Understanding Group Compensation Model Design for Hospital-Employed Physician Practices

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With the challenges in healthcare following the COVID-19 pandemic and as health systems feel the effects of reduced staffing and expanding demand, physicians must collaborate to address patient needs. Collaboration among physicians helps ensure patients receive high-quality care throughout the care continuum and minimizes the burden on a single physician. Though many employed physicians still practice independent from one another, certain employment models exist, such as the Group compensation model, that can incentivize physicians to work as a team.

Group compensation models provide hospitals the option of incentivizing a group of physicians to work together, while still rewarding individual effort and achievement. The model incentivizes collaborative care, provider engagement, and sustainable practices and rewards quality patient care.

For the purposes of this article, "Group" means more than one physician working together in a hospital-employed practice, potentially across a primary specialty with multiple subspecialties. For example, a cardiology Group may be a cardiology practice with non-invasive, invasive/interventional, and electrophysiology physicians working in the same practice.[1] A second example is a women's medicine Group, consisting of obstetrics/gynecology, gynecology only, maternal-fetal medicine, and fertility physicians working together. When designing a Group compensation model, hospitals should consult with experienced healthcare legal counsel to ensure compensation meets the regulatory requirements of the Stark Law, the Anti-Kickback Statute, and the Internal Revenue Service.

In 2020, 48,400 physicians left independent practices for employment by hospitals, health systems, or corporate entities, and by January 2021, 49% of physicians reported being employed by hospitals or health systems.[2] When leaving an independent practice, physicians can lose the feeling of responsibility for the overall financial success of the practice; however, linking compensation within an employed Group to its financial/operational achievements may bring back a sense of collaborative engagement. With the substantial number of physicians employed by hospitals and to encourage physician collaboration, we believe it is important to understand the benefits of a Group-focused compensation model.

Benefits of Group Models

Efficient Patient Care

Groups can provide benefits for physicians and patients, alike. They have been found to improve various aspects of patient care including access to care, comprehensiveness of care provided, wait times, time spent with patients, efficiency, patient safety, and use of resources within the Group.[3]

Improved Work-Life Balance

Physicians also reap the benefits of being a part of a Group. Physician burnout has increased since the onset of the COVID-19 pandemic, with the percentage of physicians reporting being very or somewhat happy with their jobs dropping from 75% to 48%.[4] Groups, however, have been found to improve work-life balance and job satisfaction of physicians. Being a member of a Group may lead to less professional isolation, improved knowledge sharing, and an improvement in professional development.[5]

Shared Common Goals

Because of the structure of an employed Group, compensation can be designed to further foster collaboration by incentivizing physicians to cooperate to achieve common goals. We typically see Group compensation models in specialty practices that rely heavily on physician collaboration, such as radiology, cardiology, oncology, emergency medicine, and obstetrics and gynecology. Multiple physicians can see a single patient over a short period of time in these specialties. Physicians compensated on an individual basis may feel they don't have control over their resulting earnings because of practice patterns, patient populations, resource constraints, and patients with multi-faceted care. Group compensation design ensures that each provider works toward the same goals and that the success of one provider contributes to the successes of the Group. Taken a step further, if the hospital employer sets goals accordingly within the Group, the successes of the physicians should lead to meeting organizational metrics and mission.

Flexible Compensation Design

Within Group models, some physicians may contribute more than others. Using Group compensation model design, hospitals can incentivize teamwork, but hospitals should still recognize physicians for their individual contributions. Group compensation provides flexibility in compensation design for hospitals. Many health systems are considering putting more focus on value-based care and less emphasis on individual provider metrics such as work relative value units (wRVUs). Within Group compensation model design, hospitals can link physician compensation to a physician's practice patterns and can use Group metrics to place more emphasis on overall patient or cost measures that cannot be easily achieved by a single provider. Physicians should be involved in the determination of metrics, and in return, they should have a sense of control over their earnings and be encouraged to focus on patient care.

Group Compensation Model Design

In Group, also called pooled, compensation model design, physicians are eligible to receive bonus compensation based on individual and Group performance. Group compensation refers to an aggregate sum of money in a single fund that is available for physician compensation. This fund is available for distribution among the physicians based upon certain predetermined metrics agreed upon by the employer and employees. These aggregate metrics must be met by the Group to trigger distribution of the funds.

Fill the Bucket, Empty the Bucket

"Filling the bucket" refers to the gathering of funds eligible for Group compensation. The build-up of dollars by the hospital can vary by practice but is based on predetermined metrics in areas such as clinical quality, engagement, citizenship, and productivity. For example, a hospital could allocate a certain number of dollars per wRVU or a percentage of base compensation to be available for Group compensation.

Filling the Bucket (Example)

1. Each physician receives annual base compensation based on market data and their contractually required work effort.
2. An additional percentage for clinical quality and engagement compensation is allocated to a bonus pool by the hospital.
3. The sum of these dollars represents the amount eligible for Group compensation.

The next step is distribution of funds to the physicians within the practice, or "emptying the bucket." Methods of distribution can vary and include but are not limited to wRVUs personally performed, clinical full-time equivalent status, clinic hours/days worked, or subspecialty roles and responsibilities. Distribution does not have to be equal among the physicians, but it should be based on a predetermined and agreed-upon formula that recognizes individual physician work effort and incentivizes physician behavior to work as a team and align with the organization's goals. Regardless of the method chosen, compensation should be designed to ensure the formula will result in fair market value total compensation for each physician.

Emptying the Bucket (Example)

1. Bonus distribution is triggered by achieving predetermined Group quality or productivity metrics set in advance. For instance, the hospital might measure the percentage of a primary care Group's patient panel seen for preventive visits in a year and pay bonuses to the Group if that percentage reaches a certain level (e.g., 80% or higher). Alternatively, hospitals could focus on the wRVUs of a group as a reflection of patient access to care.
2. Bonuses are paid based on individual performance metrics, such as the percentage of total practice patients in each physician's panel.
3. The funds are not guaranteed as compensation, but hospitals and Groups can work together to develop a distribution design that works best for all.

As reimbursement continues to shift from fee-for-service to value-based with increasing pressure from public and private payers to participate in alternative payment models[6], hospitals should consider value-based compensation methodologies to align the risk and reward of the funds received for patient care. Linking compensation to the achievement of aggregate quality measures can incent providers to meet metrics at the payer and hospital levels that take a care team to achieve. Achievement of these collective metrics will allow the hospital (and physicians) to share in additional reimbursement.

As hospitals explore different compensation models for employed physicians, they should understand the benefits of physicians working together in a Group and the design of Group model compensation. The allocation and distribution of funds can vary by practice, specialty, and organization; however, the concept of filling and emptying the bucket remains the same. As the supply of physicians decreases and demand for physicians increases, hospitals are tasked with meeting patient demand without burning out their most important resource. Shifts to value-based reimbursement and care necessitate the consideration of value-based compensation design that can meet the goals of hospitals, physicians, and patients. Successful Group compensation design can help achieve these goals as they incentivize collaborative care, provider engagement, and sustainable practices.

[1] PYA is not referring to a Group Practice as defined by the Physician Self-Referral Law.

[2] Becker's ASC Review, "70% of physicians are now employed by hospitals or corporations," <https://www.beckersasc.com/asc-transactions-and-valuation-issues/70-of-physicians-are-now-employed-by-hospitals-or-corporations.html>;, accessed on June 21, 2023.

[3] PMC PubMed Central, "Group practice impacts on patients, physicians and healthcare systems: a scoping review," <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7798803/#:~:text=Group%20practices%20improve%20patient%20quality%20of%20care&text=Group%20practices%20were%20found%20to,according%20to%20patient%2Dreported%20outcomes.>;, accessed on June 14, 2023.

[4] AAFP, "Family Physician Burnout, Well-Being, and Profession Satisfaction," <https://www.aafp.org/about/policies/all/family-physician-burnout.html>;, accessed on June 14, 2023.

[5] PMC PubMed Central, "Group practice impacts on patients, physicians and healthcare systems: a scoping review," <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7798803/#:~:text=Group%20practices%20improve%20patient%20quality%20of%20care&text=Group%20practices%20were%20found%20to,according%20to%20patient%2Dreported%20outcomes.>;, accessed on June 14, 2023.

[6] RevCycle Intelligence, "What is Value-Based Care, What It Means for Providers?", <https://revcycleintelligence.com/features/what-is-value-based-care-what-it-means-for-providers>;, accessed on June 14, 2023.