Hallmark
Healthcare Workforce Technology

Outlook 2024:

The Future of Provider Compensation in Healthcare

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The future of provider compensation in healthcare stands at a critical juncture,

faced with a series of formidable challenges in the market. With the growing shortage of healthcare providers, the complexities of implementing value-based compensation models, and the financial uncertainties brought about by constant changes in fee-for-service reimbursement plans, mastering best practices in provider compensation is a moving goal post. Navigating the future of provider compensation—and finding successful and cost-effective solutions to rising challenges—requires a proactive and informed approach.

To help healthcare organizations both answer current and emerging challenges and take advantage of newfound opportunities, we submitted the market's most pressing questions to a range of individual experts from throughout the healthcare sector as well as to organizations with deep experience in the provider compensation space. Below, we have compiled the insights, forecasts, and strategic advice from their responses.

The Challenges of the Future

1 Provider shortages will continue to loom large.

At the top of the list of current and future challenges for healthcare organizations: there aren't enough providers to go around, especially for underserved and rural areas. As a result, there are growing implications for recruitment, retention, contracting, and compensation management.

The annual physician turnover rate increased by 43% just between 2010 and 2018—and that was before COVID-19.[1] Over the course of the pandemic, over half (54%) of physicians switched jobs, retired, or left medicine.[2] "This is the most acute I've ever seen the healthcare staffing challenge," says Marty Bonick, president and CEO of Ardent.[3]

This shortage is driving an increase in compensation-related costs. For example, the average signing bonus has increased 21%, and growth in total compensation has doubled year-over-year.[4] This trend shows no signs of slowing, especially for healthcare organizations in rural and less densely populated areas.

It's not just for primary providers, either; the deployment of Advanced Practice Providers (APPs) is growing as a means of supplementing missing physicians. Commensurately, "market salaries for APPs continue to rise," Texas Health Resources, a nonprofit health system in North Texas, told Hallmark in response to our survey questions.[5] In other words, one solution to the provider shortage—increased use of lower cost resources where feasible—isn't going to continue to be as "low" of a cost as it has been.

In this environment, it's critical to develop "effective strategies surrounding retention and recruitment," says JPS Health Network.[5] Compensation plays a key role in any such strategy given the importance of compensation plans in successfully attracting and then retaining providers, while simultaneously driving enough value and productivity to produce necessary revenue.

To be clear: compensating more isn't enough because it's not financially sustainable. Successfully attracting and retaining providers rests on compensating more intelligently. That, in turn, rests on implementing more sophisticated methods of managing compensation.

"Healthcare organizations that recognize the critical importance of truly investing in their providers, paying fair salaries tied to meeting organizational expectations, and creating straightforward incentives tied to exceeding expectations in a meaningful way, will have a distinct competitive advantage."

– Stuart J. Schaff, FHFMA
Founder and Principal of Intentionate Healthcare Advisors

2 In this environment, value-based compensation models are likely to take on renewed importance.

"The emphasis by the government is to focus on value as opposed to straight production," says Bob Wade, a Partner at Nelson Mullins Riley & Scarborough LLP, an Am Law 100 firm with more than 1,000 attorneys, policy advisors, and professionals across the United States. As a result, Wade argues, healthcare organizations will have to find effective ways to implement value-based compensation models just to remain competitive."[5]

> "It is my personal opinion that value-based arrangements will become a dominant compensation methodology in the future."
>
> – Bob Wade
> Partner at Nelson Mullins Riley & Scarborough LLP

Admittedly, that argument may run counter to some industry watchers. Indeed, skeptics of value-based care (VBC) would argue that most such initiatives have underperformed. Even some proponents of VBC acknowledge these issues: "Over 50 VBC program implementations have collectively lost billions of dollars as compared to traditional fee-for-service (FFS) benchmarks," writes one VBC advocate.[6]

However, there are two interrelated issues that will drive continually increasing interest in VBC.

First, as Wade points out, both the Government itself and payers are emphasizing outcomes over productivity, regardless of healthcare organization experience. Others agree. "With the shift from a fee-for-service world towards value-based care, insurance companies' pay structures are more aligned with value-based care, impacting the healthcare organization alone rather than the actual provider themselves," says Conway Regional Health System, a comprehensive hospital in Central Arkansas.[5]

Second, as a result, Conway Regional argues that healthcare organizations will need to find innovative ways to align these changing pay structures with provider compensation and better incentivize providers to achieve more VBC outcomes. In other words, value-based compensation can potentially—if implemented intelligently—offer a better way to incentivize provider behavior.

For example, part of why so many VBC initiatives underperform is because providers don't "share in the risks [as well as] the rewards. When a patient gets sicker and needs more treatment, part of that cost [needs to be] owned by providers."[6] The only way to create that risk-sharing is through a well-designed compensation model.

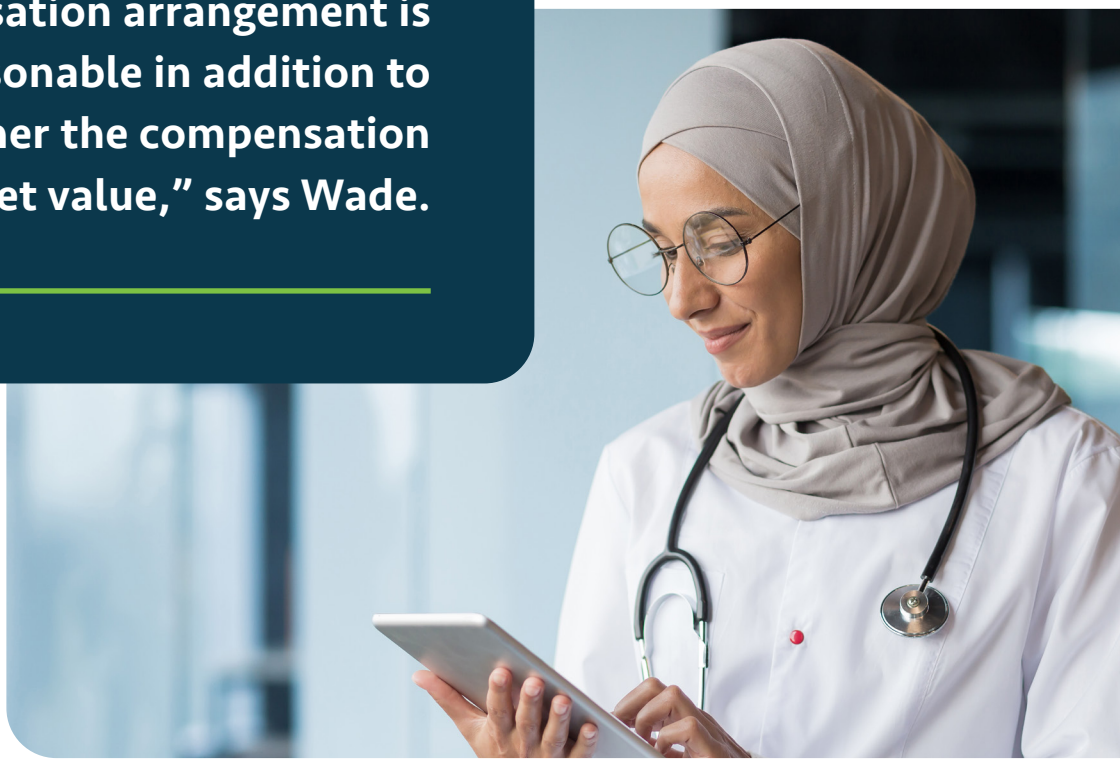
"For the U.S. healthcare system to truly realize the potential of value-based payment reform and deliver better value for patients, health systems and provider organizations will likely need to evolve the way that frontline physicians are paid to better align with value," says Rachel Reid, a physician policy researcher at Rand.[7]

Once again, however, more sophistication in the administration of compensation is needed. If nothing else, successfully transitioning to VBC requires the capability to produce the right data analytics.

VillageMD, a national leader in value-based primary care, says that many healthcare organizations overlook or lack access to the data points that are most critical to successful value-based arrangements. These include "performance analytics beyond just trailing 90-day wRVU averages – i.e., evaluating if unique patient count by day is unreasonable or very high (signaling a potential billing issue), identifying variances in practice habits between peers of the same specialty, analyzing spend for providers producing below guarantees, reporting of production trends that do not commensurate with clinical FTE status, etc."[5]

Note that in a value-based world, compliance issues like commercial reasonableness are prevalent. The Final Rules under the Stark Law and Anti-Kickback Statute offer greater flexibility when looking at specific compensation arrangement factors, says Wade, but healthcare organizations still need to document their rationale for their "strategic hires" under allowable factors. These could include under-supply of the specialty in the service area, specific challenges in recruiting and retention of physicians, new service lines or technology, engagement of "thought leaders" in a specialty, or practice locations in remote/rural areas.

"Organizations should place material emphasis on documenting why the compensation arrangement is commercially reasonable in addition to evaluating whether the compensation paid is fair market value," says Wade.



Healthcare organizations should also take care to ensure that the amount of compensation is not determined based on the volume or value of referrals. This is a consequential issue that has given rise to a series of sizable legal settlements over the past year, like Indiana-based Community Health Network's recent $345 million settlement.[8]

Organizations must monitor and ensure that compensation terms documented in the written arrangement are followed and consistent with the fair market value/commercial reasonableness documentation used when the compensation arrangement was initially created. Implementing a system of checks and balances can help, attorney Adam Robison tells the Health Care Compliance Association. That includes using FMV consultants and being conservative in evaluations. "You have to be extra cautious about not trying to justify higher compensation if it's not warranted," he says.[8]

Attending to these fine details is challenging, especially when using heavily manual tools like spreadsheets, but it is critical to ensure any initiative to shift into value-based compensation arrangements can achieve desired outcomes.

3 Even if VBC expands, however, fee-for-service models remain dominant; and changes in this area are forcing healthcare organizations to re-work and re-evaluate provider compensation.

According to a study published by the nonprofit Rand Corporation in JAMA Health Forum, "despite growth in value-based payment arrangements from payers, [most] health systems currently incentivize physicians to maximize volume."[9]

So, even if more organizations emphasize value-based arrangements, fee-for-service and productivity-based compensation models will likely remain dominant for the foreseeable future. Those health systems will then remain subject to compensation models whose discrete elements may change frequently. In fact, one of the biggest challenges in the provider compensation function is "evolving compensation plan changes from collections to more universal wRVU based models but with constantly changing fee schedule[s]," says Conway Regional. Executed poorly, managing these changes will lead to increased administrative costs and burden without increasing revenue.

Constantly changing fee schedules can also lead to existing provider compensation plans falling out of alignment with:

"We have found that clients often struggle with the task of paying providers with different specialties using different CMS year schedules," says Pavithra Pattabi, Vice President of Implementation at Hallmark, "largely because CMS fee schedule changes lead to a decrease in revenue for the services provided."

Flexibility is key to dealing with fee schedule changes successfully. JPS Health Network showcases the power of moving past outdated benchmarks and comp models: "Even if the benchmarks and wRVU values used in our physician compensation plan were aged, the plan itself allows adjustments as necessary if approved by the organization."

It may still be a challenge to figure out how to balance the positive versus negative impacts on providers from these changes, as well as the feasibility from a budget perspective ("whether we can afford them"). But, by implementing compensation plans that are flexible so they can adjust benchmarks and wRVU values at need, they can ensure their plans remain competitive into the future.

Here too, the central theme of the future of provider compensation remains the same: antiquated methods for managing provider compensation (spreadsheets) makes handling these mandated changes harder.

The Solutions of the Future

1 Optimize provider compensation functions and allow the power of automation to elevate enterprise performance.

Being adaptable to unconventional provider compensation workforce strategies that align with the evolution of healthcare unleashes the potential for maximized enterprise performance and organizational effectiveness. Healthcare organizations should be thinking about how to broaden the scope of their provider compensation department structure to leverage economies of scale and increase value. Furthermore, investments in technology and automation are the catalyst to elevating team utilization, creating platforms for transparency, and ultimately, cultivating trust in data-driven decision-making. Making these changes can allow for more focused attention on education and relationship management, creating cross-functional strategic partnerships that best support our provider enterprise, patients, and community," says James Hoag, Senior Director, Provider Compensation at New York-based Rochester Regional Health.[5]

Automation is key. Healthcare organizations need to "automate as much as possible," argues Texas Health Resources. They point out that, in their case, they are growing rapidly as an organization but do not anticipate growth in staffing to manage provider compensation. "We have to manage our 1,500 contracts via automation. The number of models and complexity, if handled manually, would take a large staff that we do not have."

"The routine, redundant, and remedial tasks prevalent in healthcare are overwhelming," Darrell Bodnar, CIO of North Country HealthCare (Flagstaff, Ariz.) tells Becker's Hospital Review. "Whether we are trying to get paid or meet a compliance directive, the volume of repetitive tasks that must be completed every day is incredible. Automation of repetitive tasks is a pain point that we can immediately have an impact on."[10]

In other words, automation reduces the labor burden and, in some cases, may be the only solution that supports compensating a growing population of providers. In turn, automation allows existing personnel to be more effective with their time and focus on more value-added activities, especially the activities that only humans can do.

2 Embrace consolidation and standardization in provider compensation planning and administration.

> "Compensation can no longer function on an exception basis."
>
> – Texas Health Resources

Complex and exception-driven provider compensation imposes labor burden and creates untenable blind spots, compliance vulnerabilities, and errors. As Texas Health puts it: "Compensation can no longer function on an exception basis."

The way to move away from "exception basis" compensation management is to standardize. Hoag and Jason Welch of Rochester Regional Health agree, advising healthcare organizations to "increase the push towards standardization of processes and governance to drive flexibility and responsiveness."

This would also drive improved visibility. Stu Schaff, Founder and Principal of Intentionate Healthcare Advisors, argues that revenue-impacting differences and potential inequities can creep into provider compensation plans when they grow inconsistent and variable.[5] For example, he says one physician in a group might be:

- Working meaningfully more or less than her colleagues but without a corresponding increase or decrease in variable pay,
- Receiving payments from another area of the organization without her primary supervisor's knowledge, or
- Subject to different contract terms than her colleagues (potentially without initial equitable compensation baselines—a prevalent scenario in an industry with "wide pay disparities for physicians by gender, race, and ethnicity"[11]).

"All of these examples are potential blind spots for management that could impact group dynamics in a negative way without much warning," says Schaff. Those inequities risk future legal action and can lead to multi-million-dollar settlements.[12]

If standardization mitigates those risks, consolidation is the way to standardize. By pulling provider compensation management into a single source, healthcare organizations can not only identify such blind spots, but they can also automatically enforce policy standards to prevent such issues from arising in the first place. Consolidating all provider compensation-related data is also the only way to extract the high-value analytics needed, for example, to improve VBC outcomes.

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“With constant change with provider compensation and reimbursement, the need to have high performing technology and resources is a must. Invest in IT resources now as this will pay off in future.”

– INTEGRIS Health

3 Implement provider compensation-specific technology.

Building a more sophisticated provider compensation function—one that automates, consolidates, and standardizes—rests on the adoption of sophisticated and targeted technology. It’s incumbent to invest in technology (and the sooner the better). “Technology should be the top priority,” says Oklahoma-based INTEGRIS Health, the state’s largest not-for-profit health care system. The right technology tool is also the best—and in some cases, only—way to power the solutions described below:

Automation:

“The automation capabilities of compensation software have been a game changer for many compensation professionals,” says Lisa Donaldson, the Director of Talent & Rewards at advisory group WTW (formerly Willis Towers Watson). “Rather than spending time setting up formulas in Excel, compensation managers can focus on analyzing what the data is saying and understanding the business impact of these insights.”[13]

Standardization:

“Automating compensation and investing in the best available solutions can help standardize compensation models across organizations,” says Pattabi. “It is crucial to have a centralized data repository that acts as a single source of truth for all compensation-related needs. This will aid in consolidating data, streamlining compensation processes, and identifying discrepancies.”

Data Analysis:

“A system with statistical documentation and readily available data helps organizations to take informed timely decisions and help address hiring/staffing issue[s],” says Conway Regional. That last point—hiring and staffing issues—can be surprisingly impactful. If a technology platform can reduce turnover rates, for example, it can generate significant (as much as 10x or more) ROI.[14]

However, investing in technology without strategy will almost always lead, as Schaff says, "to wasted time, effort, money, and broken trust." Investing successfully in provider compensation-specific technology requires organizations to do the internal work, Schaff explains, ultimately accomplishing:

- Clearly documented compensation formulas, policies, procedures, etc.
- Compensation equity terms among similar providers
- Meaningful, achievable, straightforward incentives
- A single source of truth for all data used in any compensation formulas
- Change in organizational culture and engagement to support provider and staff retention

"As we continue to grow and evolve in our compensation methodologies, the ability to model and determine new financial impact to changes in compensation plans is going to be paramount."

– VillageMD

Conclusion

Faced with challenges like provider shortages and rapidly changing compensation and reimbursement scenarios, many medical groups and healthcare organizations are scrambling to find new ways to navigate a new world of provider compensation. These challenges underscore the urgent need for healthcare organizations to adapt and evolve their compensation strategies to ensure sustainability, fairness, and alignment with the overarching goals of improving healthcare delivery and outcomes.

The good news is that there are solutions that can mitigate the impacts of these obstacles, and these challenges are matched by opportunities to make the provider compensation function more effective, more strategic, and more profitable. Armed with the power of automation and standardization—and the technology platforms that can power such solutions—healthcare organizations can successfully adapt to the evolving demands of an ever-moving healthcare marketplace, ultimately contributing to the development of a more financially sustainable, equitable, and efficient healthcare operation.

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Healthcare Workforce Technology

Hallmark offers a fully integrated SaaS platform for healthcare workforce management. The platform streamlines sourcing and deployment of contingent clinical labor and automates the provider lifecycle from contracting to compensation, all with exceptional effectiveness, transparency, and cost savings. Partnered with our advanced strategies and deep expertise, Hallmark's leading-edge technology solutions empower healthcare organizations to thrive. **To learn more, visit: www.hallmarkhcs.com.**

About the Contributors

Aarika Cofer

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At Hallmark (HHCS), Aarika leverages 10+ years of experience in healthcare operations and provider performance analytics to drive provider compensation strategic initiatives and domain expertise to inform technology adoption and innovation. She assists clients with identifying and addressing the gaps in their provider compensation infrastructure and directs them to the usability functions of the Hallmark Provider Compensation solution. She is also a change agent who advocates for reducing the compensation disparities for women and minority physicians and advanced practice providers.

James Hoag

Senior Director, Provider Compensation

Rochester Regional Health

James is a transformational healthcare leader specializing in provider compensation design and enterprise strategy with 15+ years of industry experience. He oversees a comprehensive, tactical vision for the provider compensation platform of a $3B regional health system. There, he leads a team of high-performing analysts to drive innovative compensation models that promote emerging provider market best practices in alignment with the health system's mission, vision, and goals. He is also an active contributor to provider compensation reform serving as an Advisory Council Member, Vice Conference Committee Chair, and Taskforce Member of the American Association of Provider Compensation Professionals (AAPCP).

Pavithra Pattabi

VP, Implementation

Hallmark

Pavi is an accomplished healthcare leader with an extensive background of over 15 years in Healthcare Information Technology. Throughout her career, Pavi has successfully spearheaded implementation efforts for medium to large-sized organizations throughout the United States. By closely analyzing and comprehending client needs, Pavi develops strategies that are tailored to the unique requirements of each organization. Additionally, she provides guidance throughout the scope of implementation, upgrades, and optimization initiatives. These solutions are evaluated based on their potential to increase profitability, provide a competitive advantage, generate cost savings, and enable the implementation team to scale positively with company growth.

Stuart J. Schaff
FHFMA, Founder and Principal
Intentionate Healthcare Advisors

Stuart is an expert in physician compensation and physician engagement. For over 15 years, he has worked closely with the leadership of more than 100 healthcare organizations across the United States, like Dignity Health and Trinity Health, to develop truly impactful physician compensation strategies and plans. As a trusted advisor, Stu empowers medical group leaders to break the cycle of constantly having to react to dissatisfied physicians. His proactive approach is thoughtfully tailored to each group he serves, leading to improved recruitment, retention, and engagement.

Bob Wade
Partner
Nelson Mullins Riley & Scarborough

Bob has more than 25 years of experience in the healthcare industry and counsels clients on fraud and abuse issues, fair market value, commercial reasonableness and developing, monitoring, and documenting effective healthcare compliance programs. He is currently a partner at Nelson Mullins Riley & Scarborough, an Am Law 100 firm with more than 1,000 attorneys, policy advisors, and professionals across the United States. He serves clients nationally as a compliance professional and assists in negotiating and implementing corporate integrity agreements and in documenting and defending financial arrangements being of fair market value and commercially reasonable between healthcare providers. Bob has represented healthcare providers, including hospitals, large health systems, and referring physicians in such matters and has also represented healthcare clients under investigation by the U.S. Department of Justice and the Office of Inspector General.

Organizational Contributors

Conway Regional Health System

Established in 1921, Conway Regional Health System provides complete health care services to the growing communities of north Central Arkansas. As a not-for-profit health system, it is our duty and honor to identify and address the health needs of those living within the communities we serve. From improving healthcare access in a post-COVID world to empowering patients with chronic disease, we are committed to meeting the needs of our community with high-quality, compassionate care.

INTEGRIS HEALTH

As the state's largest not-for-profit and Oklahoma-owned health care system, with hospitals, specialty clinics, family care practices and centers of excellence, INTEGRIS Health is here for you. But medicine isn't always about caring for the sick. It's about doing everything in our power to keep our friends and neighbors and every Oklahoman healthy.

JPS Health Network
Fort Worth, Texas

JPS Health Network is a public health system that provides care for over one million patients annually. It offers a range of services, from emergency care to blood donation, at 25+ clinics and one hospital. Today, JPS Health Network continues to serve the needs of the families in Tarrant County, working to improve health status and access to healthcare.

Texas Health Resources®

Texas Health Resources is a faith-based, nonprofit health system that cares for more patients in North Texas than any other provider. We serve North Texas through Texas Health Physicians Group, hospitals, outpatient facilities, Neighborhood Care & Wellness Centers, home health and preventive and fitness services.

VillageMD®

VillageMD provides high-quality, accessible health care services for individuals and communities across the United States, with primary, multispecialty, and urgent care providers serving patients in traditional clinic settings, in patients' homes and online appointments. Through Village Medical, Village Medical at Home, Summit Health, CityMD, Starling Physicians and other practices, VillageMD serves millions of patients throughout their lives, wherever and whenever they need care. Its dedicated workforce of more than 20,000 operates from more than 800 practice locations in 26 markets.

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