MERRITT HAWKINS
an AMN Healthcare company

RVU BASED PHYSICIAN COMPENSATION AND PRODUCTIVITY

Ten Recommendations for Determining Physician Compensation/Productivity Through Relative Value Units

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Overview:

Traditionally, there have been a number of ways of calculating physician productivity and compensation. Prominent among these have been volume-based metrics attached to the number of patients physicians see or the amount of revenue they bill for or collect.

Today, physician productivity and compensation are moving toward models based on Relative Value Units (RVUs).

RVUs reflect the relative level of time, skill, training and intensity required of a physician to provide a given service. RVUs therefore are a method for calculating the volume of work or effort expended by a physician in treating patients. A well patient visit, for example, would be assigned a lower RVU than an invasive surgical procedure. Given this relative scale, a physician seeing two or three complex or high acuity patients per day could accumulate more RVUs than a physician seeing ten or more low acuity patients per day. "Work," rather than number of patients or billings, is the behavior being measured and rewarded.

In 2007, the Medical Group Management Association's *Physician Compensation and Productivity Report* indicated that 16 percent of group practices used an RVU formula to calculate physician compensation and productivity. The 2007 report also showed that 34 percent of physicians had their compensation/productivity tied to RVUs. In MGMA's 2010 Report, by contrast, 35 percent of group practices were using RVU compensation/productivity metrics, and 61 percent of physicians had their compensation/productivity tied to RVUs.

There are often other productivity and quality measures which are used simultaneously with RVUs in determining a physician's overall compensation and productivity. However, over the last 4 years, the increased use of RVU has been highly significant and appears to be expanding.

This rapid growth has caused a gap in the learning curve for many doctors and administrators who may never have had in depth exposure to RVU-based compensation formulas. CMS has long used RVUs, so physicians and administrators are often familiar with their application to reimbursement from Medicare and/or Medicaid. However, wide scale use of RVU as a primary form of measuring physician performance and determining overall compensation (particularly, outside the realm of large health systems and academic institutions) is a more recent phenomenon.

There are presently a plethora of RVU formulas being used in employment contracts for determining physician compensation. Frequently, the formula used in calculating physician compensation and/or bonuses is complicated, confusing, or even incoherent. Many physicians and employers are not entirely sure how to structure RVU-based compensation, and Merritt Hawkins has experienced more frequent inquiries regarding this model.

Based on our national experience working with hospitals, medical groups and other organizations, following are ten recommendations to consider when implementing RVU-based physician compensation and productivity formulas.

Ten Recommendations for RVU-Based Compensation:

1.) **Keep it simple.** One of the benefits of utilizing an RVU compensation model is the ability of physicians to focus on patient care as opposed to spending an extensive amount of time managing the business of medicine. This can be a positive attribute for recruiting and retaining quality physicians, that value is diminished if the formula being used to determine the doctor's pay is overly complex and confusing. One simple solution is to establish an affordable and predetermined dollar amount the physician will receive per Work RVU generated. This "Compensation per Work RVU" figure can be benchmarked for the physician's respective medical specialty using an annual report by organizations such as the Medical Group Management Association (MGMA), the American Medical Group Association (AMGA), or with the help of a knowledgeable physician search firm. The physician's guaranteed base salary can be divided by this dollar amount to set a threshold of Work RVUs that must be generated before the physician begins receiving a Productivity Bonus. The physician would receive this Compensation per Work RVU for each Work RVU exceeding the threshold. Salary and bonuses can be calculated annually or on a quarterly basis.

2.) **Ensure administrators and physicians have a clear understanding** of the difference between the CMS Resource-Based Relative Value Scale (RBRVS) method, and the specific formula being used in the compensation section of the physician's employment contract to determine how he or she will be paid. These formulas are not identical. The RBRVS method is predicated on a "Total RVU" system. CMS reimburses for services based on Total RVUs (which includes the Physician Work RVU, the Practice Expense RVU and a Malpractice Expense RVU), then this Total RVU is adjusted by locality according to the Geographic Practice Cost Index (GPCI), before being multiplied by their current Conversion Factor (CF) in calculating the reimbursement for a service. However, physicians are most frequently compensated by their employer per the "Physician Work RVUs" they generate. Very few physicians have an incentive bonus based on Total RVUs. In either case, all of the RVUs generated by the physician are typically tracked and credited toward the doctor's overall productivity, since they will in most cases see patients from payers other than CMS.

3.) **Stay informed of developments with the RBRVS method.** Every Current Procedural Terminology (CPT) code used in billing for services has a corresponding Relative Value. These are periodically updated and can be downloaded from the CMS website by navigating to the Physician Fee Schedule (PFS), and clicking on the PFS Relative Value Files.

4.) **Don't' believe the myth** that an RVU Productivity Model will always pay a physician uniformly based on the amount of work they perform. No system is perfect. As an example, the national median Compensation per Work RVU for a pediatrician is $38.89. However, the median Compensation per Work RVU for an Orthopedic Surgeon is $60.05, according to the 2010 MGMA report. Discrepancies occur amongst physicians within the same medical specialty as

well. Internal medicine residency trained physicians report their compensation per Work RVU is 30% higher on average when they are employed as a hospitalist, instead of working in a traditional inpatient and outpatient general internal medicine practice.

5.) **Consider hospital and physician alignment.** Health systems and large practices today are moving toward Accountable Care Organizations (ACOs), in which they can realize income through shared savings. Implementing an RVU compensation formula can act as a bridge from fee-for-service to value based models by allowing doctors to treat all patients (regardless of insurance status) without concern for their insurance status or acuity. This is one of the primary reasons for the proliferation of RVU compensation models in the last several years.

6.) **Include quality incentives** as part of the overall compensation structure. RVU compensation allows physicians to focus less attention on generating revenue, but only using RVUs for determining physician compensation is still fee-for-service. Complementing an RVU incentive model with qualitative measures such as patient satisfaction and outcome metrics can also help bridge the gap while transitioning toward more evidence-based medicine and the anticipated "value based modifier" for Medicare patients coming in 2015.

7.) **Be practical.** Physicians considering an employed position with RVU compensation, and a hospital considering changing all of their employed physician contracts to RVU productivity, will have the same common goals. The compensation structure should pay the doctor fairly and be economically sustainable for the employer over time, or the practice will not survive. Turnover is costly for health systems, physicians, and for patients in the community. Running a pro forma with the precise CPT codes an incoming physician might utilize by polling local payers is certainly possible, but it also may result in a scenario where the employer and/or the physician may "miss the forest to see the trees." If there is demand in the market, and a qualified, hard working physician desires to practice in the area, most situations are best served by setting a reasonable dollar amount for Compensation per Work RVU, and then focusing on getting the doctor ramped up as quickly as possible. If the doctor is already practicing in the community and seeking employment by a health system, valuations can be handled by referencing the doctor's existing billing information.

8.) **Consider having a tiered plan** for Compensation per Work RVU, whereby the physician receives a lower dollar amount per RVU up to a specified threshold level, but a higher Compensation per Work RVU thereafter. Several health systems have effectively implemented a system with three or more tiers, so as the practice becomes more profitable, the physician receives a greater percentage of that margin.

9.) **Be aware of political risk** and the key entities influencing RVU values. The AMA owns the copyrights for the CPT code and receives approximately $70 million annually from charging a license fee for those wishing to associate RVU values with CPT codes. The codes are periodically amended by the CPT Editorial Panel and their use is required by statute. The RBRVS system is based on the CPT code and the RBRVS system is mandated by CMS. This system is unlikely to be

replaced any time soon. Nonetheless, the 29-member Relative Value Update Committee (RUC) is mainly a privately run regulatory committee that must maintain budget neutrality when modifying Relative Values, and their meetings are closed to the public, so paying physicians based on RVU Productivity will always have a level of uncertainty, just like any other compensation model.

10.) **Remember there is a shortage of physicians** and doctors seldom relocate their practices and their families without having an attractive financial guarantee. It is still necessary to have an established base salary set at fair market value. Numerous RVU models are structured in a way that reduces or eliminates the base salary after the first or second year, with compensation based solely on productivity after that. This can be accomplished by having a rolling quarterly reconciliation with the subsequent three month "salary" paid at whatever the previous quarter's production warrants. Physicians can be leery of this, and it may inhibit recruitment or retention, but it also establishes a system allowing for the doctor to work long-term in a stable environment with their personally desired volume of patient interaction. It can also decrease a physician's potential concern regarding termination for failing to meet targets they deem unrealistic for their style of practice. The demography of practicing physicians is changing. There are significant numbers of doctors looking to slow down either because they are in the later stages of their careers or because they place a greater value on their schedule and quality of life. Having flexibility in a compensation structure can be a perceived benefit if it is explained and positioned appropriately.

The key with RVU and other forms of physician compensation is to structure a formula that fits the culture of a particular practice or medical staff. If you have questions about RVU or other physician compensation structures, or would like to address additional physician recruiting issues, contact:

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ABOUT MERRITT HAWKINS:

Established in 1987, Merritt Hawkins is the leading physician search and consulting firm in the United States. A company of AMN Healthcare (NYSE: AHS), the largest healthcare staffing organization in the country, Merritt Hawkins recruits permanent physicians and advanced allied healthcare professionals.