Hospitals and health systems that employ physicians are continually faced with the challenge of determining the most appropriate methodology for paying them. These organizations have long sought ways to offer their employed physicians incentives for improved productivity, most often by rewarding the physicians for generating work relative value units (wRVUs). But does this methodology make economic sense in the changing healthcare environment, and is it sustainable?

Despite the current widespread use of published compensation-per-wRVU benchmarks within physician compensation structures, this approach is becoming increasingly divorced from the underlying economics of physician practices. Because of the way the data for these benchmarks are gathered and the manner in which the benchmarks typically are applied in compensation formulas, there is a built-in “benchmark creep” that defies the financial realities of individual medical practices. As a result, physician compensation levels tend to increase more rapidly than the professional fees that they generate. This situation obviously is unsustainable, and health systems across the country are wisely pursuing alternatives.

By applying benchmarks more thoughtfully, rather than simply as a default approach, health systems can design compensation arrangements that promote the financial viability of the physician enterprise.

The Appeal of Median Compensation per wRVU
The starting point for designing physician compensation typically is median compensation per wRVU, and for good reason. It is widely accepted that physicians require performance incentives to maintain the viability of a physician enterprise. Creating such incentives also necessitates being able to measure and reward work effort, and wRVUs are generally considered to be a reasonable yardstick for this purpose. These measures have the
advantage of being payer-neutral, meaning they produce the same results for a physician regardless of the payer mix of the physician’s patients. This aspect of wRVUs appeals to people’s sense of fairness and is consistent with not-for-profit health systems’ community-service mandate.

Physicians also appreciate the fact that wRVUs protect them not only from variation in payer mix but also from the business risk associated with collections performance in general. Benchmarking data are readily available from several widely known and respected surveys for the vast majority of physician specialties. Finally, the use of median compensation per wRVU is appealing because it represents the middle of the market and, unlike average compensation per wRVU, is somewhat insulated from the effects of outliers.a

For all of these reasons, median compensation per wRVU provides an attractive combination of objectivity, transparency, and fairness, making it extremely valuable for finding a middle ground on which both parties can agree and begin to direct efforts toward delivering high-quality care. It is no wonder, then, that median compensation per wRVU has been adopted widely.

The Divergence from Economic Reality
Physician compensation and productivity surveys from past years mostly reported data on physicians in private or group practices. Their compensation-per-wRVU ratios were a function of clinical practice economics, having nothing to do with compensation methodologies. For example, if a physician’s practice revenues less expenses allowed for annual compensation of $200,000, and that physician produced 5,000 wRVUs, then that physician’s compensation per wRVU would have been $40.

Over time, however, the private practice model has largely been supplanted by employment or employment-like arrangements in which practices are owned by health systems. Under this ownership model, continuing to pay physicians on a revenues-less-expenses basis usually doesn’t make sense for a variety of reasons (physician preference, increased overhead, and the transition of ancillaries to the hospital, to name a few). Instead, health systems usually seek alternative approaches, such as productivity-based methodologies that use wRVU benchmarks.

The use of wRVUs in this way produces several unintended consequences. First, it creates a selection bias, because the organizations that refer to these surveys in their physician compensation arrangements are often the same ones that participate in them. Their data then get recycled into the next year’s survey, and they and other participating organizations then benchmark against it. The result is that survey participants tend to coalesce artificially toward similar compensation-per-wRVU levels for reasons that have nothing to do with the practices’ economics.

As an example that illustrates this divergence from economic reality, one health system recently sought to answer the question, “What is the economic profile of practices in which physicians are paid the median compensation per wRVU?” Addressing this question required analysis of practice data for physicians who reported compensation per wRVU within +/- 1 percent of the median, taking into account collections performance, compensation plan type, and FTE status. The analysis disclosed significant variability in performance, with the only reliable correlation existing between wRVU productivity and physician compensation expense. What was most surprising, however, was that among these physicians, compensation-per-collections ratios ranged from 34 to 74 percent, suggesting that—at least among this sample group—physician compensation is unrelated to the finances of these practices.

More important, the way compensation per wRVU is reported and utilized creates distortions. Surveys typically ask respondents to report all forms of compensation derived from the practice

---
a. Of course, health systems must decide which survey and geographic region to use as the basis for the median compensation per wRVU. Although this decision is not trivial, it does not detract from the reasons for using median compensation per wRVU.
(e.g., clinical, administrative, call pay—usually only outside income generated on the physician’s personal time, such as honoraria, consulting services, and medical/legal testimony, is excluded from the reported compensation). Therefore, compensation-per-wRVU benchmarks should be interpreted as an all-inclusive statistic.

In practice, however, they are rarely applied that way. Instead, the compensation-per-wRVU benchmark becomes the foundation of the productivity model, and additional compensation such as administrative income and call pay is layered upon that. Periodic updates usually are built into the agreement to allow for adjustment to changing market conditions. Occasionally, an inflation factor also is included to reflect the fact that the survey data are always at least one year old. When these factors are coupled with the feedback loop described earlier, compensation-per-wRVU ratios will automatically inflate, irrespective of what is happening with revenues and practice expenses.

There are other distortions as well. When health systems acquire existing physician practices, the physicians almost never are asked to accept a reduction in compensation but are typically offered a material increase in pay. Sometimes this increase occurs because the physicians are faring poorly in private practice and the health system has a preexisting compensation plan that is more generous. In other cases, a new compensation structure must be crafted at a negotiated rate as condition for completing the transaction. These pay increases may be funded—directly or indirectly—through the health system’s superior contracting rates, increased collections due to provider-based billing, or—in the case of oncology—the 340B Drug Pricing Program.

All of these factors combine to create an unsustainable upward trend in physician compensation. The exhibit below shows the trend in median compensation and collections per wRVU, as reported in the MGMA Physician Compensation and Production Report based on data from 2008 through 2013. As these data show, physician compensation per wRVU was trending upward...
FEATURE STORY

TRENDS IN MEDIAN PHYSICIAN COMPENSATION PER COLLECTIONS RATIO

Source: Data from MGMA Physician Compensation and Production Report.

Consistently at an annual rate of about 3 percent from 2009 through 2014. By comparison, collections per wRVU saw a smaller growth rate (about 1 percent annually) over the same time.

Consequently, of the amount collected per wRVU, a larger and larger portion is being paid out to the physicians, with a shrinking amount left over to pay for other practice expenses. In MGMA’s 2009 survey, this latter amount was found to be $27.26 ($74.26 in collections per wRVU minus $47.00 in compensation per wRVU), but by 2014, it had shrunk to $23.93. At first blush, this decrease may not appear significant, but when applied to every wRVU produced in an organization, it can easily amount to tens of thousands of dollars per physician. The exhibit above depicts this phenomenon slightly differently, showing that physician compensation is increasing as a percentage of professional fee collections.

Concurrent with this trend is the well-publicized phenomenon of health systems routinely losing $100,000 or more annually per employed physician. We certainly do not mean to suggest that physician compensation is the sole—or even primary—cause of this phenomenon. Many other factors come into play, not the least of which are accounting practices that may provide a distorted view of the physician enterprise. Nonetheless, the actual losses are real and are usually significant.

A Challenge to Assumptions

Although health systems have absorbed major financial losses on their physician practices for years, they have generally been reluctant to set the rate per wRVU at anything less than the median. There is an unspoken yet widely accepted assumption that median compensation per wRVU is the bare minimum that can be offered to physicians (again, before layering in other compensation elements). It often is argued—pervasively—that paying at the median will only get you a median-quality physician. Therefore, the notion of actually paying less than the median has tended to be regarded as a nonstarter with physicians, even though, by definition, fully half of all survey respondents must receive less.

In many instances, economic pressures are forcing health systems to take the unpleasant step of not only suggesting but also insisting upon below-median rates per wRVU. Increasingly, the question of affordability is taking center stage in compensation discussions between health systems and their physicians. In essence, health
system executives are telling physicians: “We have reviewed all the data, we understand the benchmarks, and we are familiar with the local market. But we can no longer afford to pay you what you are accustomed to receiving.” Naturally, this is not an easy conversation to have, but many health systems are experiencing a level of financial pain that leaves them with no choice.

**How Best to Apply Benchmarks**

These observations are not meant to suggest that industry benchmarks for compensation per wRVU are irrelevant. The benchmarks matter, but organizations should apply them thoughtfully rather than simply defaulting to the median. The following principles and practices could be adopted—either singly or in combination—to good effect.

- **Acknowledge that a lower percentile may be appropriate.** If the median is simply out of reach financially, acknowledge that a lower target—say, the 40th percentile—may be more sustainable. In many markets, payment rates are below those experienced elsewhere—a circumstance that often can be supported with objective evidence. However, if local benchmarks for physician compensation do not exist, then the available benchmarks may not accurately reflect the local market. Tying compensation to a lower percentile can correct for this fact and still allow for a rational allocation of compensation funds across multiple specialties.

- **Use the median as the all-in benchmark.** As previously discussed, median compensation per wRVU begins as an all-in benchmark. Accordingly, healthcare organizations should follow this same logic when designing compensation plans. An organization that is targeting median benchmarks as a guide for setting compensation levels should ensure that it includes all compensation elements, including administrative pay, call pay, and quality incentives. In such an instance, clinical productivity could be paid at a lower rate, such as 90 percent of the median. The remaining 10 percent then would be provided through other means, such as administrative compensation and quality incentives, whereby physicians can earn back an amount up to the full median rate per wRVU.

This approach is illustrated in the exhibit above, where a compensation pool is funded based on 90 percent of the median compensation per wRVU, with defined administrative roles representing another 5 percent of anticipated compensation. Physicians can earn up to the median by achieving an expected level of performance against quality goals. Stretch goals allow for an additional 10 percent, but attainment of this additional amount would be predicated on a high level of performance that would not be easily achieved. A separate methodology is then established to distribute available funds to individual physicians.

- **Use peer benchmarks when available.** Benchmarks can serve as a good barometer to gauge how total
Physician compensation compares with industry standards. However, when using benchmarks to set specific elements of compensation, it is important to isolate relevant peer groups. For example, if a health system has a group of physicians who are on a compensation plan with a majority of income derived from production, the organization should try to measure the physicians against a similarly compensated physician group.

The exhibit above compares compensation per wRVU for internal medicine physicians, stratified by the type of compensation structure.

Note that for physicians paid a straight salary, compensation per wRVU is consistently higher than among those for whom some or all compensation is at risk. Failing to account for this point in the compensation plan’s design could result in comparing physicians with an inappropriate benchmark, with significant financial consequences.

It also is important to note that this hypothetical comparison is based on clinical compensation rather than total compensation because the focus is on promoting clinical productivity. Not all surveys allow for this level of specificity in benchmarking—a point that should be kept in mind when selecting a benchmark.

**Consider alternative benchmarks.** Although wRVUs constitute a tried-and-true productivity metric, they are not the only option. An often-neglected benchmark, for example, is compensation as a percentage of collections, which is much more closely related to the actual economics of the practice in question. When physicians’ compensation is tied to professional fee collections, however, the physicians must assume the business risk associated with contracting and collections efficiency, so before pursuing this option, organizations should make sure the physicians are functioning effectively. Yet even if compensation per collections does not form the basis of the physicians’ compensation, it can be effective in assessing whether the median compensation per wRVU or some other level is appropriate.

**Need for a More Nuanced Approach**

As health-system-owned physician enterprises mature, they will find it necessary to become more realistic and sophisticated in their approach to physician compensation. In many cases, circumstances will require a shift away from the median compensation per wRVU as the default methodology in favor of more nuanced approaches that better reflect economic realities.

---

**About the authors**

*Dave Wofford, MBA,* is a senior manager, ECG Management Consultants, San Diego, and a member of HFMA’s San Diego-Imperial Chapter (dwofford@ecgmc.com).

*Darin Libby, MHA,* is a principal, ECG Management Consultants, San Diego, and a member of HFMA’s San Diego-Imperial Chapter (dlibby@ecgmc.com).

---

*Reprinted from the August 2015 issue of hfm magazine. Copyright 2015, Healthcare Financial Management Association, Three Westbrook Corporate Center, Suite 600, Westchester, IL 60154-5732. For more information, call 800-252-HFMA or visit hfma.org.*