ARTICLE

COMPENSATION AND COMPLIANCE

HSG's 2023 Provider Compensation Survey: wRVU Production Incentives

Neal D. Barker, Partner I Dr. Terry McWilliams, Chief Clinical Officer

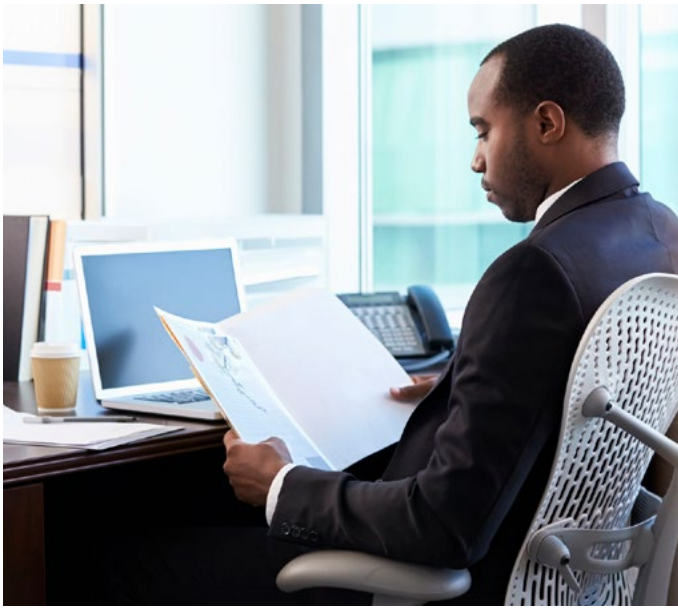
In January 2023, HSG Advisors (HSG) launched its "2023 Provider Compensation Survey." Our survey is not intended to create an expansive and robust dataset of compensation values like the industry benchmarking surveys produced by the Medical Group Management Association ("MGMA"), American Medical Group Association ("AMGA"), or Sullivan Cotter, Inc. ("SC"). While those surveys provide a wealth of intelligence and compensation-related datapoints for comparison and benchmarking, HSG's survey is designed to gather insight into factors that are driving some of the values seen in the industry benchmarks, determine environmental changes affecting provider compensation, and solicit perspectives on compensation structure.

Over the next several months, HSG will highlight various aspects of our 2023 Provider Compensation Survey results and provide different thoughts regarding the motivations and environmental factors impacting provider compensation, as well as offer our thoughts on how organizations can best respond to the ever-changing provider compensation marketplace. We start our series with a discussion of Work Relative Value Units ("wRVUs") and wRVU-based compensation models and incentive structures.

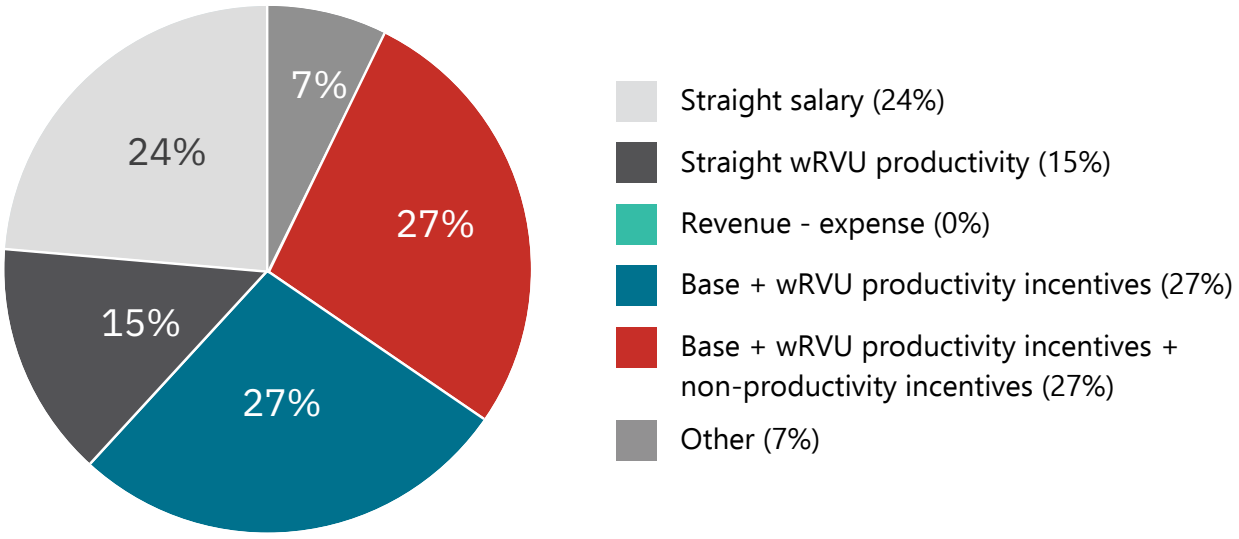
PREDOMINANCE OF wRVU-BASED COMPENSATION

While our survey is ongoing, we believe it already has enough respondents to evaluate the responses and provide feedback about the trends seen thus far. To date, we have had more than 30 organizations in (13) different states respond to the survey.

Of our survey respondents, over 70% indicated that wRVUs play a role in determining some portion of their providers' compensation. These respondents indicated that the predominant compensation model in their organization is: Straight wRVU productivity (15%), Base + wRVU productivity incentives (27%), or Base + wRVU productivity incentives + non-productivity incentives (27%). Consequently, for most of those responding to the survey, wRVU production is a significant contributing component of provider compensation.



Recognizing that provider compensation models can vary by specialty and provider type, what are the predominant types used by your organization?



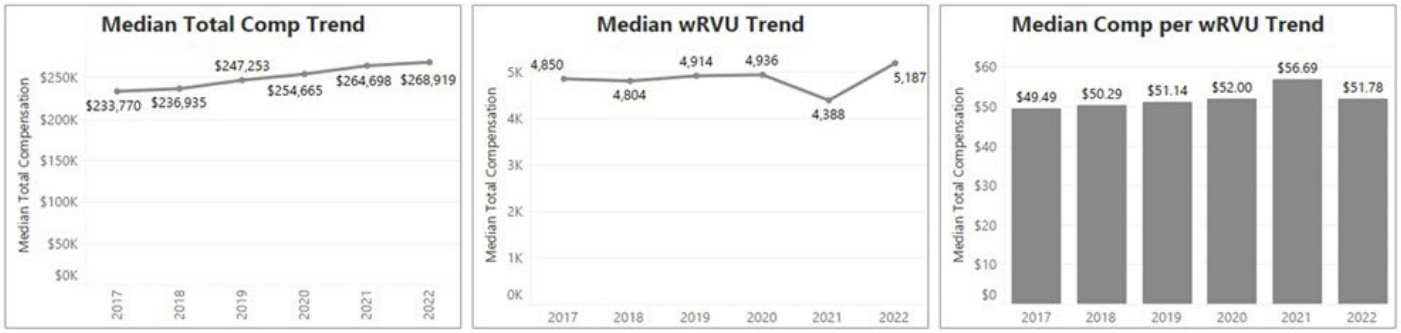
This tendency of predominance is also typical with what we see in the marketplace for physicians in primary care, medical subspecialty, and surgical specialty practices. The exceptions tend to be in hospital—or shift-based specialties such as emergency medicine, hospital medicine, critical care, anesthesia, and urgent care, where the individual physicians and advanced practice providers do not have significant influence over productivity. These specialties often have a base plus nonproductivity incentive model.

COVID IMPACT

We all know that COVID-19 had a huge impact on patient volumes and wRVU production reported for 2020. As **Table 1** demonstrates, in family medicine (as an example), compensation remained relatively unchanged—or continued its steady, modest increase, but wRVU volume declined significantly in 2020 (2021 Report). Stable, or slightly increasing, compensation coinciding with declining wRVU volumes means that reported, or calculated, compensation per wRVU ratios for the specialty increased—as was common across most specialties.

TABLE 1*

National MGMA Date[1]: Family Medicine (without OB)



3.9% increase from 2020 to 2021 Survey

Increase in 2022 not as much as trend over prior years.

11.1% decrease from 2020 to 2021 Survey

Increase in 2022, but not as much as expected due to MPFS changes. Lag in MPFS adoption and COVID?

14.8% increase from 2020 to 2021 Survey Report

2022 comp/wRVU rate much more consistent with historic values and unlike the skewed 2021 report rate.

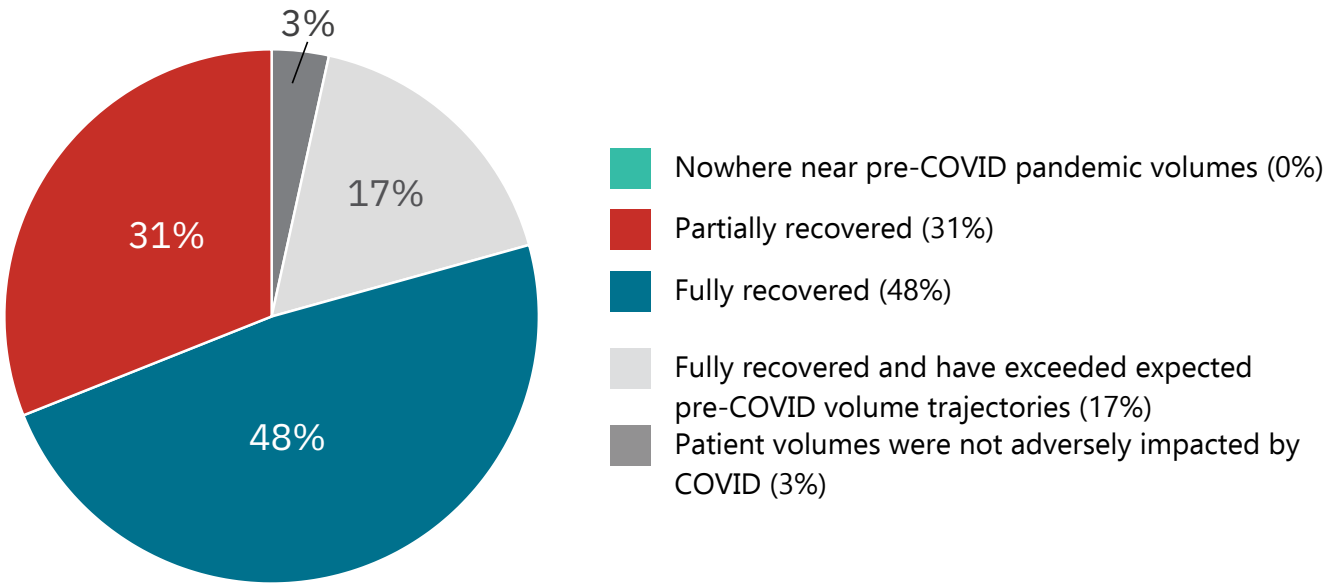
1: MGMA Provider Compensation Survey Report

* Source: 2016-2021 MGMA DataDive Provider Compensation Survey. Used with permission from MGMA. Copyright 2022. **https://www.mgma.com/data.**

> **...compensation remained relatively unchanged** ...but wRVU volume declined significantly in 2020 (2021 Report).

COVID's resulting artificial increase of compensation per wRVU will continue to impact how we evaluate the alignment of compensation and production for a period of time. While COVID is still a recurring health threat in our communities, it is not like the early waves that began in March of 2020 and continued through the early months of 2021. According to our survey respondents, 31% said that their employed network's patient volume has "partially recovered" but is still adversely impacted from the pandemic, while 48% indicated that patient volume has now "fully recovered" and a full 17% state that patient volume has "fully recovered and has exceeded expected pre-COVID volume trajectories."

Has your group/employed network fully recovered the patient volume that was lost during the COVID-19 pandemic?

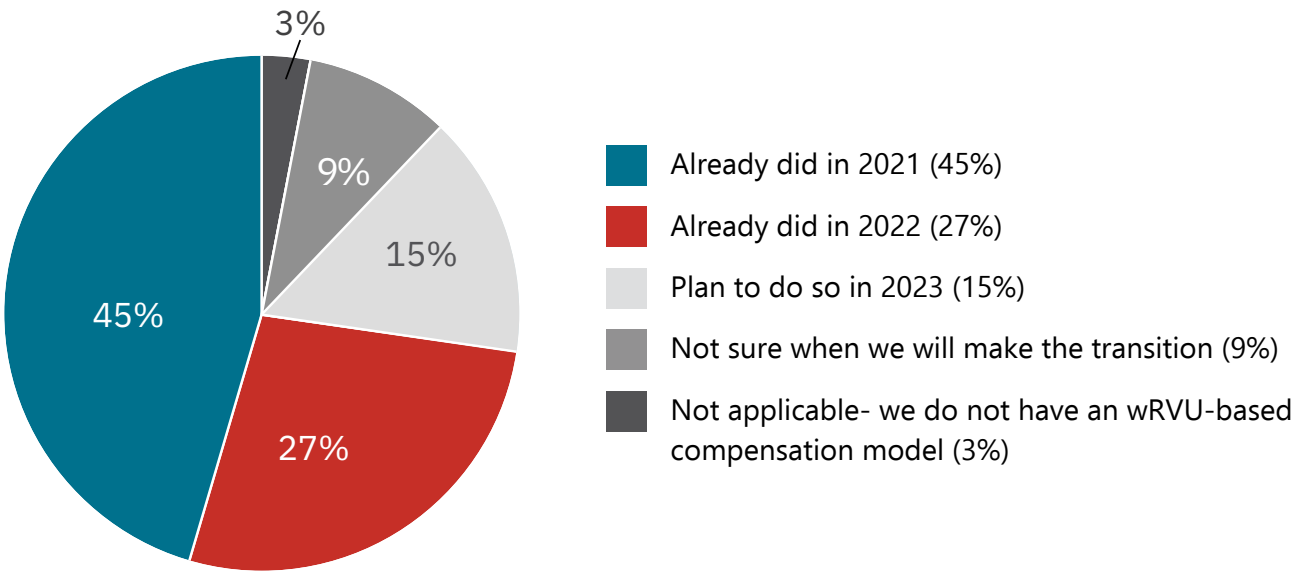


Translating this to national survey data interpretations would predict that productivity data would still be less than expected without COVID's impact since nearly one-third of responding practices are still recovering from COVID-related volume losses. Complicating this consideration, and coincident with the acute COVID volume issues, was an additional challenge—the 2021 Medicare Physician Fee Schedule ("MPFS") changes that increased wRVU values for office-based E/M codes.

ADOPTION OF 2021 MPFS wRVU VALUES

When we asked survey respondents: "Have you already, or do you plan to utilize the 2021 Medicare Physician Fee Schedule wRVU values for determining wRVU-based compensation?" the answers were somewhat surprising to us; 3/4 of respondents indicated that they have already adopted the 2021 MPFS's increased wRVU values. Over 45% said they switched in 2021 and 27% switched in 2022. Another 15% say they plan to switch in 2023. Which means by the end of this year, 87.5% of those organizations we surveyed will have adopted the new wRVU values.

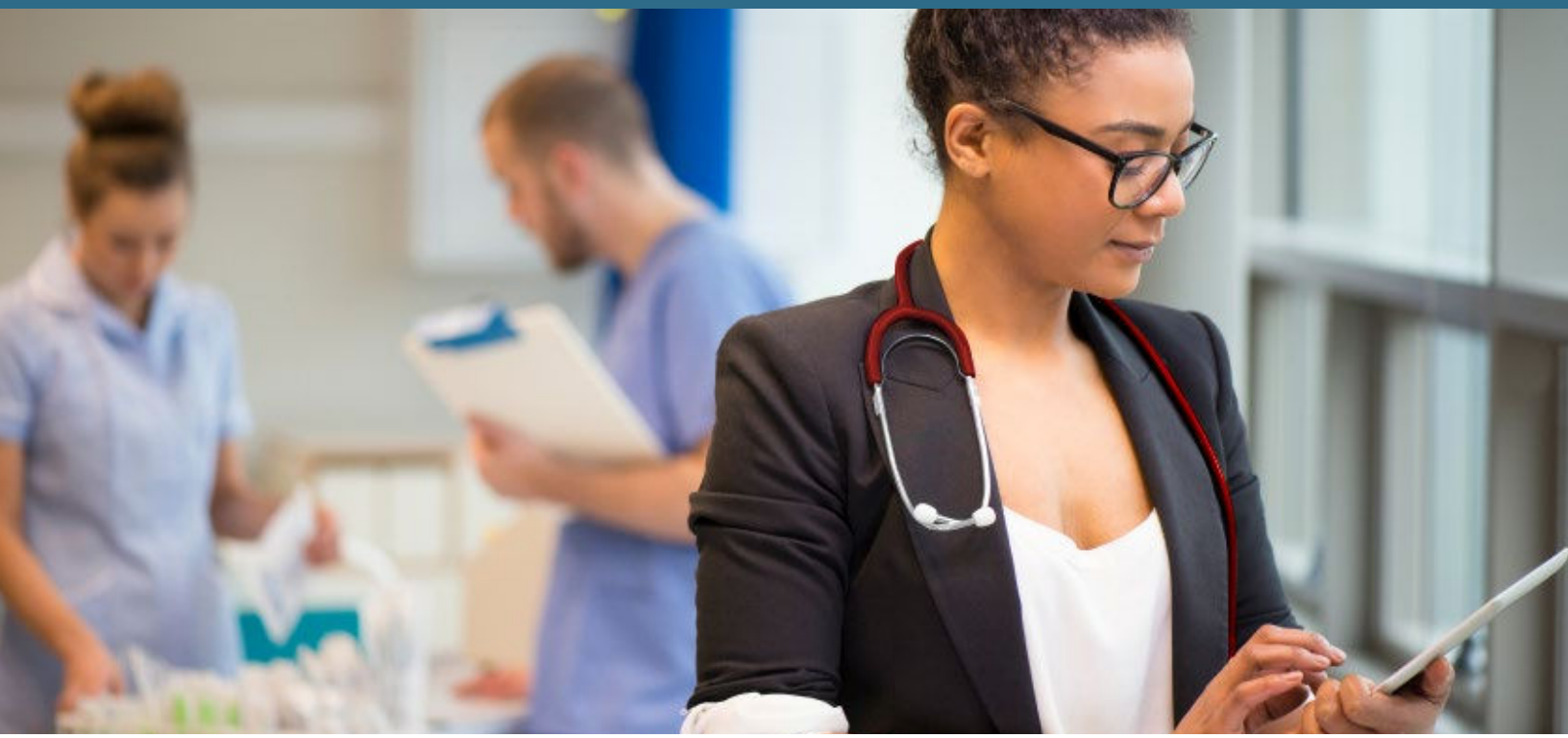
Have you already, or do you plan to utilize the 2021 Medicare Physician Fee Schedule wRVU values for determining wRVU-based compensation?



These numbers are higher than those we encountered last year through informal surveys of national conference participants and our own experiences, which implied that only about 1/3 of organizations adopted the 2021 MPFS wRVU values in 2021 and about 1/3 adopted them or planned to adopt them in 2022, with the remaining 1/3 yet to commit. The adoption variances lead to conjecture about the impact of this variable on survey data and the thought that the reported wRVU levels might be lower than if all respondents had adopted the 2021 values.

To date, Sullivan Cotter, Inc. is the only survey source we are aware of that asked participants up front if they adopted the 2021 MPFS wRVU values and then segregated the data into those that adopted the changes and those that did not. SC presents wRVUs for those organizations reporting based on the 2020 Physician Fee Schedule ("PFS") versus those reporting the 2021 PFS wRVU values. The other major surveys aggregate wRVU data from participants regardless of knowing whether they adopted the 2021 values.

In the SC 2022 Physician Compensation and Productivity Survey Report, 71,028 (49%) providers' wRVU data was reported according to 2021 wRVUs and 73,356 (51%) was reported based on 2020 wRVUs. These respondent adoption ratios are more consistent with our prior empiric impressions and lower than the above noted HSG survey results.



Perhaps this difference makes sense given the timing of the SC survey, which is based on 2021 data and would have antedated some of the planned 2021 conversions. It is not unreasonable to expect our percentage for the updated wRVU values to be higher, given that our survey was conducted a couple months into 2023. When the 2023 surveys hit the market later this year, we anticipate the results will more closely align with our survey in terms of the proportion of respondents reporting the new wRVU values.

The SC 2022 Physician Compensation and Productivity Survey Report also provides a glimpse into the variance between 2021 MPFS adopters and nonadopters. Calculating the aggregate differences across all specialties, the survey data indicate a total wRVU difference of about 7% between those that adopted the fee schedule changes (higher) and those that had not. This gives more than anecdotal impressions of the impact of adoption variance and permits specialty-specific calculations to guide decision-making based on whether you have adopted the 2021 MPFS or not.

The practical utility of this capability remains to be seen but it offers a mechanism to calculate more accurate rates and expectations.

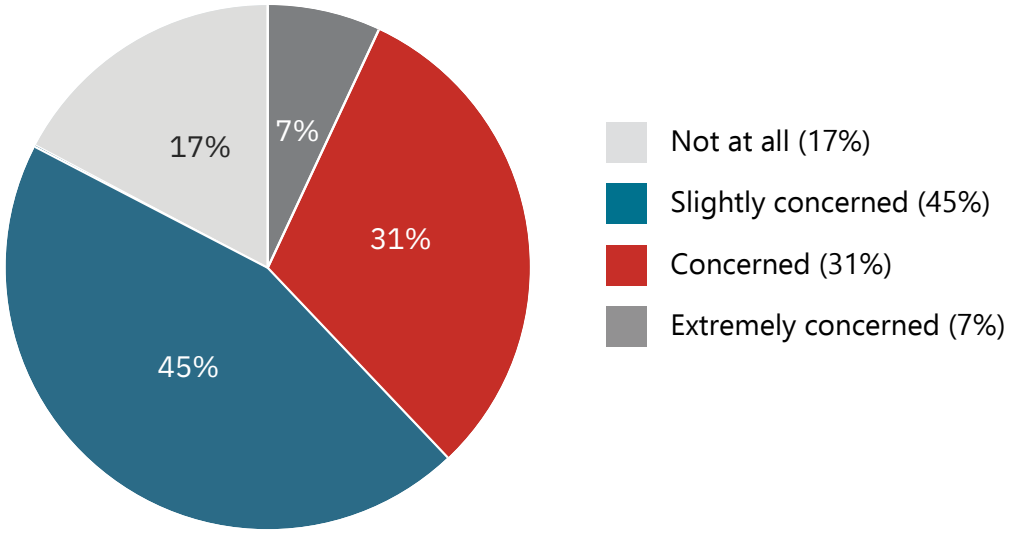
HSG developed its own predictive analytics formula to predict "true" wRVU values, and we use this data when calculating compensation rates and productivity expectations. We created our own productivity tables by averaging national survey wRVU levels for the 5 years prior to COVID (through 2019 data years) and adjusting for the CMS-indicated specialty increases in the 2021 MPFS to determine "realistic" productivity levels–especially since clients were often making the transition to the 2021 MPFS wRVU values at the same time. While excellent in theory, client acceptance was initially skeptical based on the organization's inability to readily reproduce these values and the contrast with the values published in the national surveys, which the providers they are dealing with can access. The published data in the SC 2022 Physician Compensation and Productivity Survey Report may be able to offset this reluctance.

FMV CHALLENGES AND CONCERNS

With these noted confounding productivity variables, fair market value determination has been challenging as each of these factors must be taken into consideration during the FMV determination process. This sentiment is echoed by the health care executives who responded to our survey. In the survey, we asked: "Have the 2021 wRVU increases and Stark Regulatory updates affected your feelings about Fair Market Value determination?" About 45% indicated that they are "Slightly Concerned," 31% are "Concerned," and 7% are "Extremely Concerned." Only 17% indicated that they are "Not Concerned at All."

Mechanisms to address these concerns are suggested in the following "Practical Considerations" section.

Have the 2021 wRVU increases and Stark Regulatory updates affected your feelings about Fair Market Value determination?



PRACTICAL CONSIDERATIONS FOR 2023 INTO 2024

We all utilize survey data for setting and evaluating compensation, especially when setting or evaluating the alignment of compensation with each wRVU produced by a provider. Given the reality of the past couple years, we've highlighted several considerations and options for provider compensation professionals to contemplate for 2023 and into 2024:

1 | Be mindful of the varied adoption of the 2021 MPFS wRVU values from organization to organization.

Progressive implementation of the 2021 wRVU values is increasingly reflected in national surveys, but not yet complete. If your network already adopted the 2021 values, your comparisons with most market data is not likely to be a perfect match overnight; a true "apples-to-apples" comparison will occur incrementally over time, but probably not fully until at least the 2025 survey reports. Until then, the SC 2022 Physician Compensation and Productivity Survey Report might be a good option for those that adopted the changes to consider for obtaining a more accurate comparison. If using the aggregated survey data, your provider productivity would be expected to exceed the published percentiles and result in an increase in productive compensation this year and next but would decrease each year until reaching an equilibrium when the 2021 wRVU values are fully adopted across all practices. Similarly, the converse is true for those still using the 2020 wRVU values. Expect a potential bolus increase in productive compensation when the transition is made.

2 | Consider evaluating compensation-to-wRVU alignment based on a predictive wRVU model that projects wRVUs according to pre-COVID wRVUs (i.e., 2020 reports based on 2019 data).

As noted previously, HSG frequently employed the approach of adjusting pre-COVID wRVU data based on estimated percentage increase in wRVU production, as forecasted using Medicare utilization data (see the Table 2 below), applied to the 2019 wRVU data—or the average specialty-specific wRVU data for the five (5) years ending in 2019. This approach eliminates the COVID volume downturns and projects an immediate full implementation of the 2021 MPFS—though generalized by specialty and not reflective of varying scopes of practice. Or, for those that adopted the 2021 MPFS values, use the SC 2022 Physician Compensation and Productivity Survey Report.

TABLE 2

E/M Code wRVUValue Changes – By Specialty

Specialty		Specialty	
Rheumatology	22%	Internal Medicine	11%
Endocrinology	21%	Podiatry	11%
Hematology/Oncology	19%	Dermatology	10%
Family Practice	19%	Cardiology	9%
Allergy/Immunology	18%	Pulmonology	7%
OB/GYN	16%	Orthopedic Surgery	7%
Nephrology	16%	PM&R	7%
Urology	15%	General Surgery	6%
ENT	14%	Vascular Surgery	6%
Pediatrics	14%	Plastic Surgery	6%
Psychiatry	12%	Gastroenterology	6%
Neurology	12%	Neurosurgery	5%
Interventional Pain Management	13%	Infectious Disease	3%

Based on National Medicare Database

3 | When setting the desired alignment of compensation and wRVU production, remember it is all about the rate.

HSG recommends a measured and intentional approach when determining the compensation per wRVU rates used in the calculation of thresholds (or targets) and bonus conversion factors. Our measured approach assumes that productive compensation is a large component of a provider's total compensation, but it is not the only component. Therefore, to allow room for other sources of income (e.g., non-productivity incentives, on-call compensation, medical directorships, and APP supervision stipends) and to cover other direct employment expenses (e.g., benefits), we recommend calculating a rate based on a "lag" or "gap" between the targeted compensation percentile and wRVU production percentile—with production percentile exceeding compensation percentile. For example, using the 50th percentile total compensation divided by the 60th percentile wRVU production. Using this approach helps provider compensation professionals account for the reality of needing to cover both provider compensation and benefits through provider productivity—and cover other practice expenses that are an increasing challenge with the state of staffing expenses and payer mix and rates. Given these circumstances, perhaps even consider increasing the production versus compensation gap to a 15-percentile gap until the national surveys catchup with complete adoption of the 2021 MPFS. **Table 3** in is an example of our rate calculation approach with an inherent compensation-to-production lag.

TABLE 3

Framework –Rates Rate Determination

Selecting a rate
Detailed Rate Range Calculation Example

Percentile	Total Compensation		wRVUs	Implied Lag	Rate	
25	$271,547		3,719	-25	$87.67	FMV compliance risk
30	$280,779		3,937	-20	$82.82	
35	$292,626		4,185	-15	$77.91	Financial sustainability risk
40	$303,910		4,434	-10	$73.53	
50	$326,054		4,949	0	$65.88	
60	$344,342		5,441	10	$59.93	Financially sustainable target zone
65	$355,810		5,771	15	$56.50	
70	$377,466		6,120	20	$53.28	Potential recruitment / retention challenges
75	$399,923		6,454	25	$50.52	

Rate = Total Compensation / wRVUs for selected percentile

4 | Published compensation per wRVU ratios in the national survey data are an informative datapoint and benchmark, and a helpful litmus test, but they should not be utilized blindly to set compensation per wRVU rates.

A "75th percentile physician" should not receive a 75th percentile compensation per wRVU ratio as a bonus rate. Select a standard rate calculation as discussed above for all in the specialty.

An additional consideration is the potential inaccuracies of the $/wRVU tables at various percentiles—especially the higher percentiles. These individuals tend to be those that have a significant mismatch between compensation and production and could represent any of the following situations:

- Individuals on a salary guarantee while ramping up practice and having low productivity.
- Individuals on a straight salary model who have a total disconnect between compensation and productivity, including a lack of incentive for coding documentation accuracy.
- Individuals who are compliance risks for some of the responding organizations.

It is better to not use this table directly and to actually use the compensation and productivity tables to calculate your desired rates.

We hope that you find these suggestions to be insightful, practical considerations in your daily activities.

> HSG recommends a measured and intentional approach when determining the compensation per wRVU rates used in the calculation of thresholds...

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Provider compensation model development and implementation guidance for hospitals and health systems focused on sustainable solutions that promote market competitiveness, financial sustainability, and regulatory compliance.

CONTACT THE AUTHORS

Neal Barker, MBA
Partner at HSG Advisors

(502) 814-1189
nbarker@hsgadvisors.com

Dr. Terrence R. McWilliams, MD, FAAFP
Chief Clinical Officer

(502) 614-4292
tmcwilliams@hsgadvisors.com

