Building Aligned Provider Compensation
AMGA Virtual Executive Roundtable Summary
October 16, 2025

The AMGA Hospital & Health System Advisory Committee convened physician executives and compensation leaders to discuss **compensation alignment strategies** amid rising costs and market pressures. Led by AMGA Consulting's Kelsi O'Brien and Fred Horton, the discussion explored compensation model design challenges, productivity management, APP integration, and call pay inflation across health systems.

Key Themes & Takeaways

1. Base Compensation and Productivity Alignment

- **Overpaying at the low end**: Systems commonly set base guarantees too high or maintain them too long, creating situations where most providers produce well below their guarantee with little incentive to increase productivity.
- **Below-median starting points**: Effective models start RVU rates below the 50th percentile (around 47.5th) up to median production, then increase rates above median to reward high performers, contrary to traditional approaches.
- **Limited attrition risk**: Redesigns typically result in only 2-3% provider departures when handled with proper physician engagement and committee involvement, contradicting common fears of mass exodus.

2. Managing High Producers and Access

- **The high producer dilemma**: Systems struggle when top performers exceed the 90th percentile—they become expensive per RVU and may resist recruiting additional providers to protect their high earnings.
- **Declining rates at high tiers**: Survey data show compensation per work RVU naturally declines at very high production levels; some systems intentionally reduce rates above the 75th percentile to encourage capacity building rather than individual overproduction.
- **Guardrails for extreme performers**: Organizations are implementing policies requiring high producers (above 85th percentile) to work with advanced practice providers (APPs), who must also maintain minimum productivity levels, preventing work RVU hoarding.
- **Access vs. compensation tension**: Rewarding unlimited production can create long wait times and discourage recruiting, requiring 2+ years for providers to adjust behavior when incentives change.

3. APP Compensation Evolution

- **Productivity-based models emerging**: Approximately 10% of organizations now tie APP compensation to productivity (10%+ of total pay), resulting in 10-15% higher RVU production compared to salary-only models.
- **Primary care leads adoption**: Productivity-based APP compensation is most common in primary care, where impaneled APPs want recognition comparable to physician counterparts.
- **Specialty variation**: Hospital-based and procedural APPs typically remain salary-based due to shift work and assisting roles, while ambulatory APPs increasingly seek productivity rewards.

- **Benchmark challenges**: Organizations using physician benchmarks prorated to 85% (e.g., if physician target is 6,000 RVUs, APP target is 5,100), rather than separate APP surveys with lower sample sizes.
- **Incentive pools as middle ground**: Some systems use tiered bonus pools (e.g., $5,000 increments at specific RVU thresholds) to reward productivity without full per-RVU payment risk.

4. Call Pay Inflation

- **Universal upward pressure**: Nearly all participants reported call pay increases over the past five years, with half to majority of systems affected.
- **Shifting baseline expectations**: Provider expectations evolved from 1-in-3 call being standard to demanding 1-in-4 or 1-in-5 schedules built into base compensation, with extra pay for anything beyond that.
- **Competitive market dynamics**: Competitors using call pay premiums as recruitment tools, forcing systems to match or lose candidates.
- **Unstructured negotiation problems**: Systems lacking formal call pay governance experienced "metastasizing" costs as individual physicians negotiated directly with hospital executives, creating wide variation and inequities.
- **Weekend premium demands**: Systems are seeing increasing requests for additional compensation specifically for weekend call coverage, separate from weekday call expectations.
- **Need for systematic oversight**: Recommended approach includes physician committees establishing rules, guidelines, and standards before call pay proliferates uncontrollably.

Implementation Strategies Highlighted

- **Physician compensation committees essential**: Physician-led committees consistently produce less expensive, more sustainable plans than administrative negotiations; physicians often set stricter standards than administrators worried about retention.
- **Phased transitions reduce risk**: Allowing providers to opt into new productivity-based formulas (with 50%+ adoption in year one versus projected 30%) while grandfathering others prevents wholesale resistance.
- **Carve-outs compound over time**: Organizations permitting 10% exceptions in year one see 20%, then 30%, then 40% exceptions in subsequent years—discipline in limiting carve-outs critical.
- **Supply-demand analysis**: Dividing total specialty work RVUs by target percentile (60th or median) reveals actual provider need versus current staffing, exposing cost inefficiencies.
- **Pooled models for team-based specialties**: Interventional cardiology and imaging departments are successfully using group incentive pools distributed by FTE or equal work effort rather than individual work RVU attribution.
- **Rolling mid-year true-ups**: For APP incentive pools, conducting mid-year assessments allows providers to earn partial bonuses and adjust behavior rather than waiting for annual payouts.
- **Compensation simplicity should be a goal:** Over-engineered incentives fail, so organizational capability limits must be taken into account, and simplicity wins.

Overall Conclusion

The discussion revealed that **health systems face a widening compensation cost gap** compared to independent practice models, driven by high base guarantees, productivity shortfalls, APP compensation evolution, and call pay inflation. The cumulative effect—base overpayment plus APP model changes plus call pay increases—creates a cost structure burden significantly higher than what existed in independent models.

However, **strategic compensation design with proper governance can reduce costs without mass attrition**. Success requires:

- Physician-led compensation committees with real authority
- Below-median work RVU rates for low producers, above-median rates for high performers
- Systematic call pay policies established before individual negotiations proliferate
- Simple, transparent incentive structures matched to organizational data capabilities
- Thoughtful APP compensation evolution balancing productivity rewards with role differentiation
- Limited carve-outs and consistent enforcement of compensation standards
- Recognition that proper culture building and engagement mitigate attrition risk to 2-3%

Participants emphasized that addressing these challenges requires **multi-year cultural transformation** rather than overnight policy changes, but organizations that strategically optimize compensation through proper structure, physician engagement, and disciplined governance will achieve substantial gains in cost efficiency without sacrificing workforce stability.