

Practice Management: A Comprehensive Update on Trends in the Cardiovascular Service Line

Compensation 101

“What, we get paid for this?”

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Disclosures

Stock ownership:

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The St. Vincent Heart Center of Indiana, LLC

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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
- **1991: Stark Laws (I – 1992, II – 1993, III – 2007)**
 - Ban self-referral of Medicare patients, exempted sites/services
- **2000: Hospital Out-Patient Payment System (HOPPS)**
 - Payments for hospital based services >office.

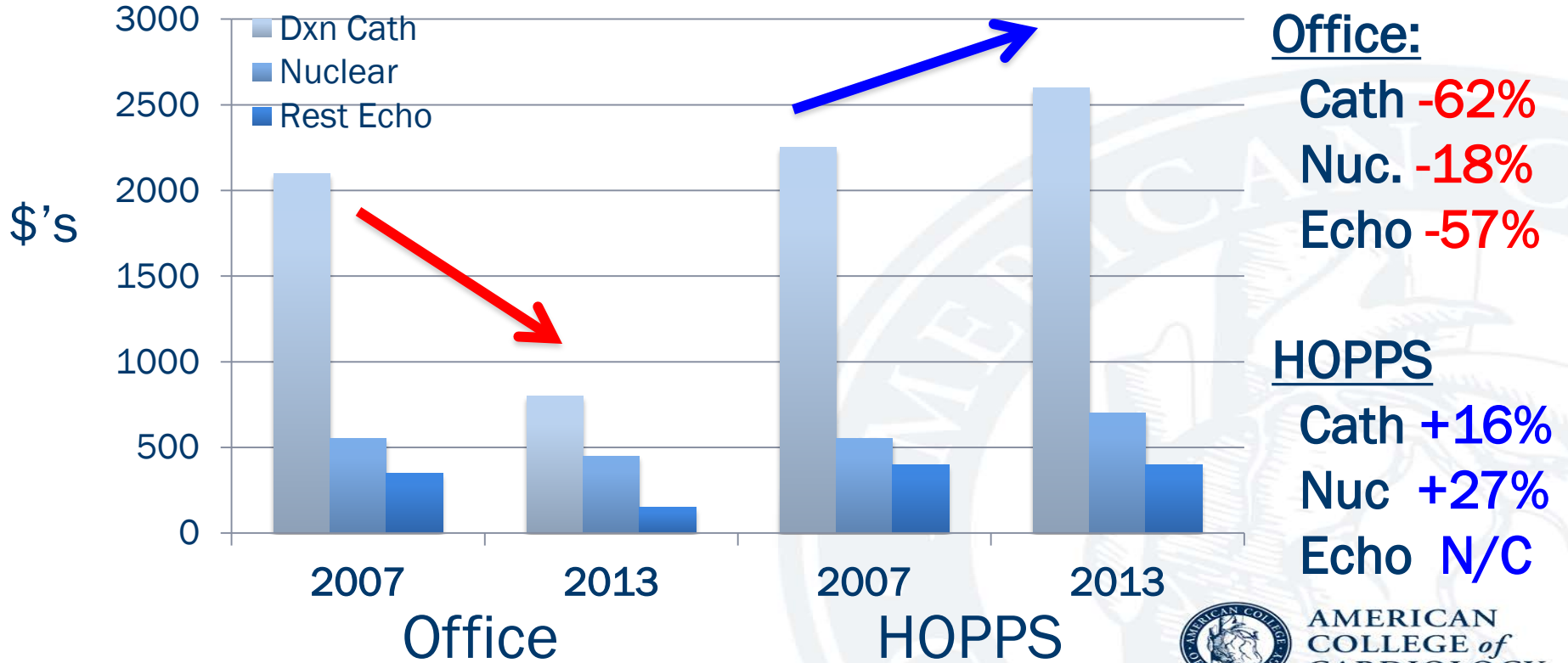


Compensation: Historical Milestones

- 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



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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

**COMP
POOL**

Distribution Plan



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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



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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



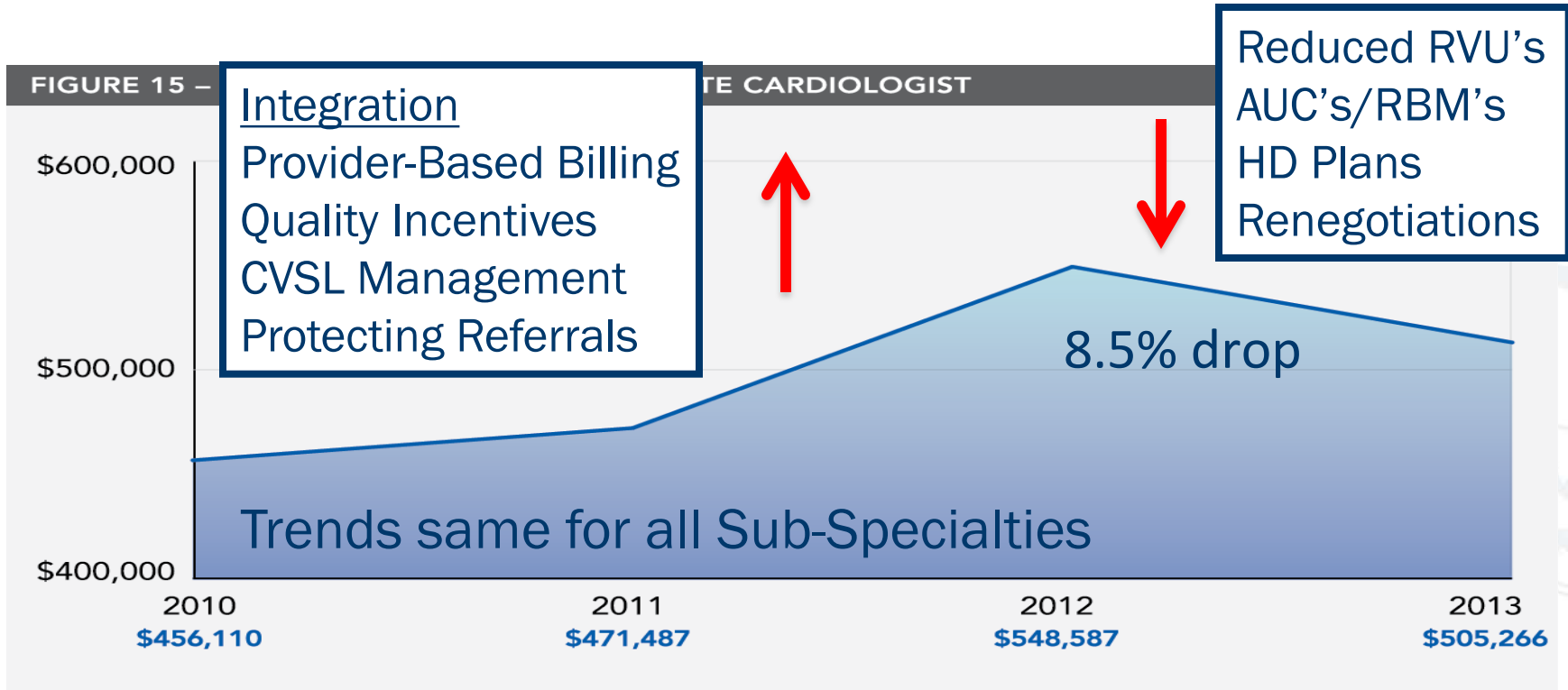
- Tools to determine FMV:

- Benchmarks: MedAxiom, MGMA, FMV Consultants
- Hourly Rates
- \$/RVU



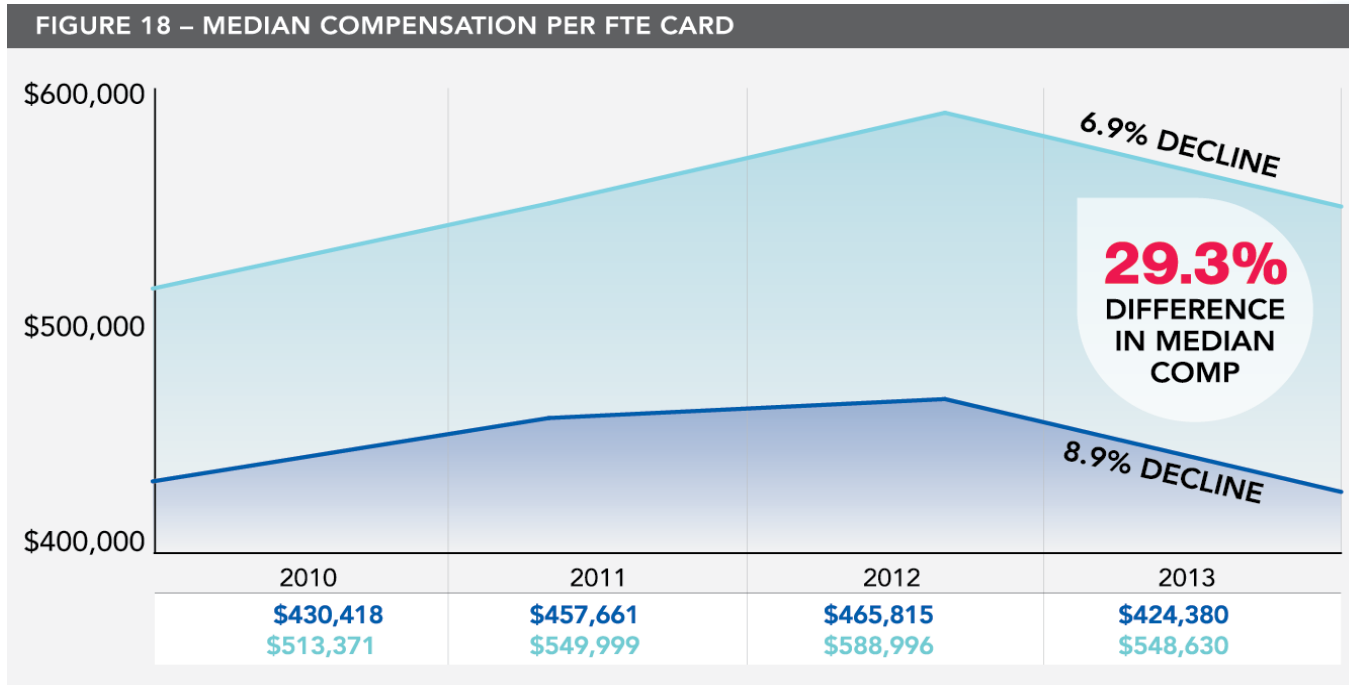
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Compensation Trends



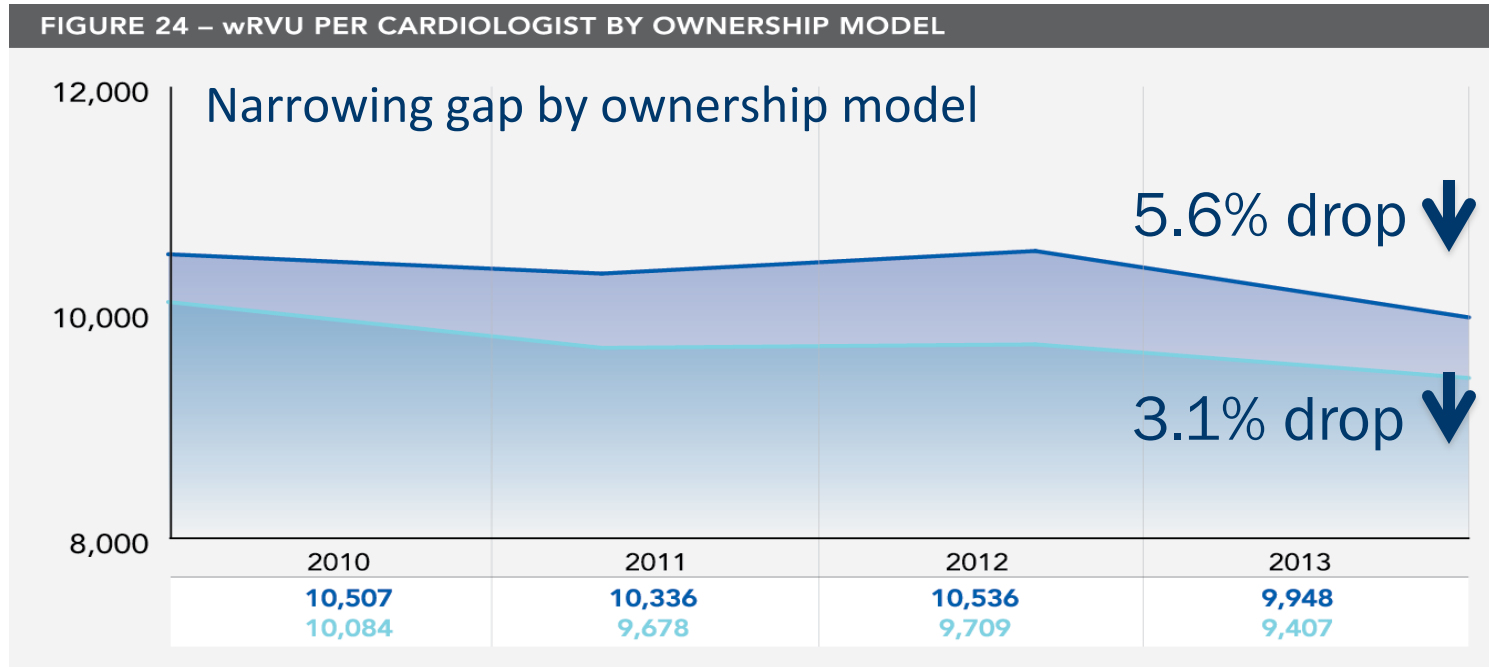
Integration Still Enjoys a Premium

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



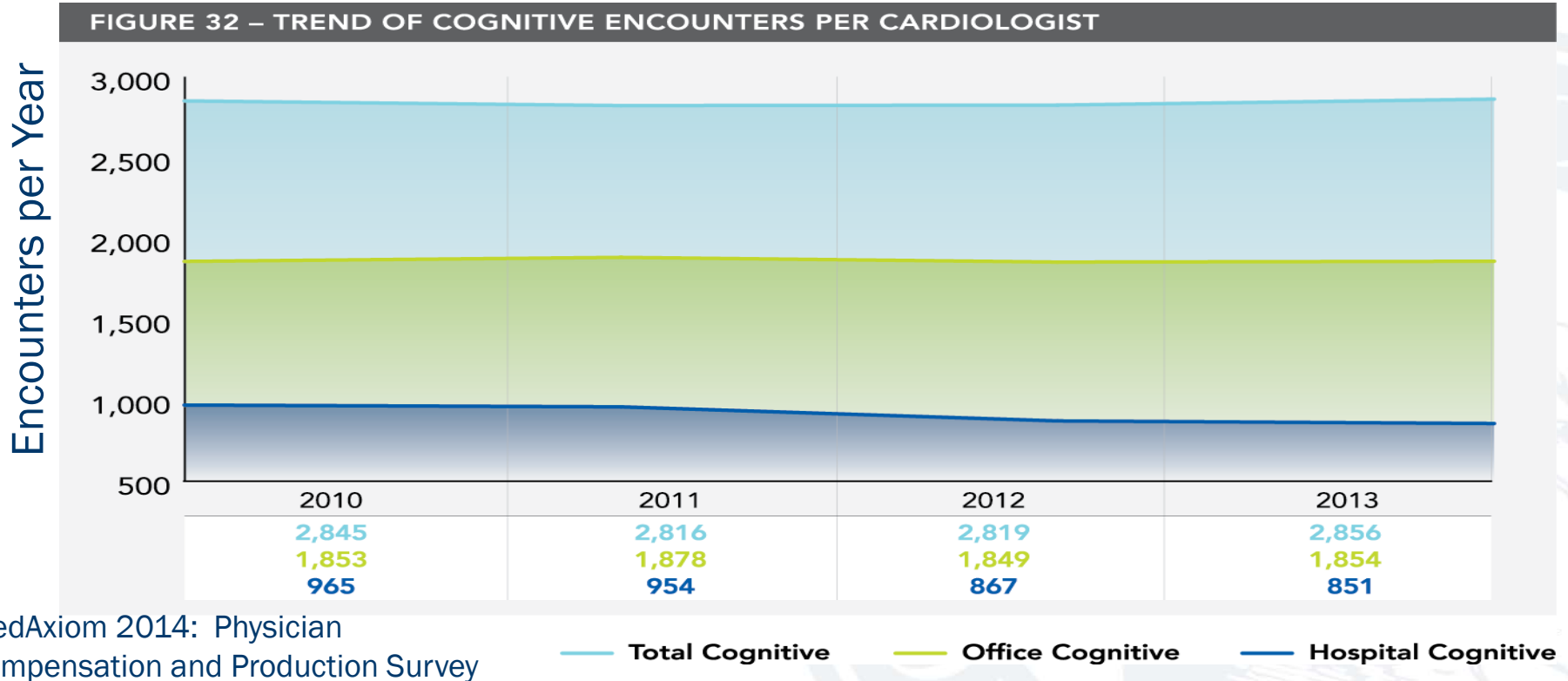
Recent Reduction in Compensation Parallels Reduction in RVU's

FIGURE 24 – wRVU PER CARDIOLOGIST BY OWNERSHIP MODEL

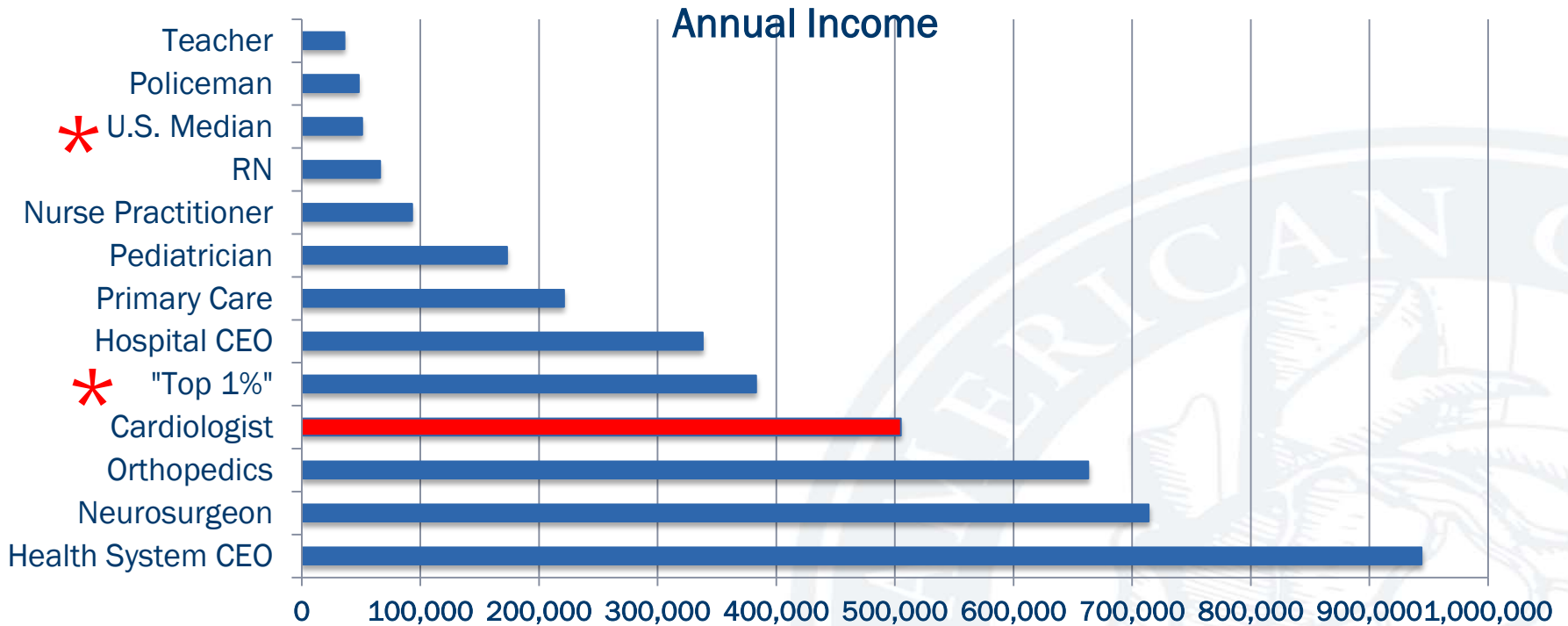


... Despite seeing the Same Patients

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



Compensation: Perspective



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



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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



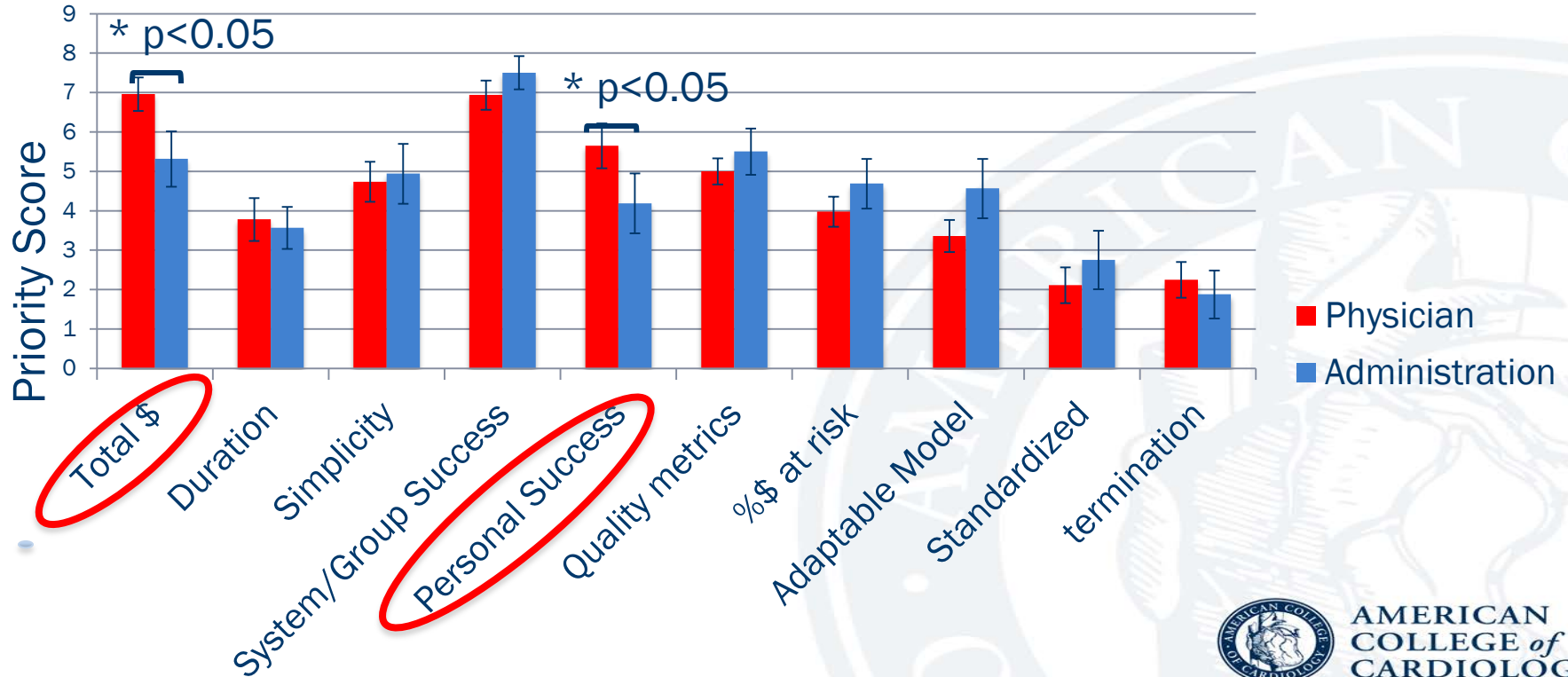
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Survey: Priorities for Comp. Plan

- 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



Compensation: Different Points of View

Rank	Physicians	Administration
1.	Total Amount (\$'s)*	System/Group Incentives
2.	System/Group Incent.	Quality Metrics
3	Personal Incentives*	Total Amount (\$'s)

Least important for all: Termination language, Standardization

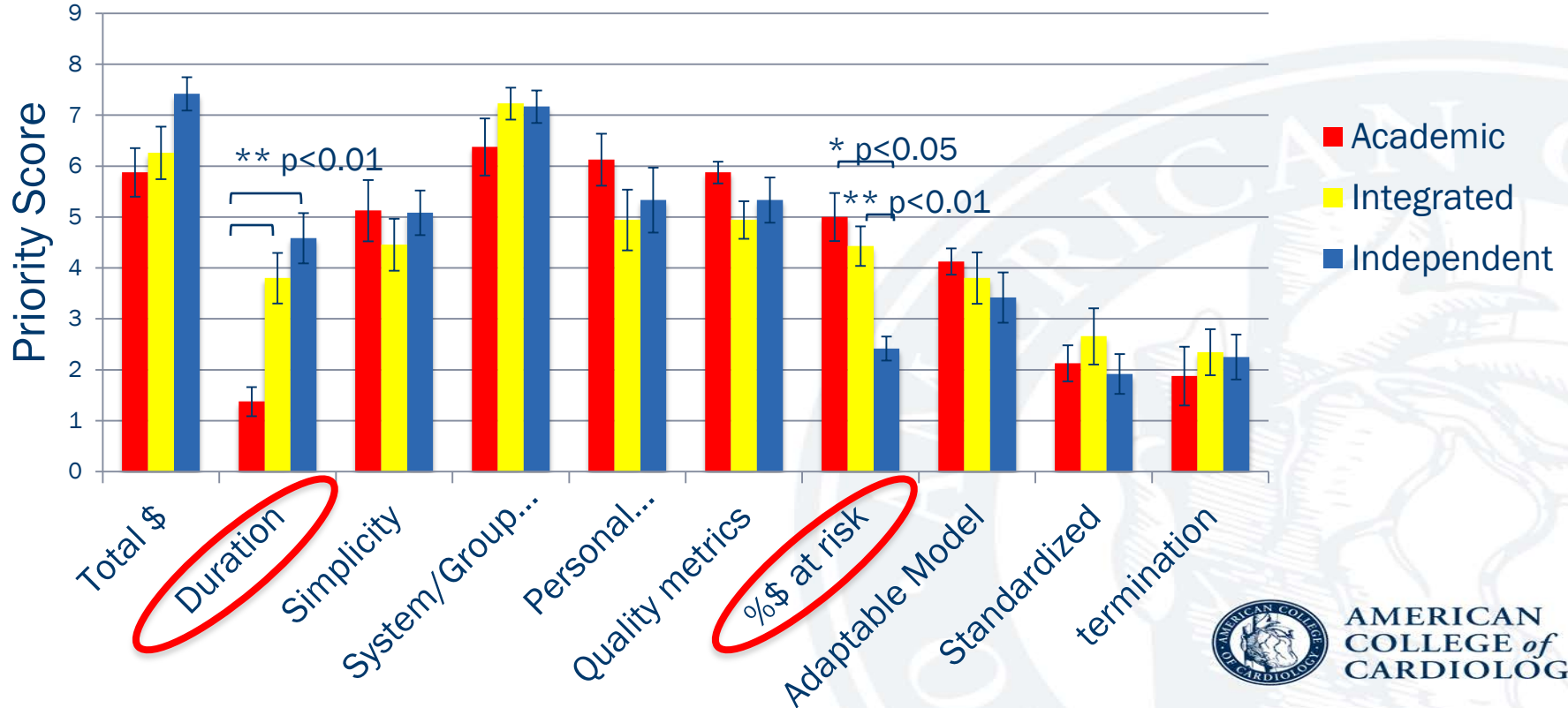
*Difference $p < 0.05$ vs other group



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Practice Type:

Academic v. Integrated v. Independent



Compensation: Different Points of View

Same Priorities, different order

Rank	Academic	Integrated	Independent
1.	System/Grp Incent.	System/Grp Incent.	Total \$'s
2.	Personal Incentives	Total Amount (\$'s)	System/Grp Incent.
3.	Total \$'s/Quality	Personal Incent./Quality	Personal Incent./Quality

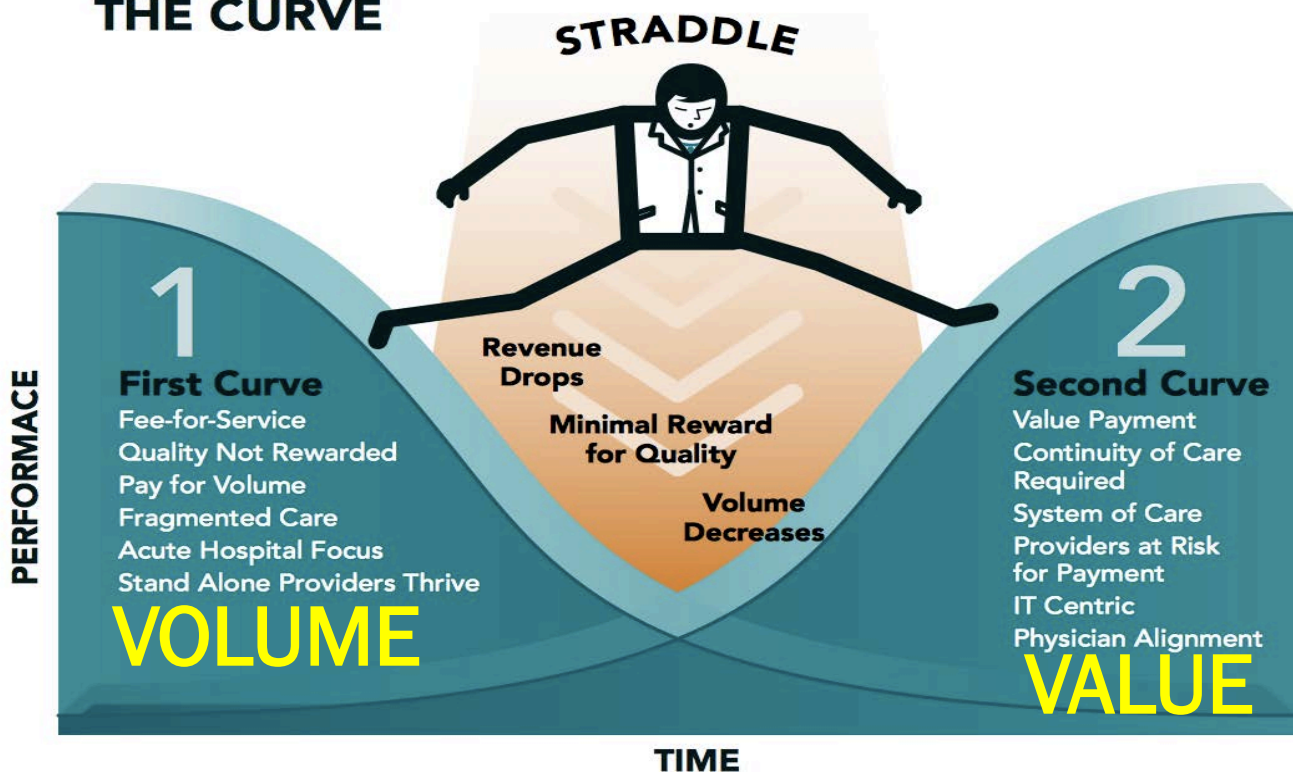
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Shifting from Volume to Value

THE CURVE

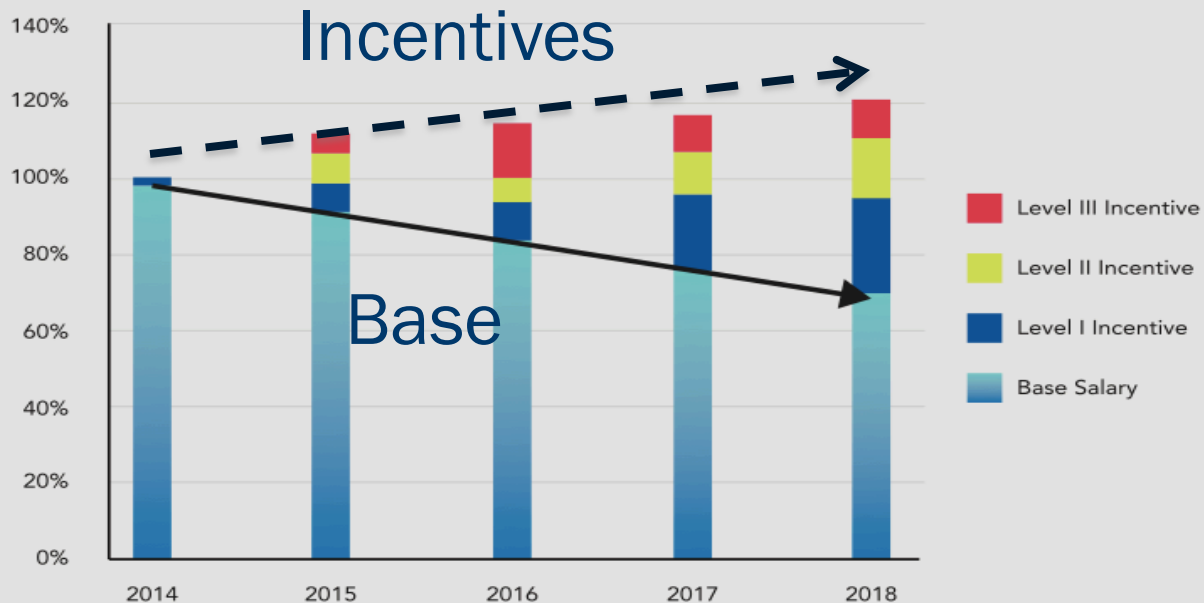


Less from FFS, but more from:

- Quality metrics
- CVSL mgmt.
- Cost reductions
- System success
- Pop. health
- Education
- Research
- Outreach

Volume to Value: Evolving New Plans

FIGURE 4
EXAMPLE OF VALUE-BASED PLAN ADOPTION OVER TIME



As payment models evolve, compensation funding and distribution can adapt to promote and reward desired behaviors and outcomes



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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

- Ferrari V., et al. Cardiovascular Imaging Payment and Reimbursement Systems. JACC Imaging 2014;7:324-332
- MedAxiom Physician Compensation and Production Survey 2014
<http://www.medaxiom.com/main/surveys/>

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Questions?



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