Value-Based Care’s Impact on Physician Compensation

Pay Increases in Primary Care amid Stalling Productivity Levels across Specialties

BY WAYNE M. HARTLEY, DANIELLE DUBORD, AND AARON DOBOSENSKI

An analysis of the AMGA 2017 Medical Group Compensation and Productivity Survey finds that the proportion of quality incentives in compensation plans advancing slower than expected.
With the Medicare Access and CHIP Reauthorization Act (MACRA) driving industry changes, the march toward value-based reimbursement continues despite the debate over the future of the Affordable Care Act (ACA). The changes from a compensation perspective, however, are measured and incremental, as evidenced by the proportion of quality incentives in compensation plans advancing slower than expected. This article reviews the AMGA 2017 Medical Group Compensation and Productivity Survey’s overall findings, provides detailed analysis of select specialties and medical groups by size, queries regional variations in pay, and discusses trends for advanced practice providers.

**Overall Findings**

One of the key questions physician organizations continue to debate is how much compensation should be put at risk for the achievement of quality metrics. This year’s survey shows value-based compensation as a percentage of total cash compensation continues to rise but at a slower rate than some expected.

While most participant groups report having a value-based pay component in their compensation plans (61%), there was only a slight increase in the average percentage of compensation actually paid based on the achievement of these measures, from 6.7% to 7.5%, since last year. Our analysis indicates some market-leading groups have 15% to 20% of compensation or more linked to value-based metrics, but these are the exception. In our experience, there are often particular external or organizational circumstances influencing the decision to lead the market in at-risk compensation, such as unique commercial payer contracts with substantial downside risk or employer-driven pay-for-performance initiatives.

While the proportion of value-based compensation increases, overall provider compensation also continues to increase. This year, median compensation increased in 77% of specialties, with a weighted average increase in median provider compensation of 2.9%, similar to increases over the last few years. Primary care led the physician specialties with a weighted average increase of 3.3%. Other healthcare providers, including nurse practitioners and physician assistants, saw the largest increases in median compensation for providers overall, with a weighted average increase of 3.6%, which is likely reflective of the expanding use and scope of practice of advanced practitioners.

Based on survey results, work relative value units (wRVUs) remain the predominant productivity measure in contemporary compensation plans, with net collections coming in a distant second. Even with health
care shifting from volume to value, the prevalence of wRVUs as a factor in compensation rose from 79% of respondents last year to 83% this year. The number of survey participants providing wRVU values in addition to compensation also rose to roughly 81%.

Overall median wRVUs increased over last year with a weighted average increase of 1.5%, a small rebound after remaining relatively flat over the course of the last few years. While quality and efficiency are receiving more attention, productivity remains an important consideration for medical groups.

Net collections followed wRVU productivity with an overall median weighted average increase of 1.1% over last year. Accordingly, median compensation-to-productivity ratios, also values commonly used in modern compensation plans, increased slightly over last year, with a weighted average increase of 2.2%.

Changes in compensation and productivity varied by specialty type (see Figure 1). In medical specialties, compensation increased by 2.7%, wRVUs increased by 0.9%, and compensation per wRVU increased 2.7%. In surgical specialties, compensation increased 2.0%, wRVUs increased 2.3%, and compensation per wRVU increased 1.0%. In radiology, anesthesiology, and pathology (RAP) specialties, compensation increased by 2.3%, wRVUs increased by 1.4%, and compensation per wRVU increased 2.2%. Additional insights are outlined for selected specialties in the next section.

A comparison of the changes in median data from 2009 to 2017 shows a significant gap between compensation and productivity (see Figure 2). Median wRVUs increased 3.8% between 2009 and 2017, which is an average increase of 0.5% per year. Production, however, has grown at a much slower rate. Median wRVUs increased by 2.5% in compensation per wRVU and a weighted average increase of 2.2% in compensation per net professional collections. Although productivity increased over last year, it is still significantly outpaced by the increases we continue to see in compensation.
same time frame (an average of 1.8% per year), which means that compensation today claims a much larger part of the net collected dollar than in 2009.

With MACRA moderating inflationary increases in the Physician Fee Schedule, how much longer can this level of compensation growth relative to collections be sustained? We suspect that groups will soon conclude that a standard annual 3.0% increase for all providers is cost-prohibitive. Given value-based reimbursement programs’ heavy emphasis on metrics and initiatives that are driven by primary care, material amounts of incentives earned in these alternative payment programs will likely be shifted toward primary care versus specialists. Primary care pay already seems to be increasing at a slightly faster pace than it is for specialists (see below).

**Specialty Highlights**

Overall changes in compensation, wRVUs, and net collections for common specialties appear in Table 1. Next, we examine some selected specialties in more detail.

### Cardiology

Given the large increases in median compensation in general cardiology over the last few years, as shown in Figure 3, we expected that the market would steady soon. This year, median compensation increased by 0.5%, much smaller than the 5%-7% increases we saw over the last two years. While median wRVU productivity and median compensation per wRVU increased only marginally (1.4% and 0.8%, respectively), median collections increased 4.9% this year, and compensation to net collections saw a significant decrease of 5.4%.

**Primary Care Specialties**

This year, using a weighted average of the medians for the three major primary care specialties (Family Medicine, Internal Medicine, and Pediatrics and Adolescent), median compensation increased by 3.3%, slightly outpacing physician increases overall (see Figure 4). In addition, median wRVUs increased by 1.5% and net collections increased by 1.6%. Compensation per wRVU increased 1.7%.

These results cause the authors of this article to suggest that primary care physicians might already be garnering some of the benefits of value-based reimbursement. While risk-based payment programs generally purport to apply to all providers who care...
for a program’s beneficiaries (think MACRA), success or failure in these endeavors is often significantly influenced by primary care. Many of the early pay-for-performance metrics were focused on prevention measures, such as immunization rates or screenings for certain conditions, with accountability typically with the primary care physician. In practice, many groups distribute a portion of their shared savings with the role of primary care in mind.

**Urgent Care**

Survey data over the previous few years showed expanding compensation and shrinking productivity for urgent care physicians (see Figure 5), likely due to increased competition from workplace and retail clinics. The same is true this year, although compensation seems to be leveling off. This year, compensation increased only 0.9%, while wRVU decreased by 1.2%, and net collections dipped by 4.7%. Therefore, compensation per wRVU increased over 2.9%, and compensation to net collections increased over 6.3%. Urgent care continues to be a specialty that straddles productivity- and shift-based approaches to compensation.

**Psychiatry**

For years, psychiatry has been considered a difficult-to-recruit and difficult-to-retain specialty, given the market demand for access to these physicians. Compensation climbed this year by 4.5% (see Figure 6), matching the increases over the last three years. At the same time, median wRVU for psychiatry also increased 2.3%.

**Group Size Analysis**

A common assumption among medical groups is that larger groups tend to pay more. Presumably, this
phenomenon occurs because larger groups are often in urban areas with higher costs of living, some larger groups have better leverage in negotiating reimbursement rates due to their size, and larger groups simply have more resources. We decided to test this theory by analyzing median survey data in groups with 1-300 FTE physicians (small to midsize groups) and groups with more than 300 FTE physicians.

With the important exception of primary care physicians, we found an opposite relationship between group size and pay for most specialties (see Figure 7). In our analysis of the 28 largest specialties reported in this year’s survey, we observed that median compensation at small to midsize groups was 3.7% higher than in large groups. Median wRVUs were also higher in small to midsize groups by 2.4%. Lower productivity in large groups might be the result of more provider worktime flexibility due to larger department headcounts or more significant non-clinical responsibilities like research or residency programs. Higher compensation in small to midsize groups might be due to productivity and possibly the fact that it’s often harder to recruit in rural group practice settings.

**Regional Analysis**

Generally, we advise groups to focus on national data for benchmarking based on the reliability of larger sample sizes. Nonetheless, regional data is commonly used, and we suspected a regional analysis of the survey would offer some insight. We have found some consistency in regional data. The west region tends to have the highest median compensation by specialty, followed closely by the north region which includes the upper Midwest (see Table 2). Seventy-five (75) specialties met minimum data reporting requirements in all four regions. Of those, 29 specialties in the west have the highest median compensation, 27 in the north, and 17 in the south. Only 2 specialties in the east have the highest median compensation. Additionally, the east region includes 43 of the 75 specialties with the lowest median compensation.

**TABLE 2**

<table>
<thead>
<tr>
<th>Analysis by Region</th>
<th>Highest Median Comp</th>
<th>Lowest Median Comp</th>
<th>Highest Median Work RVU</th>
<th>Lowest Median Work RVU</th>
<th>Highest Median Comp/wRVU Ratio</th>
<th>Lowest Median Comp/wRVU Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>East</td>
<td>3%</td>
<td>57%</td>
<td>22%</td>
<td>9%</td>
<td>4%</td>
<td>47%</td>
</tr>
<tr>
<td>North</td>
<td>36%</td>
<td>9%</td>
<td>8%</td>
<td>38%</td>
<td>24%</td>
<td>8%</td>
</tr>
<tr>
<td>South</td>
<td>22%</td>
<td>23%</td>
<td>61%</td>
<td>4%</td>
<td>7%</td>
<td>40%</td>
</tr>
<tr>
<td>West</td>
<td>39%</td>
<td>11%</td>
<td>9%</td>
<td>49%</td>
<td>65%</td>
<td>5%</td>
</tr>
</tbody>
</table>

* Must have reportable data in all four regions.
Although the west region most often has the highest median compensation relative to the other regions, the south leads with the most frequent highest median wRVU relative to the other regions (46 of 75 specialties). The west most frequently has the lowest median wRVU (37 of 75 specialties). With the west having the most frequent highest compensation and the most frequent lowest wRVU, it is not surprising that most specialties have the highest median compensation per wRVU in the west (49 of 75 specialties). The east, with frequently low median compensation and moderately high median wRVU ends up with the most frequent lowest median compensation per wRVU compared to the other regions (35 of 75 specialties).

Nurse Practitioners and Physician Assistants

The number of provider responses for nurse practitioners and physician assistants increased by nearly 25% again this year. In the last three years, reported nurse practitioner provider counts increased from 2,600 to more than 9,000 providers, and reported physician assistant provider counts increased from 2,100 to more than 5,500 providers.

Median compensation for nurse practitioners and physician assistants on average increased 4.6% this year, while median work RVUs increased by 1.7% for both (see Figure 8). The survey now contains a subsection specifically for nurse practitioner and physician assistants. It contains compensation and productivity by subspecialty, as well as information on advanced practice provider (APP) compensation models. We expect to see continued growth in these roles as more healthcare organizations adapt their care models, including the emphasis on APPs practicing to the full scope of their licensure.
FIGURE 8

Median Values for Nurse Practitioners and Physician Assistants

<table>
<thead>
<tr>
<th>Metric</th>
<th>2016 to 2017</th>
<th>Weighted Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Comp Change</td>
<td></td>
<td>4.6%</td>
</tr>
<tr>
<td>Median wRVU Change</td>
<td>1.7%</td>
<td></td>
</tr>
<tr>
<td>Comp per wRVU Change</td>
<td>2.9%</td>
<td></td>
</tr>
</tbody>
</table>

**Summary**

Quality- or value-based components in compensation plans are now common among AMGA survey participants. Most groups who participated in the survey in 2017 reported having some amount of physician compensation at risk for the achievement of these types of metrics. While the amount of pay directly attributable to value is still far below the amount typically tied to productivity, it is rising to a significant and influential amount.

Increased focus on value as an element of compensation, however, has not translated into lower compensation growth. Overall, compensation continues to grow at rates higher than general inflation, likely due to standard market pressures to recruit and retain, though there are some specialty-specific exceptions. Moreover, the market may soon need to correct for the fact that compensation continues to climb as a percent of net professional collections.

With MACRA and similar initiatives of private payers rolling forward, the move toward value-based reimbursement will accelerate. Groups with scalable compensation models will be able to adjust as necessary to keep compensation formulas aligned with reimbursement models.

The annual AMGA Medical Group Compensation and Productivity Survey is conducted by AMGA Consulting, which produces various compensation and financial surveys for benchmarking and offers a host of consulting services in various areas. For more information, visit amgaconsulting.com.

**About the 2017 Survey**

The AMGA 2017 Medical Group Compensation and Productivity Survey opened for participation in January 2017. AMGA Consulting received valid responses from 269 medical groups, representing over 102,000 providers. The average number of providers per participant group is approximately 380, showing a continued increase in participant group size over the last few years. Out of the 269 participants, 70% are AMGA members and represent many of the largest medical groups in the country.

The report also provides data on panel sizes, gross charges, fringe benefits and benefits expense to compensation ratios, patient visits, compensation for experienced new hires and new residents/fellows, compensation and productivity for academic facilities, and compensation and productivity for nurse practitioner and physician assistant subspecialties.

For more information about AMGA Consulting, visit amgaconsulting.com.

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