primary care POs that cited volume as a compensation model component, it comprised, on average, just over 68% of the PCPs' total compensation; for specialist POs, that component was nearly 74% on average.[12] Beyond volume-based compensation methods, capitation and salary were the next most common forms of physician payment, leaving VBR models at the bottom.[13] However, many physicians on capitation and salary payment models still receive benefits from increased volume.[14] Of the 31 primary care POs, 26 POs (nearly 84%) did include some form of incentives based on quality and cost effectiveness, although they accounted for (on average) just 9% of a physician's overall compensation and benefits.[15] Further, compensation plans for specialists within the POs studied relied more heavily on the volume of patients seen compared to the primary care providers.[16] Within the "quality" and "cost effectiveness" incentives studied by RAND were various subcategories; the most prominently incentivized subcategories included clinical quality and patient safety/patient experience/satisfaction.[17] However, these subcategories only added up to half of the total compensation incentives from VBC practices.[18]

The study highlights the issues with U.S. healthcare system's payment hierarchy, which includes payors at the top imposing payment policies onto health systems, which, in turn, pass those incentives down to the POs.[19] The problem, according to RAND, is that health systems often pass down the incentives, but not the larger payment model, to the POs.[20] The study noted the challenge of "translat[ing] risk-bearing payment arrangements and many measures of quality, utilization, or value to the individual physician level for payment purposes owing to limitations in panel sizes and reliability concerns with measuring individual physician performance."[21] In response, many health systems and physician practices position themselves "as a buffer between payers' incentives and physicians…[which] also likely contributes to the dominance of volume-based compensation and modesty of quality and cost performance incentives."[22] This leads to the current

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challenge facing the U.S. healthcare delivery system – how to incentivize VBC.

These study results are in direct contradiction to the longstanding narrative that the U.S. healthcare delivery system is shifting away from volume-based reimbursement and toward VBR. Over a decade after the passage of the ACA, the limited incentives for physicians to incorporate more VBC measures into their care routines is unsettling. Despite the low percentage of a physician's compensation that these incentives comprise, they are higher than before the ACA's passage.[23] It is difficult to change decades-old payment models, especially when considering that POs and health systems have undergone tremendous growth the last decade. This strong growth makes it all the more critical for health systems to incentivize patient volume to keep pace with competitors for market share, revenue, and physician retention. It is worth considering, however, that incentivizing physicians to incorporate VBC measures is not the only way health systems can affect patients' care experience. Other ways to improve the quality, safety, and outcomes of care include nonfinancial incentives, leadership incentives, and improving referrals and ordering support.[24]

The shift to VBR is certainly occurring, albeit much slower than expected. Nevertheless, many health systems and physicians are active in pursuing this shift. In response to RAND's study, Evident Health in California noted that physicians' minds are being changed, but there is still a long way to go.[25] Additionally, a physician and researcher at RAND noted that current physician compensation models are designed for volume, not value and emphasized the need to re-think payment models across health systems.[26] This comes at a time when many experts are pointing to evidence suggesting that more can be done at an organizational level to pass down value-based incentives (but not risk) to physicians, rather than keeping them.[27] Of course, that alone will not be enough to ensure a smooth transition to VBR.

As noted above, physician buy-in is crucial to the movement because many will not want to assume more risk if they are not appropriately compensated for it. Beyond physician buy-in is health system buy-in. While many systems are forced by payors, through VBR models, to incorporate VBC practices, health systems will need to know for certain that they can maintain revenue levels under a VBR model. The shift to value-based care is underway, but is by no means secure.

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Todd A. Zigrang, MBA, MHA, CVA, ASA, FACHE, is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 25 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "*The Adviser's Guide to Healthcare – 2nd Edition*" [2015 – AICPA], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Accountant's Business Manual* (AICPA); *Valuing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies; Business Appraisal Practice*; and, *NACVA QuickRead*. In addition to his contributions as an author, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); American Health Lawyers Associate (AHLA); the American Bar Association (ABA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter, and is current Chair of the ASA Healthcare Special Interest Group (HSIG).

Jessica L. Bailey-Wheaton, Esq., is Senior Vice President and General Counsel of HCC. Her work focuses on the areas of Certificate of Need (CON) preparation and consulting, as well as project management and consulting services related to the impact of both federal and state regulations on healthcare transactions. In that role, Ms. Bailey-Wheaton provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services.

Additionally, Ms. Bailey-Wheaton heads HCC's CON and regulatory consulting service line. In this role, she prepares CON applications, including providing services such as: health planning; researching, developing, documenting, and reporting the market utilization demand and "need" for the proposed services in the subject market service area(s); researching and assisting legal counsel in meeting regulatory requirements relating to licensing and CON application development; and, providing any requested support services required in litigation challenging rules or decisions promulgated by a state agency. Ms. Bailey-Wheaton has also been engaged by both state government agencies and CON applicants to conduct an independent review of one or more CON applications and provide opinions on a variety of areas related to healthcare planning. She has been certified as an expert in healthcare planning in the State of Alabama.

Ms. Bailey-Wheaton is the co-author of numerous peer-reviewed and industry articles in publications such as: The Health Lawyer; Physician Leadership Journal; The Journal of Vascular Surgery; St. Louis Metropolitan Medicine; Chicago Medicine; The Value Examiner; and QuickRead. She has previously presented before the ABA, the NACVA, and the NSCHBC. She serves on the editorial boards of NACVA's QuickRead and AHLA's Journal of Health & Life Sciences Law.

Janvi R. Shah, MBA, MSF, serves as Senior Financial Analyst of HCC. Mrs. Shah holds a M.S. in Finance from Washington University Saint Louis. She develops fair market value and commercial reasonableness opinions related to healthcare enterprises, assets, and services. In addition she prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services and applies utilization demand and reimbursement trends to project professional medical revenue streams and ancillary services and technical component (ASTC) revenue streams.