Compensation 101

“What, we get paid for this?”

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Disclosures

Stock ownership:


Ownership:

The St. Vincent Heart Center of Indiana, LLC

Details available as reported on acc.org
Compensation: 101

- Historical perspective
- What makes up Physician Compensation?
- Models: Funding and Distribution
- Benchmarks/Trends
- Designing a Compensation Plan
- Future directions: “Volume to Value”
Compensation: Purpose

• To assign a monetary value to services rendered
• To reward achieving defined measures of success
• To incentivize desired behaviors and outcomes
Compensation: Historical Milestones

• **1989: RBRVS – RVU’s**
  – Physician Work based on time and intensity for each CPT - RUC

  – Ban self-referral of Medicare patients, exempted sites/services

• **2000: Hospital Out-Patient Payment System (HOPPS)**
  – Payments for hospital based services >office.
Compensation: Historical Milestones

- 2006: Medicare PFS cuts for cath, imaging
- 2008: Integration takes off
- 2009: Bundling of Medicare payments
  - Cath (-11%), Nuc (-15%), Echo (-22%)
- 2013: Expansion of MPPR
  - Each Additional office service -25%
Cuts in the Office, Gains in the Hospital

Office:
- Cath: -62%
- Nuc: -18%
- Echo: -57%

HOPPS:
- Cath: +16%
- Nuc: +27%
- Echo: N/C

Compensation Funding

Clinical Production:
- Salary
- Time based Pay
- RVU Production
- Provider
- Technical

Non-Clinical Work:
- Quality Incentives
- Management/Admin.
- MSSP, Supply Chain
- Education/Research
- Outreach

Distribution Plan

COMP POOL

$ $ $
Distribution Plans

“When you have seen one compensation plan, ... you have seen one compensation plan!”

Cardiac Socialism
- Straight Salary
- Even Split

Compassionate Conservatism
- Base Salary (80-90%)
- Group/System incentive
- Personal incentive
- Quality incentive
- Non-clinical work
- Time Value Units (rTVU’s)

Cardiac Capitalism
- “Eat what you kill”
- Individual production
- Revenue minus expense
Compensation: Fair Market Value Analysis
Must be applied to the “Pool” and Individuals

• Statutes – Goal: Prevent “Inurement”
  – Stark Laws, False Claims Act
  – Anti-Kickback Laws
  – Tax Code – “Non-Profit” organizations
  – U.S. vs. Toumey Healthcare, SC - $237 million

• Tools to determine FMV:
  – Benchmarks: MedAxiom, MGMA, FMV Consultants
  – Hourly Rates
  – $/RVU
Compensation Trends

8.5% drop

Integration
Provider-Based Billing
Quality Incentives
CVSL Management
Protecting Referrals

Reduced RVU’s
AUC’s/RBM’s
HD Plans
Renegotiations

Trends same for all Sub-Specialties

Integration Still Enjoys a Premium

Despite recent decline in Total Comp., physicians in Integrated practices still are ahead of where they were pre-integration.

**FIGURE 18 – MEDIAN COMPENSATION PER FTE CARD**

<table>
<thead>
<tr>
<th>Year</th>
<th>Private</th>
<th>Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>$430,418</td>
<td>$513,371</td>
</tr>
<tr>
<td>2011</td>
<td>$457,661</td>
<td>$549,999</td>
</tr>
<tr>
<td>2012</td>
<td>$465,815</td>
<td>$588,996</td>
</tr>
<tr>
<td>2013</td>
<td>$424,380</td>
<td>$548,630</td>
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</tbody>
</table>

Recent Reduction in Compensation Parallels Reduction in RVU’s

FIGURE 24 – wRVU PER CARDIOLOGIST BY OWNERSHIP MODEL

Narrowing gap by ownership model

<table>
<thead>
<tr>
<th>Year</th>
<th>Private</th>
<th>Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>10,507</td>
<td>10,084</td>
</tr>
<tr>
<td>2011</td>
<td>10,336</td>
<td>9,678</td>
</tr>
<tr>
<td>2012</td>
<td>10,536</td>
<td>9,709</td>
</tr>
<tr>
<td>2013</td>
<td>9,948</td>
<td>9,407</td>
</tr>
</tbody>
</table>

5.6% drop
3.1% drop

... Despite seeing the Same Patients

Why? Fewer Nuc’s, echo’s, cath’s, PCI’s, CRM devices, etc.

**FIGURE 32 – TREND OF COGNITIVE ENCOUNTERS PER CARDIOLOGIST**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Cognitive</th>
<th>Office Cognitive</th>
<th>Hospital Cognitive</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>2,845</td>
<td>1,853</td>
<td>965</td>
</tr>
<tr>
<td>2011</td>
<td>2,816</td>
<td>1,878</td>
<td>954</td>
</tr>
<tr>
<td>2012</td>
<td>2,819</td>
<td>1,849</td>
<td>867</td>
</tr>
<tr>
<td>2013</td>
<td>2,856</td>
<td>1,854</td>
<td>851</td>
</tr>
</tbody>
</table>

Compensation: Perspective

Annual Income

- Teacher
- Policeman
- U.S. Median
- RN
- Nurse Practitioner
- Pediatrician
- Primary Care
- Hospital CEO
- "Top 1%"
- Cardiologist
- Orthopedics
- Neurosurgeon
- Health System CEO

Sources: Bureau of Labor Stat., NY Times 1/14/12, USN&WR 2013, Becker’s Hospital Review 10/21/13, Forbes 2/12/13, MedAxiom 2014, MGMA
Designing the Perfect Compensation Plan

• There is no perfect compensation plan!

• Comp. Plans are a reflection of philosophy, values, environment, and desired behaviors
  – Fair
  – Transparent
  – Mutually beneficial to both parties
  – Promote performance excellence
  – Define effective Governance
Designing the Perfect Compensation Plan
When in doubt, ask the experts!

• Highly scientific on-line survey: 3/8 – 3/10/15
  – ACC BOG
  – MedAxiom Members
  – St. Vincent Health/SVMG leadership

• 60 Respondents:
  – Role: 66% Cardiologists, 34% Administration
  – Practice: 63% Integrated, 21% Independent, 16% Academic
Survey: Priorities for Comp. Plan

- Total dollar amount possible (base + bonus)
- Duration of contract
- Simplicity of design
- Incentives: System/Group
- Incentives: Personal success or production
- Incentives: Quality metrics
- Amount (%) of total compensation "at risk"
- Adaptable to changing payment models
- Standardized across a system
- Defined terms of termination
Role: Physician v. Administration

Priority Score

* p<0.05

- Total $
- Duration
- Simplicity
- System/Group Success
- Personal Success
- Quality metrics
- % at risk
- Adaptable Model
- Standardized
termination

Physician
Administration
# Compensation: Different Points of View

<table>
<thead>
<tr>
<th>Rank</th>
<th>Physicians</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Total Amount ($’s)*</td>
<td>System/Group Incentives</td>
</tr>
<tr>
<td>2.</td>
<td>System/Group Incent.</td>
<td>Quality Metrics</td>
</tr>
<tr>
<td>3</td>
<td>Personal Incentives*</td>
<td>Total Amount ($’s)</td>
</tr>
</tbody>
</table>

Least important for all: Termination language, Standardization

*Difference $p<0.05$ vs other group
Practice Type:
Academic v. Integrated v. Independent
### Compensation: Different Points of View

**Same Priorities, different order**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Academic</th>
<th>Integrated</th>
<th>Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>System/Grp Incent.</td>
<td>System/Grp Incent.</td>
<td>Total $’s</td>
</tr>
<tr>
<td>2.</td>
<td>Personal Incentives</td>
<td>Total Amount ($’s)</td>
<td>System/Grp Incent.</td>
</tr>
<tr>
<td>3.</td>
<td>Total $’s/Quality</td>
<td>Personal Incent./Quality</td>
<td>Personal Incent./Quality</td>
</tr>
</tbody>
</table>

Least important for all: Termination language, Standardization
Shifting from Volume to Value

Less from FFS, but more from:
- Quality metrics
- CVSL mgmt.
- Cost reductions
- System success
- Pop. health
- Education
- Research
- Outreach
As payment models evolve, compensation funding and distribution can adapt to promote and reward desired behaviors and outcomes.

Gerald Blackwell, ACC CV Summit 2015
Compensation 101: Summary

• Impact of Medicare payments and regulation
• Comp. Pool Funding: Clinical vs Non-Clinical
• Comp. Pool vs Distribution
• Integration vs Pvt. Practice
• Shift from Volume to Value
• Remember, it is still all about the Patient
Suggested Reading


– MedAxiom Physician Compensation and Production Survey 2014
http://www.medaxiom.com/main/surveys/

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Questions?

Institute for Advanced Training in Cardiology