Coker GROUP

Business Advisors for the Healthcare Industry

PHYSICIAN COMPENSATION IN AN AGE OF DECREASING REIMBURSEMENT:

A NEW PERSPECTIVE ON THE MEDIAN

Justin Chamblee, CPA
Vice President

Jessica Combs
Staff Associate

March 2014

INTRODUCTION

The current trends of hospitals heavy (and oftentimes sole) use of benchmark data in establishing physician compensation is inadvertently increasing physician compensation, presenting a situation that is likely to undergo mounting scrutiny in an environment under pressure to lower costs. The merits and consequences of using benchmark data, focusing on median compensation per wRVU ratio, to build a compensation model and its long-term feasibility are examined in this paper. Also presented are modifications that can be made when developing wRVU-based compensation models that will address the issues of using benchmark data to derive compensation that aligns with productivity levels and general market trends.

BACKGROUND

The healthcare industry has dramatically changed of late, wherein many physicians are employed by health systems. This change has impacted how physicians are compensated. Unlike private practice, in hospital employment, the focus is less on what is left over after subtracting expenses from the revenue generated, and more on providing/receiving compensation at fair market value. This level of compensation often exceeds the amount left over after subtracting expenses from revenue.

Because compensation under hospital employment is not necessarily constrained by the profit of the physician's practice, in most cases compensation models other than a "private practice" model (i.e., revenue less expenses) are applied. The most common models today are work-only relative value unit (wRVU) based models. Going forward, we will assume a basic understanding of wRVU based models.[1]

wRVU-based compensation models can take on many different forms, but the most basic wRVU-based compensation structure is illustrated with the following formula (Figure 1).

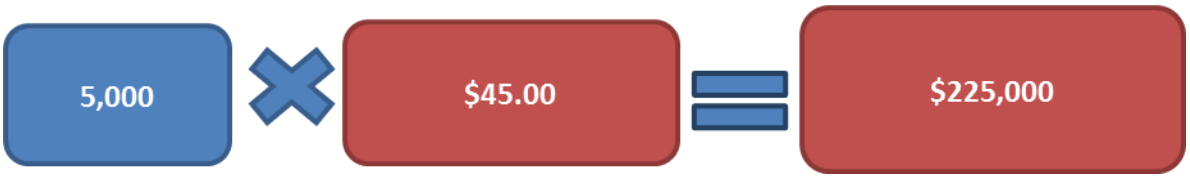
[1] For more information, refer to *RVUs at Work: Relative Value Units in a Medical Practice, 2nd Edition*, ©2014, Greenbranch Publishing.

Coker GROUP
Business Advisors for the Healthcare Industry
Atlanta • Charlotte • Dallas • Philadelphia
2400 Lakeview Parkway, Suite 400, Alpharetta, GA 30009
800.345.5829 | www.cokergroup.com

FIGURE 1—WRVU-BASED COMPENSATION MODELS: *FORMULA*

A physician's wRVUs are multiplied by a conversion factor that translates the raw measure of productivity into cash compensation. Figure 2 is an example using actual numbers.

FIGURE 2—WRVU-BASED COMPENSATION MODELS: *EXAMPLE*



While the wRVUs are what they are, the conversion factor must be established. There is no set approach for deriving conversion factors and each health system approaches it differently; however, the most common approach involves the use industry benchmark data.

A number of key industry surveys provide physician compensation and productivity data. The three most frequently used and accepted are the following:

- Medical Group Management Association (MGMA) *Physician Compensation and Production Survey*
- American Medical Group Association (AMGA) *Medical Group Compensation and Financial Survey*
- Sullivan, Cotter and Associates, Inc. (SCA) *Physician Compensation and Productivity Survey*

Although all three surveys are heavily used, the MGMA publication is used most frequently. We will use MGMA data for our examples, but the same results could be experienced by using the other surveys.

The benchmark data is extremely helpful in providing an understanding of compensation and productivity levels in the market. However, there is a frequent over-reliance and perhaps improper use of the data that is resulting in a continual increase in physician compensation.

THE ISSUE AT HAND

Physician compensation revolves largely around the use of industry benchmark data, which can be a valuable tool in establishing compensation that aligns with productivity levels and general market trends. Mainly, the market data is used to establish the conversion factor (or compensation per wRVU ratio). While there is no "rule", the most common approach has tended to be using the median of market data for the specialty under consideration. For example, if general surgery is the specialty, the median rate per wRVU for general surgery from the respective survey would be used. In many respects, this is sensible. Specifically, using the median conversion factor tends to result in an alignment in compensation and productivity. Consider Table 1 using data for cardiology.

TABLE 1—EXAMPLE USING CARDIOLOGY DATA

wRVUs	MGMA Benchmark	Comp/ wRVU	MGMA Benchmark	Total Compensation	MGMA Benchmark
7,584	25th %tile	$54.69	40th %tile	$414,769[2]	15th %tile
9,574	Median	$54.69	40th %tile	$523,602	42nd %tile
12,394	75th %tile	$54.69	40th %tile	$677,828	72nd %tile
7,584	25th %tile	$58.47	Median	$443,436	22nd %tile
9,574	Median	$58.47	Median	$559,792	49th %tile
12,394	75th %tile	$58.47	Median	$724,677	77th %tile
7,584	25th %tile	$62.49	60th %tile	$473,924	30th %tile
9,574	Median	$62.49	60th %tile	$598,279	57th %tile
12,394	75th %tile	$62.49	60th %tile	$774,501	85th %tile

As illustrated, using a rate per wRVU below the median results in wRVU productivity that outpaces compensation, while using a rate per wRVU above the median results in the opposite trend. However, using a median rate per wRVU results in a rather close correlation between productivity and compensation.

The example helps to support the foundational premise of using the median rate per wRVU. It makes sense when considering the correlation of compensation and productivity. There is nothing wrong with this approach, when considering in isolation of any other compensation component. The issues arise as other forms of pay are added to the model. However, it is important to note that there is only an assumed correlation between the productivity and compensation tables, as they are populated separately. Meaning, not every physician generating median wRVUs is receiving median compensation. It could be that they are producing seventy-fifth percentile wRVUs and generating

[2] 7,584 x $54.69

Coker GROUP
Business Advisors for the Healthcare Industry
Atlanta • Charlotte • Dallas • Philadelphia
2400 Lakeview Parkway, Suite 400, Alpharetta, GA 30009
800.345.5829 | www.cokergroup.com

twenty-fifth percentile compensation. Other tools, such as the MGMA Pay to Production Plotter, (discussed later) help to understand the true correlation.

With respect to applying a median rate per wRVU in a compensation model, frequently the median rate per wRVU being used is reset annually (per the terms of the employment agreement) to be consistent with the most recent survey data. This reset makes a big difference in compensation, as historically, the compensation per wRVU has climbed each year.

In Table 2, we used MGMA median data to illustrate the year-over-year inflation for six key specialties: cardiology (noninvasive), family medicine (without OB), internal medicine, obstetrics-gynecology, orthopedic surgery, and general surgery.

TABLE 2—MGMA MEDIAN CONVERSION FACTOR (2009--2013)

Specialty	2009	2010	2010 % Change	2011	2011 % Change	2012	2012 % Change	2013	2013 % Change	2009 – 2013 Change
Cardiology: Noninvasive	$54.05	$53.54	-0.95%	$57.95	8.24%	$60.19	3.87%	$57.36	-4.71%	**6.12%**
Family Medicine (without OB)	$39.11	$39.13	0.05%	$40.47	3.43%	$43.24	6.83%	$43.63	0.90%	**11.55%**
Internal Medicine: General	$41.73	$42.50	1.83%	$43.68	2.78%	$45.65	4.52%	$48.31	5.83%	**15.76%**
Obstetrics/Gynecology: General	$43.90	$43.54	-0.82%	$44.59	2.41%	$46.47	4.21%	$46.89	0.90%	**6.80%**
Orthopedic Surgery: General	$59.00	$60.05	1.78%	$60.39	0.57%	$62.64	3.73%	$69.22	10.51%	**17.33%**
Surgery: General	$49.25	$50.10	1.74%	$52.69	5.17%	$54.10	2.67%	$56.23	3.94%	**14.19%**

Each noted specialty has experienced at least a five percent total increase between 2009 and 2013, some more than others. For example, internal medicine has increased consistently over the five-year period, while orthopedics spiked in 2013.

Physician reimbursement, in general, has declined for the last several years, which begs the question of how compensation can be increasing in an era of reimbursement pressure. Costs of running a medical practice have certainly not declined to allow for such. Likely, the increases are largely driven by the influx in hospital employment and the use (or misuse) of benchmark data in developing employed physician compensation models.

As the overall healthcare environment has continued to shift from a volume-only focus to a value-based focus, hospitals and health systems have moved away from compensation plans that pay only based on wRVUs, beginning to build quality incentives and other forms of compensation in addition to the production-based component. In many situations, the starting point for the compensation model remains the "median" rate per wRVU. As a result, the overall effective conversion factor (dividing total compensation by wRVUs) is much higher than the median.

Coker GROUP
Business Advisors for the Healthcare Industry
Atlanta • Charlotte • Dallas • Philadelphia
2400 Lakeview Parkway, Suite 400, Alpharetta, GA 30009
800.345.5829 | www.cokergroup.com

Considering the details within the MGMA survey data definitions, the compensation data reported is total cash compensation. The survey defines total compensation as the amount reported as direct compensation plus all voluntary salary reductions and should include salary, bonus or incentive payments, research stipends, honoraria, and distribution of profits.[3] Further, if we look at the compensation per wRVU data definitions, it is total cash compensation divided by wRVUs. Thus, inherently, all forms of compensation, including quality incentives and other forms of payment, are reflected in the compensation per wRVU data. Therefore, when applying the median rate per wRVU as the starting point, it already includes some element of all of the other components of compensation that are being added on top of the median rate per wRVU.

To understand further the impact, we illustrate a typical compensation model, below, for family medicine. Basic compensation models will pay wRVUs at a set rate per wRVU (i.e., conversion factor) with the addition of incentive pay. Due to the ACA, many compensation plans are incorporating a quality-based payment wherein the payment is tied to meeting certain quality metrics. Another common addition is a stipend for midlevel oversight, as the use of physician extenders is also on the rise.[4]

Over the noted five-year period, Table 4 shows the effect of paying the median rate per wRVU before and after the addition of a quality incentive and midlevel oversight. We have kept the wRVUs consistent over the five-year period and illustrated clinical compensation as paid at the MGMA median rate per wRVU.

TABLE 4—TYPICAL COMPENSATION MODEL

Family Medicine (without OB)	2009	2010	2011	2012	2013
wRVUs	5,000[5]	5,000	5,000	5,000	5,000
Rate per wRVU (Median)	$39.11	$39.13	$40.47	$43.24	$43.63
Clinical Compensation	**$195,550**	**$195,650**	**$202,370**	**$216,186**	**$218,138**
Quality Incentive	$15,000	$15,000	$15,000	$15,000	$15,000
Midlevel Oversight	$10,000	$10,000	$10,000	$10,000	$10,000
Total Compensation	**$220,550**	**$220,650**	**$227,370**	**$241,186**	**$243,138**
Rate per wRVU (Median)	$39.11	$39.13	$40.47	$43.24	$43.63
Total Effective Rate per wRVU	**$44.11**	**$44.13**	**$45.47**	**$48.24**	**$48.63**

[3] MGMA Physician Compensation and Production Survey: 2013 Report Based on 2012 Data.
[4] Japsen, B. "Amid Doctor Shortage, Hospitals Turn to Dwindling Supply of Nurses, Physician Assistants," *Forbes*, March 21, 2013. http://www.forbes.com/sites/brucejapsen/2013/03/21/amid-doctor-shortage-hospitals-turn-to-dwindling-supply-of-nurses-physician-assistants/. Accessed Feb 21, 2014.
[5] Approximately median wRVUs.

Coker GROUP
Business Advisors for the Healthcare Industry
Atlanta • Charlotte • Dallas • Philadelphia
2400 Lakeview Parkway, Suite 400, Alpharetta, GA 30009
800.345.5829 | www.cokergroup.com

This table illustrates that there has been an inherent increase in clinical compensation as a result of consistently paying at the median. The value of 5,000 wRVUs in 2009 and 2013 is $195,550 and $218,138, respectively, before the addition of incentive pay. The other key factor to note is the difference between the clinical only rate per wRVU, which is consistent with the median, and the total effective rate per wRVU, which is $5.00 higher and consistent with the sixty-fifth percentile. The addition of incentive pay increases the total compensation by $35,000 and an additional ten percent increase to the overall effective rate on top of the twelve percent increase in the median rate per wRVU reported in MGMA over the five year period.

The issue lies in the fact that the median is used as the starting point; all other components are then added to the model, which inflates the total cash compensation per wRVU ratio. The result is reported back to MGMA and other survey resources; it is not the clinical only rate per wRVU, which is a common misconception. This and other factors result in the median rate per wRVU increasing year over year, simply as a result of how the data is used and not necessarily because there is a true need for compensation to increase. Ultimately, this will become unsustainable, with health systems unable to afford the perceived built-in increases to compensation.

For emphasis, we have created a sample scenario where forty percent of survey respondents reported a rate per wRVU below the median to the survey resources for that respective year, and sixty percent of physicians reported a rate per wRVU at or above the median for that respective year. This distribution makes sense in that we more frequently see rates per wRVU at or above the median being applied as a starting point. The assumption in this illustration, Table 5, Physician Reported Rates over a Five-Year Period, is that, for those who are above the median, the starting point each year is the median, with other components of pay being added on top of this baseline. Then, the rate is updated each year to reflect the new median. The result is shown over a five-year period.

TABLE 5—PHYSICIAN REPORTED RATES OVER A FIVE-YEAR PERIOD [6]

Physician Reported Rate	Year 1	Year 2	Year 3	Year 4	Year 5
Respondent 1	$34.11	$34.61	$35.11	$35.61	$36.11
Respondent 2	$35.11	$35.61	$36.11	$36.61	$37.11
Respondent 3	$36.11	$36.61	$37.11	$37.61	$38.11
Respondent 4	$38.11	$38.61	$39.11	$39.61	$40.11
Respondent 5 (at the Median)	**$39.11**	**$39.61**	**$40.11**	**$40.61**	**$41.11**
Respondent 6	$40.11	$40.61	$41.11	$41.61	$42.11
Respondent 7	$41.11	$41.61	$42.11	$42.61	$43.11
Respondent 8	$42.11	$42.61	$43.11	$43.61	$44.11
Respondent 9	$43.11	$43.61	$44.11	$44.61	$45.11

[6] These values are for illustrative purposes only.

Coker GROUP
Business Advisors for the Healthcare Industry
Atlanta • Charlotte • Dallas • Philadelphia
2400 Lakeview Parkway, Suite 400, Alpharetta, GA 30009
800.345.5829 | www.cokergroup.com

Respondent 10	$44.11	$44.61	$45.11	$45.61	$46.11
Median of Respondents	**$39.61**	**$40.11**	**$40.61**	**$41.11**	**$41.61**

As is illustrated in the simple (and clearly non-statistically valid) example above, the median rate increases each year, increasing pay for all respondents, which then repeats itself annually. The impact on the compensation model is shown in the above example with the median rate per wRVU values based on the above illustrated calculated median.

TABLE 6—COMPENSATION MODEL WITH PHYSICIAN REPORTED RATES [7]

Family Medicine (without OB)	Year 1	Year 2	Year 3	Year 4	Year 5
wRVUs	5,000	5,000	5,000	5,000	5,000
Rate per wRVU (Median)	$39.11	$39.61	$40.11	$40.61	$41.11
Clinical Compensation	**$195,550**	**$198,050**	**$200,550**	**$203,050**	**$205,550**
Quality Incentive	$15,000	$15,000	$15,000	$15,000	$15,000
Midlevel Oversight	$10,000	$10,000	$10,000	$10,000	$10,000
Total Compensation	**$220,550**	**$223,050**	**$225,550**	**$228,050**	**$230,550**
Rate per wRVU (Median)	$39.11	$39.61	$40.11	$40.61	$41.11
Total Effective Rate per wRVU	**$44.11**	**$44.61**	**$45.11**	**$45.61**	**$46.11**

In Table 6, Compensation Model with Physician Reported Rates, the median rate per wRVU is rising based on the values reported for the previous year. Further, the physician's total cash compensation continues to be well above the median, resulting in compensation that outpaces the level of productivity.

While other trends and factors are at play, in our opinion, the reliance on median survey data, especially in determining a baseline conversion factor for production-based pay, is inflating compensation throughout the industry. This inflation is despite the fact that all other factors point toward downward pressures on reimbursement and, in turn, less availability of the funds for physician compensation. Using benchmark data is not bad, but it should be used smarter.

HOW TO ADDRESS

Some clear modifications can be made when developing wRVU-based compensation models that will address these issues, as follows.

[7] These values are for illustrative purposes only.

Coker GROUP
Business Advisors for the Healthcare Industry
Atlanta • Charlotte • Dallas • Philadelphia
2400 Lakeview Parkway, Suite 400, Alpharetta, GA 30009
800.345.5829 | www.cokergroup.com

- ***Education on what the data represents.*** Users of industry data should review the manuals and contemplate how the compilation of data affects how they are using the information in building their compensation models.

- ***Use All Resources Available.*** Certain surveys offer more tools than simply the rate per wRVU data. The MGMA survey, for example, provides the MGMA Pay-to-Production Plotter, which plots the total compensation and productivity of each survey respondent on a graph and then calculates a linear regression that shows the "best fit." Use of this in evaluating the projected total compensation under the proposed model will help establish an appropriate baseline rate per wRVU, when considering the other components in play.

- ***Is This a Median Situation?*** The median is just that--it infers that fifty percent of the respondents are below, and the rest are above. Not every situation is a median or above situation and not every physician should be compensated as a median or above physician.

- ***Consistency May Backfire.*** Some may want to achieve consistency across specialties in application of compensation models, as in paying all physicians at the median rate per RVU for their particular specialty for their clinical productivity, down to the rate per wRVU. However, this may have consequences. The challenge then comes in the "add-ons", which may differ by specialty. For example, some specialties may have no add-on compensation components and, therefore, the median rate per wRVU may be very appropriate, but others may have significant add-ons, which may warrant a lower clinical rate per wRVU. In this situation, consistency becomes an impairment and not a benefit.

- ***Leave the Rates Alone.*** Many believe that the rates per wRVU must be constantly updated as soon as new benchmark data is available. However, it may be reasonable to establish rates per wRVU, then, leave them intact for two to three years with the understanding that future changes will respond to a fair market value analysis.

- ***Think Holistically.*** When establishing the rates per wRVU, consider all the components being included in the compensation model and whether it is realistic to assume that they are inherently built into the baseline rate per wRVU being applied. Call compensation is a great example. It is a reasonable assumption that a baseline level of unassigned call coverage is built into a median rate per wRVU. Thus, if the call pay will begin with the first day of coverage, it may warrant establishing a rate per wRVU that is below the median to account for this added call pay component. Other examples would apply, as well. Thus, look at the total model and then build up to (or back into) an appropriate rate per wRVU.

Coker GROUP
Business Advisors for the Healthcare Industry
Atlanta • Charlotte • Dallas • Philadelphia
2400 Lakeview Parkway, Suite 400, Alpharetta, GA 30009
800.345.5829 | www.cokergroup.com

CONCLUDING REMARKS

Certain trends within the industry in the application and use of benchmark data are leading to increases in physician compensation. As hospitals experience more pressure to lower costs, there will be an enhanced focus on physician compensation. Many health systems will realize that the current approach is unsustainable and simply using the "pick-a-percentile" approach to establishing a compensation model is no longer feasible. Further, the "add-ons" will only continue to grow. As more focus is placed on value-based care, more compensation will continue to be focused on incentives outside of productivity, leading to further increases in the benchmark data if the current cycle is not broken.

For additional information on how Coker Group can assess, develop, and improve compensation plans for your health system, contact Justin Chamblee at jchamblee@cokergroup.com.

Coker GROUP
Business Advisors for the Healthcare Industry
Atlanta • Charlotte • Dallas • Philadelphia
2400 Lakeview Parkway, Suite 400, Alpharetta, GA 30009
800.345.5829 | www.cokergroup.com