WHITE PAPER

Trends in Compensation Rates for Higher Producers

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Trends in Compensation Rates for Higher Producers

Insights from Fred Horton, MHA, and Jeff James

By Matthew Wells, PhD, and Danielle DuBord

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Are you paying too much per work relative value unit (wRVU)? Whether you pay through a compensation model that rewards providers directly for their personally performed wRVU production or not, your organization focuses on production in some form or fashion. If not directly based upon wRVUs, your model may depend on professional collections, panel size, access/availability, other measures, and/or a combination of several of these (related) metrics. These metrics, including wRVUs, point to the magnitude of providers' engagement with their patients, which is the lifeblood of your organization.

Independent research shows that volume is still a primary catalyst in compensation programs. A recent study found that volume represented a substantial portion of compensation for primary care and specialist compensation, averaging between 68% and 74%, respectively.[1] This study also found that performance-based incentives, while also included in compensation arrangements, represented less than 10% of compensation. Whether directly or indirectly, wRVUs are an important metric to understand within your operational and/or compensation structure.

Examining wRVUs

Thus, the question: "Are you paying too much for wRVUs?" This is a loaded question, and one that requires careful examination and thorough diligence, which is what we hope to present through this white paper. Before we unpack and examine this issue through the lens of market survey data, it is helpful to view wRVU and compensation rates per wRVU through an operational lens.

Jeff James, CEO of Wilmington Health, provides this perspective when viewing and interpreting the market survey tables at face value: "Taken as single data points, the compensation measures and (separately) the wRVU measures are accurate. However, it concerns me that, when combined to report compensation per wRVU rates, the data lend themselves to misinterpretation. There is no direct correlation between the individual providers who work at a certain level and their compensation. My belief is that higher producers are actually paid at a relatively lower rate per wRVU. That is not necessarily discernible when viewing the compensation per wRVU rates in the survey."

Although there are times when wRVUs may not be as much of a focus (such as for new-hires in a ramp-up period), wRVUs and provider production are important to think through if you are an operator/executive within an organization. Also, wRVUs continue to be a fundamental metric that government and commercial payers rely on in their reimbursement structure, which leads many organizations to include some variation of wRVU production in their compensation model, directly and/or indirectly.

[1] Reid, Tom, Ross, Duffy, et al. 2022. Physician Compensation Arrangements and Financial Performance Incentives in the US Health Systems. *JAMA Health Forum*, 2022, 3: e214634

Fred Horton, MHA, president of AMGA Consulting, agrees with the perspective offered by James and goes further (as it relates to data reported through the market surveys): "If someone does not understand the comprehensive nature of the market data, one may misapply the market data in a way that is inconsistent with actual practices in the market. It is my fundamental belief that most organizations understand that compensation per wRVU tends to be higher for those on guarantees. However, I also believe that most misunderstand the dynamics of compensation per wRVU for higher producers—namely, that compensation per wRVU rates decline as production increases."

Common Misunderstandings

How could these data be misunderstood? Let's consider market data from the *AMGA 2023 Medical Group Compensation and Productivity Survey Report* (AMGA's Survey).[2] For the sake of simplicity, we consider the specialty of **Cardiology – General (Noninvasive)** (Cardiology) throughout. The data in the table below show national benchmarks from AMGA's survey for compensation, wRVUs, and compensation per wRVU.

Cardiology – General (Noninvasive)	**# of Providers**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**90th Percentile**
National Compensation					
AMGA 2023 Medical Group Compensation Survey	2,586	$430,933	$552,056	$661,722	$829,757
National Clinical Productivity - Work RVU					
AMGA 2023 Medical Group Compensation Survey	2,004	6,081	8,368	10,639	13,671
National Clinical Productivity Ratios - Compensation per Work RVU					
AMGA 2023 Medical Group Compensation Survey	2,004	$53.40	$63.66	$81.68	$109.36

At first glance, you might be inclined to look at these data vertically and align. If you are paid at the 50th percentile ($552,056) and produce at the 50th percentile (8,368 wRVUs), then your compensation per wRVU should be at the 50th percentile ($63.66). You might then extend this line of thought to the 75th percentile (for example), and say that a 75th percentile producer should earn 75th percentile compensation per wRVU of $81.68. But this is where that line of thinking falls apart. Let's suppose we calculated compensation in this manner:

	25th Percentile	**50th Percentile**	**65th Percentile**	**75th Percentile**	**90th Percentile**
National - Work RVU	6,081	8,368	9,553	10,639	13,671
National - Compensation per Work RVU	$53.40	$63.66	$72.37	$81.68	$109.36
Calculated Compensation (wRVU x Comp per wRVU)	**$324,718**	**$532,735**	**$691,346**	**$869,029**	**$1,495,080**
National - Compensation	$430,933	$552,056	$622,502	$661,722	$829,757
Percent Difference: Calculated vs. National	**75.4%**	**96.5%**	**111.1%**	**131.3%**	**180.2%**

[2] Though we rely on data from the 2023 survey, we argue that insights shown throughout this article will follow when viewed through other survey years.

The calculated compensation, at the 75th percentile, would be $869,029 (based on 75th percentile production of 10,639 wRVUs × 75th percentile compensation per wRVU of $81.68). But this calculated compensation figure is 31.3% higher than the actual 75th percentile compensation of $661,722—which is what we should be expecting (actual 75th) when aligning compensation and wRVUs.

Horton explains these misunderstandings: "When considering benchmarks in a silo, compensation and wRVUs may indicate that comp per wRVU should be higher. Often, we mistake terminology and application of approach on one metric (such as compensation) to another metric (such as wRVUs). How you apply thoughts for total clinical compensation (TCC) and wRVUs does not apply to the compensation per wRVU metric."

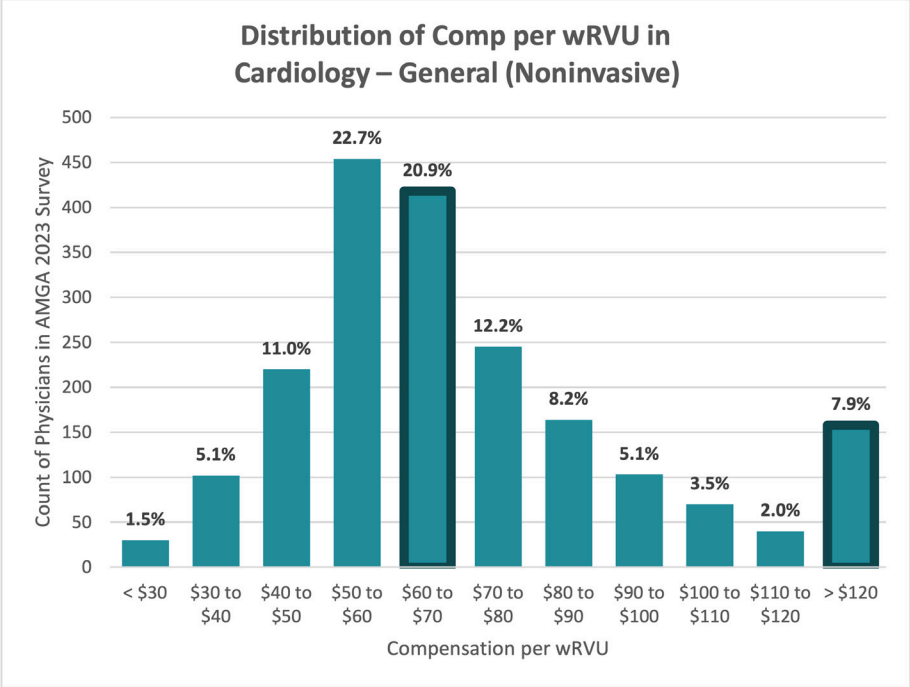
Compensation per wRVU reported within AMGA's survey (and others like it in the marketplace) are based on matched pairs of compensation and wRVU for an individual provider. Said another way, we calculate compensation per wRVU for each individual provider in the database (2,004 individual computations for Cardiology), and then calculate the percentile positions on these calculated values. The median for Cardiology of $63.66 means that about 1,002 physicians in the database have compensation per wRVU below $63.66, and the other half are above. We do not divide percentiles, meaning that we do not divide compensation and wRVUs in the aggregate at the same percentile to get compensation per wRVU. Again, the methodology is to utilize matching data points to determine compensation per wRVU, which is then arrayed by percentiles.

Compensation per WRVUs in Cardiology

What do the compensation per wRVU ratios in the survey look like for physicians within the specialty of Cardiology? Below is a depiction of the distribution of physicians' earned compensation per wRVU for the 2,004 physicians in AMGA's database.

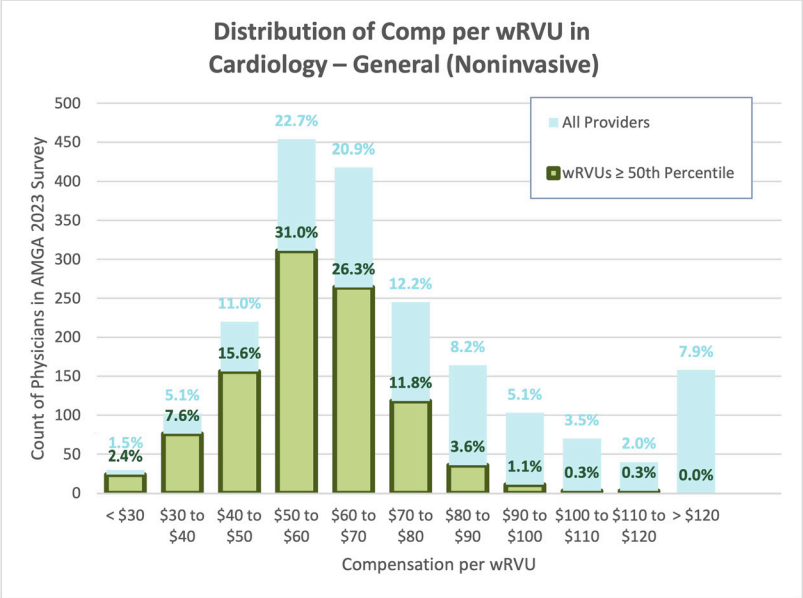
Per the graph, approximately 20.9% of physicians (418 out of 2,004) within AMGA's survey database for Cardiology receive compensation per wRVU between $60 and $70 per wRVU. We also observe that there is a decent "spread" to the compensation per wRVU rates, which reflects organizational differences and compensation approaches across the country.

Like an abstract piece of artwork, though, we notice something when we stare at this distribution long enough. Most notably, we see that this is not a "normal" distribution, meaning that the distribution of compensation per wRVU is not symmetrical. In layman's terms, that bar to the right (for compensation per wRVU >$120) is much higher than bars just to the left.



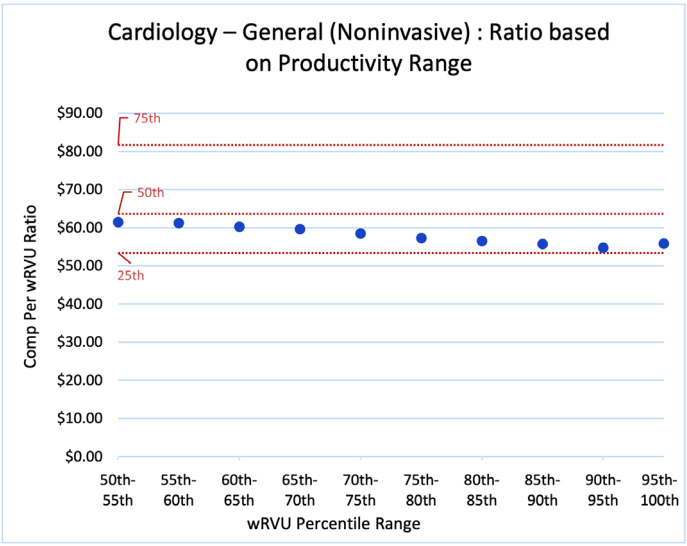
Who are the physicians in this range? To answer this question, we recalibrated the distribution by compensation per wRVU while restricting for levels of productivity. The graph below shows the new distribution when we include only those physicians whose wRVU productivity is **at or greater than the median of the market**.

Perhaps unsurprisingly, much of the skew in the original distribution disappears when we focus on physicians with higher levels of wRVU productivity. We also see a tighter distribution, which can be seen by looking at the two tallest bars, which increase from a combined 43.6% in the original distribution to 57.3% for the new distribution (which is based on physicians with wRVUs greater than the 50th percentile). Indeed, the data appear more symmetrical (normal).



However, we can go further. If we were to also recalculate the compensation per wRVU metrics for the subset of physicians whose wRVUs are at or above the 50th percentile, we would find that the "new median" would be $57.89, reflecting **an approximate 9% decrease** from the national median of $63.66.

Before we dive into whether this addresses the question of "are you paying too much," let's continue to pull the thread. For the same specialty of Cardiology, using a similar approach as above, we calculated compensation per wRVU for each decile of wRVU production. The graph to the left shows how the calculated median varies by each decile of wRVU production for wRVUs above the 50th percentile.



Interestingly, we see that the "median" compensation per wRVU within each decile of production (above the 50th) decreases as productivity increases. Visually, we see that the compensation per wRVU appears closer to the national 25th percentile for higher levels of wRVU production.

How much do these "decile medians" differ from national data? The table below quantifies the differences when compared to the national median compensation per wRVU of $63.66 for Cardiology.

	50-55th	55-60th	60-65th	65-70th	70-75th	75-80th	80-85th	85-90th	90-95th	95-100th
Calculated Median within Decile	$61.47	$61.24	$60.28	$59.66	$58.50	$57.28	$56.55	$55.72	$54.73	$55.83
% Difference from National Median	**3.4%**	**3.8%**	**5.3%**	**6.3%**	**8.1%**	**10.0%**	**11.2%**	**12.5%**	**14.0%**	**12.3%**

What This Means for Compensation Practices

These are the numbers, but what does this mean for a medical group? We posed this question to James relative to compensation and wRVU practices at Wilmington.

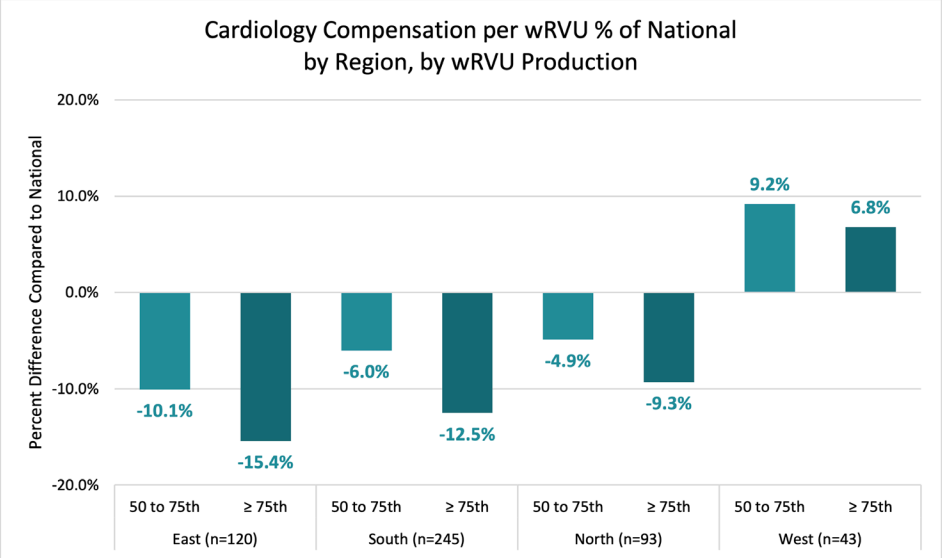
According to James, "In all the examples, cardiologists that produce higher wRVUs (above the 50th percentile) do make more (which is what you should expect). However, the compensation per wRVU rate is actually an inverse relationship, meaning that the higher a cardiologist produces, the lower the compensation per wRVU. This is a meaningful distinction for compensation plans that use a static conversion factor without regard to the number of wRVUs produced. To say it another way, a cardiologist's compensation is more closely aligned with wRVU production when using a compensation rate at or about the 27th percentile of the market."

"There is no one-size-fits-all approach," he continued. "Compensation plans are designed based on several needs of an organization. However, the correlations described above should be considered in the design. Additionally, these correlations should be socialized so that they are understood by your compensation committee and providers."

The impact on your organization in choosing the "right" market data (or benchmark within the data) can be substantial. Using an oversimplified example, if your compensation costs within Cardiology are $10.0M annually based on the national median compensation per wRVU rate of $63.66, compensation costs using a reduced rate of $57.28 (taken from table above) would be approximately $9.0M (10% lower).

Are we saying that you should compensate your physicians based on lower per-wRVU rates (or lower compensation relative to wRVU production)? Well, it depends, which is a convenient and a great political answer! But in all seriousness, there are several factors that one might consider when establishing compensation plans within an organization. Pertinent in the market survey data, for example, factors such as geography and size of organization frequently are presented as variables that impact compensation per wRVU. Ultimately, your compensation formula should be tied to your overall compensation philosophy and guiding principles. The level of compensation per wRVU should be discussed at your compensation committee meetings, and they should make the recommendation related to compensation per wRVU after having an opportunity to thoroughly dissect the market data and the manner in which compensation per wRVU shifts as production increases past the median level of productivity.

When considering geography, for example, we see (using the AMGA survey database for Cardiology) that compensation per wRVU rates in the East can vary by as much as 15% below national compensation per wRVU. Of course, this is based on analyses that serve to limit the reporting power of the data even more, which is evidenced by the smaller and smaller sample size as we refine and cut these data.



Recommendations and Next Steps

So how should we interpret these data and the insights presented?

Horton offered perspective on application and considerations when using these (and other) market survey data: "Most (if not all) will be looking forward: What do we do prospectively for our compensation arrangements? We have to be careful to align goals within the compensation plan with overall organizational strategic initiatives. There are other factors, such as recruitment and retention goals, that play a role in establishing a competitive compensation plan. I would challenge organizations to make certain that they strive for financially achievable alignment between compensation and production, regardless of organization type—whether independent, system affiliated, or other."

We are all challenged with navigating the complexities of the market. But certain guiding principles help when interpreting and applying benchmarks to your organization.

"I still remember a project from graduate school in which the professor challenged us to bring in (statistical) findings that were inaccurate based on what was displayed," said Horton. "The lesson learned? Never let the numbers (statistics) be your sole driver, and never simply look at one number. For effective strategic decisions, consider all context, both quantitative and qualitative."

Are these the only considerations? Certainly not. We are amid a provider shortage, which is projecting to fall short of demand by about 8% over the next decade.[3] These shortages, coupled with operational and clinical challenges, continue to amplify issues with provider recruitment and retention. Each component of pay should be evaluated carefully to ensure overall pay remains financially and operationally feasible, while at the same time leading to success in recruitment and retention. Understanding what is, and just as importantly what is not, in reported benchmarks within market surveys will be key to making informed decisions within your organization.

At the end of it all, "Are you paying too much (or conversely too little) per wRVU?" We will leave that for you to decide—though we are happy to partner with you to help you navigate these challenging times. It is crucial to be well informed on pay practices in these (and other) market data, as this will put you in an advantageous position in the marketplace, allowing your organization to continue to provide quality clinical care while simultaneously being financially sustainable, all while having the ability to recruit and retain highly qualified providers.

[3] Reflects shortages within physician workforce; as published by HRSA through the National Center for Health Workforce Analysis. "Physician Workforce: Projections 2020-2035.", November 2022

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