

Today's surgeon compensation models fall short: Aligning incentives to create more equitable and value-based compensation models



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HIGHLIGHTS

- Summarizes the evolution of physician reimbursement models and the transition to value-based care
- Describes the continuum of surgeon compensation ranging from fixed pay to exclusively volume-based plans
- Outlines how nonclinical activities create value for current and future patients
- Describes a better compensation model, one that incorporates value creation as a guiding principle
- Identifies the challenges for implementing compensation models that reward value creation

Modern medicine is undergoing a transformation, which involves innovative surgical approaches, increased medical treatment options, and increased team-based care. Today's surgical practices also must understand and incorporate new concepts and tools, such as new digital health technology, health data captured by numerous digital sources, and how to manage and leverage vast amounts of health care knowledge. All of these changes add to the complexity of care delivery. This transformation challenges the health care business model, including the physician compensation model, to evolve, and it prompts questions about the alignment—or lack thereof—between care delivery and the incentive system. How do the moving parts of a modern surgical team combine to produce the value required to achieve optimal patient outcomes? Does the more than 30-year-old relative value units (RVUs) structure, tied to the volume of surgical services, encompass all the contributions surgeons bring to the health care system? Are the existing compensation systems providing proper incentives and motivation to deliver value-based care?

This article examines the state of surgeon compensation and explores concepts that would reform compensation for modern surgical practice. Physician compensation historically has been directly linked to the revenue generated from services rendered to patients and is expressed in the volume of RVUs, specifically physician work RVUs. Increasingly, compensation models are accounting for the additional work that surgeons perform that is not captured by RVUs.

This change in compensation models for surgeons is important because surgeons typically wear many hats within their practices and institutions. In addition to leading successful surgical teams, surgeons may take on added responsibilities, such as coordination of the full cycle of patients' care, oversight for quality and improvement programs, clinically enriched data analytics, supply chain optimization, marketing, branding, and more. In academic settings, productive research, teaching, advocacy, participation in national conferences, and collaboration with other institutions also are part of the surgeon's responsibilities. Within traditional compensation models, much of this work goes uncompensated.

Evolution of the payment system

The revenue system for payment predates the Medicare physician fee schedule (MPFS). It began when individual surgeons practiced in small groups with limited specialization and set fees according to usual, customary, and reasonable (UCR) rates. In 1989, significant reforms changed Medicare's methodology for paying physicians by replacing UCR rates with the resource-based relative value scale (RBRVS). Under this reformed system, the MPFS was adopted, and the concept of RVUs was introduced. RVUs were created to reflect the resources—time, effort, and expenses—required for a medical procedure or service.

Since then, care delivery models have become increasingly complex. Today, more information about

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patients, their conditions, potential treatments, and so on is available than ever before, and care for a single patient often is delivered across teams of clinicians throughout the life cycle of their condition. The RVU-based compensation model has failed to keep pace with the evolving resources required to provide modern care effectively.

Transition to value-based care

As payors, health care systems, and institutions shift toward value-based health care, compensation models must transition as well. A system that refrains from compensating surgeons for their other essential duties implies that these activities are unimportant and fails to acknowledge the full value surgeons bring to their patients, hospitals, and health care systems.

Thus, to align and motivate surgeons with proper compensation, it is vital to examine the current state of physician compensation and assess its adequacy to reflect physicians' workflows in the modern surgical care environment. If we seek to focus on delivering care that meets patients' personalized goals, incorporating advanced applied sciences of surgical care at the bedside, and optimizing quality improvement programs, the incentives in a compensation plan must reflect the significance of these elements. These themes converge with the concept of value, which should be foundational in the design of modern physician compensation models.

Principles of modern compensation theory and applications in health care

Surgeon compensation plans vary along a continuum, spanning from fixed pay arrangements to plans that heavily—and, at the extreme, exclusively—are anchored to volume-based metrics, such as RVUs, revenue generated, and so on. Most compensation plans combine some characteristics of both extremes; however, a large share of these plans is closer to the volume-based end of the spectrum. In many cases, these compensation plans are designed to reflect the

structure of the reimbursements the provider facility receives from its payors; that is to say, surgeons may be compensated based on the volume of activities that are reimbursed by the payors. For example, if payors adopt a fee-for-service approach, then surgeons effectively are paid using a fee-for-service model, too. A fundamental issue underlying this practice is that surgeon compensation risks becoming aligned with the strategic priorities of the payor, which may not reflect the goals of the health care facility and optimal patient care.

Unquestionably, there are good reasons to link the incentive system to the payment system. For example, it ensures financial sustainability, at least in the short term, as the activities that are incentivized internally are the same ones that generate revenue for the institution. In addition, revenue-generating activities are typically recorded in the billing system, making them easier to measure for compensation purposes. However, this compensation design creates some real challenges.

A fundamental principle of compensation design is that “you get what you pay for.” This is more than a catchphrase, as this principle is backed by a large body of academic literature exploring the roles that compensation arrangements play beyond simply rewarding physicians for their effort. For example, compensation plans highlight and clarify strategic institutional priorities. When individuals perform complex jobs and face multiple competing demands on their limited time and attention, they tend to focus more on those activities that are clearly stated in their compensation plan, easy to measure in objective terms, and rewarded with higher payoffs relative to other activities. Other activities that may contribute significantly to creating value in a health care system may then receive less attention and time and, in extreme cases, may be ignored entirely. Therefore, explicit links between revenue-generating activities and compensation plans lead surgeons to prioritize volume at the expense of other value-creating activities. This approach has the following undesirable consequences:

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- Prioritizing volume may serve as a distraction from outcomes, safety, and quality
- Efforts to maximize volume promote innovations in optimizing throughput, which then contributes to professional burnout
- An excessive focus on revenue often translates into prioritizing short-term performance, thus reducing investments in activities that may benefit future patients
- Volume-based contracts focus on individual performance and do not explicitly reward teamwork toward optimal patient goals

These issues affect the delivery of quality care to current patients. They also can lead to critical motivational consequences for the surgeons, which may affect their well-being and, in turn, the value of health care delivery for future patients.

By implying that nonrevenue-generating activities are less valuable, volume-based compensation plans expose surgeons to a moral disconnect ensuing from the conflict they face between performing activities that they believe are adding value for their patients and taking time away from revenue-generating work. In extreme cases, peer pressure can exacerbate this tension and introduce feelings that belittle the contributions of those surgeons who act in discordance with their incentive system and perform those value-generating activities despite not being financially rewarded for them. This dilemma is a consequence of the communication role of compensation, whereby incentives highlight and clarify institutional priorities. Therefore, pursuing activities that take time and resources away from these stated priorities may be regarded as playing against the institution's best interests.

To avoid the downsides of volume-based compensation, some institutions opt for flat-pay physician contracts. These arrangements reduce the concerns related to focusing surgeons' attention excessively on revenue-generating activities but exhibit other

important shortcomings. For example, flat-pay contracts are ineffective in communicating institutional priorities. In many cases, institutions accompany flat-pay arrangements with a stack of performance metrics for which members of the institutions are held accountable. By not linking pay with performance while, at the same time, monitoring several metrics, these pay arrangements lead individuals to focus on activities that are more clearly and visibly measured, easier for them to carry out based on their abilities, and more enjoyable. Again, this system does not ensure alignment between individual behaviors, institutional strategic goals, and value for patients.

Furthermore, flat-pay contracts fail to reward effort. When incentives to work hard are weak, they may lead to complacency and low motivation, which are reflected in suboptimal institutional performance. In addition, weak performance incentives spur insufficient creative tensions, hampering innovative and collaborative problem-solving and improvement.

So, how do we improve surgeon compensation design? A fundamental philosophical change lies in decoupling the internal incentive system from the payor to ensure that compensation design corresponds to the institution's strategic priorities, not those of the payor. Revenues provide the resources that fund the operations of the health care provider, including surgeon compensation. The allocation of such funds to surgeon compensation needs to be informed by the institution's value creation. Therefore, health care providers need to start by mapping their activities into their value-creation flow.

Understanding value and value creation

Michael Porter and Elizabeth Teisberg, in their 2006 book *Redefining Health Care*,* state that a value-based health care system defines value in terms of patient-centered results and, when implemented, unites the

*Porter ME, Teisberg EO. *Redefining Health Care: Creating Value-Based Competition on Results*. Boston, MA: Harvard Business Review Press; 2016.

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interests of patients and providers. When paid for value, providers who improve patient outcomes and lower costs will succeed when patients succeed. As health care institutions transition to a value-based system, the compensation system also must reflect and reward how surgeons contribute to the hospital's ability to create value for the patients it serves.

Within hospitals and medical centers, value is created in the care delivered and measured by the results achieved for both current and future patients. Clinical teams create value not only when they see patients or provide billable services but through the full set of activities, decisions, conversations, supervision, and so on that contribute to their patients' improved health. Value is created over the full longitudinal cycle of care that patients receive and is created not only through the actions of individual surgeons but also through their leadership and collaboration with surgical and medical teams. These actions include delivering evidence-based treatment plans to other supporting providers and ensuring that patients are informed and engaged in their care. This approach includes bringing in appropriate resources for patients based on their physical, mental, and social needs.

Think of value creation in terms of impact on current and future patients. For current patients, value is most easily recognized as direct patient care with face-to-face interactions (for example, surgical procedures, inpatient care, office visits, telehealth visits, and patient phone calls). Surgeons also generate value through nonclinical activities—multidisciplinary team meetings, consults, medication ordering, and note writing—that contribute to their patients' outcomes, even without direct interface.

Surgeons contribute tremendous value through the indirect management of their patients' overall care cycle, which often is unrecognized. Patients have better outcomes when coordination of care between surgical and consulting services is optimized. Time spent communicating, managing, and overseeing other members of a clinical team, or coordinating perioperative care, all contribute to patient outcomes and costs of

care. The surgeons' time, attention, involvement, and leadership in these care processes generate value for the patient (see Table 1, page 38, and sidebar, page 39).

Beyond the value that surgeons create for their current patients is the value that can and must be built today for future patients. In this category of value creation, physicians hold several roles in three primary areas of performance management: staff development, strategic leadership, and institutional leadership. Clinician involvement in the institution's future investment and improvement is critical for a health care center's ability to deliver higher levels of value.

Value creation is not a one-size-fits-all solution. It depends on the mission, context, and strategy of the individual institution. Academic medical centers often have separate mission statements for patient care, education, and research. All three of these missions create value and deserve recognition. Rural medical centers create value differently than urban or suburban centers; they provide value to a community by being accessible even when not fully used. Based on location, providers must focus their resources on addressing the most common conditions in their geography.

Even within the clinical care mission, different providers choose to focus on different patients for various reasons. Some providers are best positioned to treat more complex patients and novel diseases, whereas others, such as health care centers that support rural communities, provide the highest value for their populations by meeting the urgent care needs in the area and by having generalized medical and surgical staffing available to treat or stabilize a range of conditions. Many providers specialize in families of conditions or special populations, for example, cancer centers, orthopaedic centers, or groups of geriatricians. The goal—to optimize value for the patient focus group—is the same, but the institutional approach varies based on institutional means and their mission statement.

Each institution needs to think about its mission and strategy to deliver value to patients and inform the notion of value creation within their institutions. Each institution must map its value creation flow. The way

TABLE 1. VALUE CREATION BUCKETS WITHIN CLINICAL CARE

Value creation for current patients	
Direct patient care	<ul style="list-style-type: none"> •Face-to-face care (that is, delivered in the OR, clinic visit, telemedicine visit, shared decision-making) •Nonfacing patient care (notes, multidisciplinary meetings)
Indirect patient care	<ul style="list-style-type: none"> •Management of other members of the care team (that is, communication with physical therapy, management of discharge process, and so on) •Accountability over entire cycle of care, patient outcome measurement •Management of the institution
Value creation for future patients	
Performance measurement and improvement	<ul style="list-style-type: none"> •Safety initiatives •Outcome and quality measurement •Process improvement •Integrated practice model design
Development of people and teams	<ul style="list-style-type: none"> •Human resources investments •Training and career development
Management, leadership, and strategic planning	<ul style="list-style-type: none"> •Leadership decision-making •Committee involvement •Innovation activities •Community development •Antiracism work

it generates value for patients is largely idiosyncratic to its institutional characteristics, such as size, location, patient demographics, affiliation with medical schools, and so on. These activities should be rewarded in proportion to their contribution to value creation.

A starting point for health care institutions is to think about the unique value proposition for their patients and analyze the sources of value creation that are most critical to delivering on their mission. Filling in the specific details of each facility’s value creation map is the work not only of clinical and management leadership, but, most importantly, it is a collaborative data-driven process involving people at all levels of the institution.

Some activities that create value are easily measurable and quantifiable, whereas others, such as teamwork and mentoring, are more difficult to capture using objective measurement and may often be unplanned. Subjective evaluations will be necessary

to assess and reward these activities. Most information systems that providers have adopted are structured to support billing and the collection of information about patients to aid in the design and implementation of care plans. Providers will need to develop repositories to record performance evaluations and link them to pay for performance.

Imagining a better compensation model

Surgeons and surgeon leaders can envision a better compensation model—one that incorporates value creation as its guiding principle. Surgeon compensation based on the volume of activities performed tends to align surgeons with payor goals and strategies rather than those of the institution. A compensation model that empowers institutions to distribute payor funds internally, based on their value creation flows, rewards behaviors that contribute to a facility’s goals. Successful

OTHER FORMS OF VALUE CREATION

- Value creation in education: Teaching medical students and residents—the next generation of physicians who are likely to leave your institution—versus training attendings and other team members who anticipate staying at the institutions
- Value creation in research: Basic science, clinical research, and delivery science research that leads to better treatments, pathways, and delivery of care

models recognize the importance of fiscal autonomy within the institution.

A better system bases compensation on both productivity and other value-adding activities with the appropriate balance tailored to the practice, hospital, and region. Examples of value generators not directly linked to revenue include research, teaching and training, administrative tasks and appointments, participation in quality improvement initiatives, clinical care coordination, and perioperative care. An ideal compensation model accounts for these essential contributions.

When hospitals fail to compensate for value-adding activities, it implies that they are tangential to the institution's overall success. Often, bonuses are used at the chair's discretion to reward productivity, quality, and outcome metrics. Still, a lack of transparency in how funds are used leads to questions about how surgeons' contributions are valued. A better compensation model includes explicit compensation for the activities that add value yet are not captured by RVUs. Transparency in the way bonuses are distributed fosters trust and facilitates departmental and surgeon goal alignment.

Anticipated challenges

A shift from the traditional “eat what you kill” compensation mantra—compensation tied to the number of patients seen, operations performed, and RVUs earned—will come with anticipated challenges. This article addresses an entirely new way of thinking about compensation, which is important because incremental changes instead of comprehensive revisions are less likely to catalyze significant shifts in existing compensation models.

There is foreseeable difficulty with aligning ideas of value for the institution, the surgeon, and patient care. However, under a value-based model, patient care is the aligning force. The challenge is to orient the stakeholders to patient value by changing the underlying

incentive systems. Furthermore, assigning value to clinical and nonclinical activities is challenging. There can be significant variation in the value that the same activity provides, based on variables such as location, supply and demand, health system priorities, practice setting, patient population, and specialty. Successful compensation models that reward value creation will be developed within each institution, based on its strategic plan and idiosyncratic constraints.

Furthermore, this shift will require novel ways of thinking and financial investment in new systems. Finite resources and budget constraints mean that when innovative ways of distributing the revenue funds are adopted, there are limitations on what can be accomplished. It is essential to secure buy-in from physicians and health care systems regarding increased or more liberal distribution of funds. Leaders must be willing to invest in the messy work of changing compensation structures and should allow for providers' short-term stability during transition from one compensation model to another.

Moreover, compensation systems cannot be changed in a vacuum without attention to other changes and a commitment to patient-centered, value-based care delivery and payment systems. A final challenge will be to confront the seeded belief of many surgeons, that those tasks that generate the most revenue are the most “valuable,” and that by extension, value-generating surgical functions that contribute to education, improved patient care, and the hospital system are equally important and deserve financial reward under an evolved compensation model. ♦