Evaluating RVU-Based Compensation Arrangements

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Relative Value Unit (RVU) based compensation arrangements are increasingly popular for compensating physicians. Where collected revenue-based systems—historically common in group practice, for example—reflect the individual physician's underlying payor mix, RVU systems are payor-mix neutral. A RVU system[1] is therefore attractive to a physician employed by a hospital that treats patients regardless of their ability to pay. However, RVU systems may be tainted by payor mix and other market conditions, requiring that the analyst understand and examine the effects of this issue when using compensation survey data to establish fair market value incentive compensation based on RVUs.

There are several RVU measurement systems associated with physician billing codes (Current Procedural Terminology or CPT™), but the most commonly used is the Resource-Based Relative Value Scale (RBRVS), which is also used by the Medicare program for establishing its physician fee schedule (MPFS). The RBRVS allocates RVUs to each procedure or service in the CPT™ based upon the amount of physician work, the cost of delivering the service, and the cost of malpractice insurance associated with the service. These RVUs are then multiplied by an amount known as a Conversion Factor and adjusted for geographic differences (the GPCI) to arrive at the fee for the service.

RBRVS has its weaknesses. The Medicare Conversion Factor suffers from a statutory construct, which attempts to peg overall Medicare physician spending to an annual limit that would seem to make that measurement unit meaningless in the present environment. Sitting at around $38 per RVU before geographic adjustment, the rate has been virtually flat for many years and does not maintain pace with inflation, which the Medicare Payment Advisory Commission (MedPAC) estimates at approximately 3.0% per annum in physician practices. Nonetheless, the vast majority of physicians continue to accept Medicare patients, suggesting, at least to government agencies such as MedPAC, that payment rate has some relevance in assessing value. RBRVS is also subject to government manipulation that manifests itself in instability. For example, legislative intervention into the formula used to account for the practice expense formula and statutory five-year adjustments to the physician work component of the RVU affect how RBRVS impacts physician payment.

Payment rates per RVU vary significantly from region to region, as well as from payor contract to contract. Providers and, particularly, provider-systems with negotiating strength may have payment rates per RVU well in excess of their competitors. Evaluating reasonable compensation for a physician therefore requires knowledge of the specific contract rates being paid for that physician's services, as well as knowledge of the underlying payor mix. Consider the following example of how contract rates and payor mix impact physician compensation:

Example

Payor Mix	40.00%	10.00%	60.00%	
Payor	Medicare	Best	Non-Medicare Avg *Including* Best	Weighted Average
Total RVUs	10,000	10,000	10,000	10,000
Rate	38.00	55.00	48.00	44.00
Collections	380,000	550,000	480,000	440,000
Practice Expenses	250,000	250,000	250,000	250,000
Physician Income	130,000	300,000	230,000	190,000
Compensation per total RVU	13.00	30.00	23.00	19.00

Note: Payor Mix weights are used to determine the Weighted Average Rate per RVU. Each column indicates what the Physician would have earned if 100% of the services provided were for each of the Payor Columns shown. For purposes of the example, assume that none of the Total RVUs include Stark or other prohibited incentives.

In the example, the physician is earning $190,000 per year on collected revenue of $440,000. The physician's earnings would vary from $130,000 if the practice were entirely Medicare to $300,000 if it was entirely "market-best," a difference of 230%. The key observation to be taken from the example is that because expenses are fixed for a given volume of services in each scenario, all of the additional revenue from better contracts drops to the bottom line as physician compensation. That in turn suggests that "reasonable compensation" for 10,000 RVUs of services could range from $130,000 to $300,000, depending upon the mix and strength of the underlying payor contracts.

Lest that seem unrealistic on its face, consider the view from the physician working in a private practice holding only "market-best" contracts. Certainly, he/she would not be willing to work for $130,000 per year as if seeing only Medicare patients. Similarly, a physician employed by a hospital or Integrated Delivery System (IDS) with strong contracts for physician services would expect to be compensated at a commensurate rate, rather than have the employing institution retain the excess as profit. Similarly, it is unlikely that the managed care companies and other payors would be paying premium rates per RVU, unless market conditions warranted it and made it necessary to attract physician providers into their networks.

The Non-Medicare Average value per RVU of $48 is an initial reference point for what "market" value for physician services is in this particular circumstance, assuming the Weighted Average Conversion Factor, as described in the following paragraph. The Medicare Conversion Factor is not negotiated but is rather a legislatively imposed *force majeure* disconnected from market forces. As such, it has limited worth in assessing "market" value.

The compensation reported in Survey data such as that of the Medical Group Management Association will reflect the "Weighted Average" compensation or Rate per RVU of only those entities participating in the Survey. In the Example, this compensation would be $190,000. The actual Rate per RVU in a given practice may be more or less than the Survey result. If practices participating in the Survey have a better Payor and Rate mix than all practices in a given area, the compensation will be higher and conversely, if the participating practices have poorer rates, the Survey compensation will be less.

This type of analysis is critical to assessing the fair market value of compensation for hospitals employing physicians. In many markets, integrated provider networks that include both physicians and hospitals succeed in obtaining superior reimbursement from payors, which in turn results in superior compensation. The contracts may be a function of enhanced clinical quality from integration, market-based negotiating leverage, reduced administrative costs to payors due to single-signature contracting, or shifting of contract administration. Traditional analysis focusing solely on Compensation Surveys to determine fair market value may well fall short of the market value of services based upon actual negotiated contracts for providers with a strong market position.

Returning to the Example, assume that an IDS has managed care and other payor agreements that result in the following Payor Distribution and Revenue for a physician practice.

Payor Mix	35.00%	30.00%	35.00%	100.00%
	Medicare	Best	Other Payors	Weighted Average
Total RVUs	3,500	3,000	3,500	10,000
Rate	38.00	55.00	48.00	46.60
Collections	133,000	165,000	168,000	466,000
Practice Expenses	87,500	75,000	87,500	250,000
Physician Income	45,500	90,000	80,500	216,000
Compensation per total RVU	13.00	30.00	23.00	21.60

Note: This Example differs from the first in that the Payor Mix has been applied to the total RVUs of services performed to arrive at the actual compensation earned based upon the given payor mix.

In this case, the actual contracts in place generate physician compensation of $216,000 as compared to the "market" compensation described in the first example of $190,000, or about 14% greater. Solely relying on the Survey result would seem to understate what is "reasonable compensation" for a physician employed in this

particular provider entity. The determination of what is reasonable requires the valuation analyst and the employing provider to have keen insight into market conditions to arrive at an appropriate conclusion.

An appropriate alternative to sole reliance on survey data is to measure the value of compensation per RVU based on data from the practice on revenues and RVUs produced by major payor or payor group. Some analysts will benchmark the physician practice on a more global scale, analyzing collections per RVU to get an overall sense of favorable or unfavorable payor arrangements when the practice is compared against survey data. After this initial "litmus test" is interpreted, exploration of data by payor group, drilling down to compensation per RVU as in the example above, can give an indication as to whether and to what extent favorable or unfavorable payor contracts impact physician compensation. This, essentially the use of the income-based approach in analyzing physician compensation value, supplements the market-based approach conclusions derived from an interpretation of raw survey data.

What becomes clear to the analyst is that simple reliance on single survey data is not enough to yield a completely defensible conclusion of value for compensation under a RVU arrangement. Use of as many independently published surveys and as many different valuation methods as are reasonably available is certainly a prudent practice for those with the responsibility for determining compensation that must be defended as fair market value. Not only should the use of RVUs be considered, but other physician productivity benchmarks (i.e., encounters/visits for primary care, surgical cases for surgeons) may also be appropriate.

Finally, as an observation, physician practice acquisition value is often considered simultaneously with an employment decision and reasonable compensation analysis. In the practice valuation model, it is NOT appropriate to consider payor contracts held by a *particular* purchasing provider entity unless such contracts are common to the universe of potential purchasing entities in the market. This is because such an adjustment would be inconsistent with fair market value's requirement for "*any* willing buyer."

In contrast, compensation is a function of who employs you and what your services are worth at the time they are performed. From the standpoint of the hypothetical seller of services—i.e., the employed physician—being employed at a rate less than what the market is paying his or her employer currently for the physician's services would be inconsistent with the expected result in arms-length negotiation where reasonable knowledge is present. Thus, a physician practice may have a low value because there is little profit once the physician receives reasonable compensation for services based upon the practice's existing contracts. However, the physician may be better compensated in the future because his or her new employer holds better payor contracts.

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[1] It is important to note that most compensation systems focus on the physician Work RVU component (WRVU), which is but one component of the RBRVS measuring of total RVU values; the other two are practice expense and malpractice insurance cost. This allows for measurement of physician productivity using a measurement tool that essentially measures those areas of productivity that are under the control of the physician.