RELATIONSHIP STATUS WITH PRODUCTIVITY-BASED COMPENSATION: IT'S COMPLICATED

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Talk of the shift from volume to value is constantly in the air. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is making it official. But with all this talk, many healthcare organizations are still going steady with wRVU-based productivity compensation, and for a good reason.

The healthcare community broadly accepts that physicians require performance incentives to maintain the viability of physician enterprises. To date, using wRVUs is one of the best measures to track and reward work effort. Further, wRVUs are payer-neutral, which appeals to physicians as protection from payer mix variation. It also appeals to many not-for-profit health systems as being consistent with their community-service mandate.

Productivity-based compensation will not be likely, and probably should not be completely replaced by quality-based compensation. However, designing compensation agreements with properly implemented compensation-per-wRVU benchmarks in the value-based realm requires a better understanding of the parameters used in developing those benchmarks.

DIVERGENCE FROM ECONOMIC REALITY

One of the complicating factors with compensation and productivity benchmarks is their increasing divergence from economic reality. Historically, benchmark surveys--like those published by MGMA, AMGA, Sullivan Cotter, and others--reported compensation and productivity data on physicians primarily from private or group practices. Initially, compensation-to-productivity ratios were simply a function of practice economics, having little to no relationship with compensation methodologies. Over time, the private practice model was supplanted by employment or near employment compensation arrangements.

Under an employment (or employment-like) arrangement, the revenues-less-expenses compensation model typically seen in private practice becomes more complicated and less desirable to implement. This factor is due to, among other things, hospital overhead being much higher than in a typical physician practice. The physicians also lose revenue as ancillaries are transitioned to the hospital, squeezing physician compensation from both ends.

With an increasing number of physicians opting to become employed or to enter employment-like arrangements, the makeup of compensation benchmarks is also changing, unhinging compensation-per-wRVU benchmark metrics from practice economics. This change is especially significant given the way compensation-per-wRVU ratios are reported in benchmarks versus how those benchmarks are utilized in compensation plans.

Most surveys build up benchmarks using all forms of compensation earned by physicians. The "compensation" component of "compensation per wRVU" often includes payments for administrative leadership, call coverage, supervision of residents or advanced practice providers, and other services the physicians might be providing. When used in practice, however, the benchmarks are rarely applied that way. At Coker Group, we often see healthcare organizations using the compensation ratios to build up base clinical compensation, with other forms of compensation then being layered in on top. This use of benchmark ratios can unwittingly cause compensation arrangements to fall outside of fair market value parameters or simply to be economically unviable.

The mismatch in the way compensation is built up in the benchmarks, and the way these benchmarks are applied in practice is doubly harmful. The organizations referring to the physician compensation benchmarks are frequently the same organizations that are participating in those surveys. Combined with the widely-held belief that if an organization pays less than median compensation per wRVU, the organization will attract only less than median quality physicians, a feedback loop is created that unsustainably drives up compensation-per-wRVU ratios at a faster rate than collections-per-wRVU ratios.

Suggestions for Implementation

All this is not to say that applying physician compensation benchmarks is inappropriate. The benchmarks are useful and relevant. Healthcare organizations simply need to be thoughtful in how benchmarks are applied instead of automatically defaulting to median compensation per wRVU. The following are some suggestions on how to avoid the pitfalls mentioned above:

1. **Choosing Benchmark Percentiles**
   Acknowledge that it may be appropriate to use below-median benchmark ratios. Many areas of the country are subject to reimbursement rates that are lower than national or even regional averages of the healthcare organizations included in the benchmark surveys. Accordingly, paying median compensation per wRVU may not be financially feasible, and that's okay. Make sure the compensation plan is economically sustainable.

2. **Including All Forms of Compensation**
   Consider including all forms of compensation when comparing physician metrics to benchmark ratios. As previously stated, the benchmark surveys include various forms of administrative pay, call coverage compensation, and quality incentives, among other forms of compensation. Not all physicians included in the benchmarks will have all those forms of compensation, so a potential for mismatch exists in the other direction as well.

3. Dicing Benchmarks in New Ways

Consider gathering benchmark data differently from how it has been gathered it in the past. Some surveys allow users to filter the benchmarks by years in service, plan type (i.e., straight salary vs. minority or majority at-risk compensation), or by geography. If possible, conduct local market research on physician compensation practices rather than relying exclusively on benchmark surveys. The downside to filtering for specificity is that the sample size is reduced and may only be available for certain specialties. However, a smaller sample that is more representative of the subject arrangement can be meaningful in assessing value. However, skill is needed to make sure the smaller sample size is truly representative of the subject arrangement.

With the changing compensation landscape, healthcare organizations may find they need to become more sophisticated in their physician compensation methodologies. As always, consider engaging an advisor with experience across the country in dealing with complex compensation issues.

Please share your thoughts about Productivity-Based Compensation and any questions you may have about how Coker Group can help your organization by contacting Matthew Jensen, MBA, ASA, Senior Manager at mjensen@cokergroup.com or by calling 678-832-2021.