Physician Compensation in a Value-Based World
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Basing physician compensation on work relative value units (WRVUs) has been a prevalent model in a productivity-based world. Translating this model to a new world of value-based reimbursement will not be easy.

Paying physicians based on dollars per WRVU or a percentage of net collections works well to reward physician work and effort. This method is clearly aligned with the revenue stream of a medical practice – the more you do, the more you get paid. It attempts to match compensation to the work effort of the physician. Those that work more are paid more and those that work less are paid less. What could be more equitable than that? – but wait!

The federal government and commercial payers are banking on a new model to reimburse physicians for their work. Value-based purchasing programs, ACO financial contracts, bundled payment, shared savings models, and flat fees are models that are being tested and tried today. Doing more and more may mean getting paid less and less in the new world of paying for the quality and cost of care – and the appropriateness of that care, to the patient's situation.

There is a long road ahead before all payers transition away from fee-for-service. Relative value units are not set to expire any time soon. CMS's underlying strategy for the Medicare Physician Fee Schedule is based on Relative Value Units – attempting to determine the right balance of work, expense of practice, and malpractice expense, to pay the "right" amount for a CPT code. This model has many faults, but it is an attempt to apply a quasi-scientific, numbers-based approach to a very complicated situation.

So, what is the answer for the new world of reimbursement reform? Base plus incentive plans for physician compensation likely will emerge as a key strategy in the next few years, followed by more robust plans – once we have "perfected" the quality and cost measures. Base plus incentive compensation plans include targeted expectations for the base salary portion of compensation, coupled with incentives or variable compensation based on "extra" performance. Expectations for base salary earnings include clinical productivity, quality care, coding and documentation accuracy, patient experience scores, and others. These base salary expectations essentially define the culture of a practice and what is expected of its physicians.

The transition time is now. A portion of the dollars per WRVU payments or net collections can be set aside, with this fund used to reimburse physicians on cost and quality indices. Down the road if we have mixed revenue streams it would be nonsensical to try to tie each revenue stream to the physician's compensation. Can you imagine the administrative complexity involved of tracking the bundled payments, the

shared savings, the pay-for-performance, and the flat fee payments received to each patient's individual service and then tracking this information for each physician? It would not be prudent to try to create "add-on" situations for this revenue or that revenue, however, an aligned model – transitioning from productivity to performance is in the cards.

If you are interested in transitioning along the path away from a focus on productivity to value, consider the following steps:

1. Lower the dollars per WRVU to be paid or the percent of net collections to be paid by 10 percent (or more) and create a value pool.
2. Determine the cost and quality measures important for your practice. You can adopt measures from PQRS, eRx, EHR meaningful use, your patient satisfaction surveys and other similar tools – until we develop better measures in the future. Create a 5-point scale for each of the measures and evaluate each physician on the scale.
3. Compute the percent to total points for each physician and distribute the value pool accordingly.

What will this accomplish? It will begin the dialogue with physicians and facilitate a shift in focus from productivity to value. A continued reliance on productivity just may mark you as a tier 2 or tier 3 medical practice in the payers' eyes – not the kind of reputation you need with payers or your patients in today's value-based world.