Five “Must-Have” Components of a Cardiology Physician Compensation

What You Should Know to Make Your Coming Negotiations Flow More Smoothly

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The past five years in cardiology have seen a tremendous shift from private practice to integrated practices. Today, those initial contracts are coming up for review, with physician compensation once again a major issue. During the initial contracting discussions, most deals between physicians and health care organizations stabilized physician compensation. By contrast, the coming round of contract negotiations will be centered on ensuring continued value for both sides from the relationship. While compensation redesign can be a very disruptive and potentially contentious process, we have identified five components that should be considered in the redesign of any cardiology physician compensation plan.

1. Your practice must value team members’ contributions:

In cardiology, more than any other specialty, creating internal equity is complicated by the natural sub-division of the specialty, now defined as Interventional, Electrophysiology, Invasive and Non-Invasive. Recent trends are further defining sup-specialization as a method of differentiating the expertise of the program and division of labor. This may add, however, to the complexity of developing an equitable cardiology compensation plan.

One trend that may be further enhancing the division is the continued integration of practices into larger groups. Most integration efforts have been based on market share gain, economies of scale, or leverage in buying power or negotiation power and have not taken the impact on compensation models into account. As a result, these integrated groups and organizations are now faced with compensation re-design; the new plans must take into account the fact that these newly developed groups may have inherent divisions based on their location; groups that may not have worked together in the past must now share in compensation, even if they are not equally sharing their workload.

Most cardiology groups have traditionally deployed an equal share distribution model, also called “Lump and Split.” These models were designed to value each sub-division’s contribution, sharing of work and for the most part the sharing of call assignment, the exception being interventional call.
Today, groups are finding that there is less sharing of work, primarily because of geographic spread, or the further development of expertise models, e.g., Heart Failure sub-specialization. As a result, compensation models now value productivity to a greater degree than contribution.

Figure 1 is a graph of 2012 median physician compensation and WRVU (Work Relative Value Unit) productivity, measured by the type of distribution plan. Productivity compensation models have the best correlation to work output and compensation, and are best used in single specialty groups where access to work is not an issue. However the plans do not recognize contribution outside of pure WRVUs. The Equal Share models show little correlation to work output and compensation, while these models have traditionally rewarded contributions; however, organizations are finding it increasingly harder to quantify contributions when work is not shared. There is a trend in the data that shows more physicians now using a blended distribution model, defined as a blend between equal distribution and productivity-based distribution. The majority of the 1,002 physicians who are using a blended model (49%) are part of integrated practices, with the remaining 45% practicing in privately-held practices.

Another emerging trend reveals that productivity incentives are not going away. The data reveal that more than 70% of cardiologists now consider some element of production in their compensation model, with either full productivity or blended models.

2. Your practice must adapt to the changing environment

Over the last five years, MedAxiom has measured a substantial movement from privately-held, independent cardiology practices to integration, with doctors either merging with similar-sized practices, or their practices acquired by larger health care organizations (HCOs), such as hospital systems. Most of the business contracts, including physician compensation, are now coming up for re-negotiation; both sides are asking whether the integration model makes sense from a business perspective.

A similar question was raised more than a generation ago: during that time physician employment models did not meet the business expectation of the hospital partners, the result was a majority of the physician employment deals were undone and physicians went back to private practice. As a result, a majority of the physician employment deals were undone and physicians returned to private practice. Today, the situation is vastly different, with declining reimbursements and uncertainty with the accelerated change in healthcare reform, including bundled payment projects and the rise of Accountable Care Organizations (ACOs). Today’s conventional wisdom has the future of healthcare centered on developing partnerships, where partners seek economies of scale, transforming care delivery to reduce cost. In this environment, the development of an advanced IT infrastructure and the intensive analysis of data will be needed to survive.

Even with the shift in healthcare toward outcomes-based medicine, most systems and physicians still rely on fee-for-service to pay the bills. Figures 2 and 3 illustrate physician compensation and work productivity (defined by WRVUs) by ownership model. While cardiologists in integrated practices earned an average of 15% more than their private practices counterparts in 2012, cardiologists in private practices worked harder, generating an average of 8.9% more WRVUs.
3. Your practice must be aligned, and measurable

Revising compensation plans should not be used to change a bad culture nor to fix existing problems within a practice or organization. On the other hand, it is certainly true that a bad compensation design can either create barriers to success or enhance already unwanted behaviors or outcomes.

Take, for instance, a health system that wants to implement an EMR system. In order to qualify for Affordable Care Act (ACA) funding, meaningful use criteria requires the implementation and demonstrated use of CPOE (Computerized Physician Order Entry). If the system’s physicians are paid purely on traditional productivity criteria (e.g., WRVU, visits, net revenue), any disruption in the established pattern will likely be met with severe resistance. This can end up costing the organization not only revenue, but political capital as well.

As organizations consider alignment-based incentives, there must be clear definitions of the metrics, as well as clear communication on how physicians can affect those measures. The first issue is, “Can the organization measure effectively things like patients satisfaction or employee engagement?” While these may be important to the organization, the ability to have solid data, available in a timely manner, is challenging for some. It will be important that these issues are considered as you want to build a trusting culture.

Second, when designing alignment metrics, it is important to clearly define how physicians can change or influence the outcomes, as well as to identify where they cannot. Physicians are inherently concerned with measures that they cannot control. For example, patient satisfaction scores tend to measure the entire patient experience, including non-medical items such as parking, check-in, and facilities. Yet, physician compensation may be at risk, even if they may have only interacted with the patient for less than 10% of that time. While patient satisfaction may be a first generation metric, groups that are more mature are looking at metrics that are much more relevant to the care delivery such as length of stay, cost per case and readmission rates.

Today, more than ever, health systems are looking to develop clinically, organizationally and culturally integrated systems, where care is considered across the continuum and not just in episodic care. Furthermore, they seek to promote the idea that the talents of the newly integrated organization can come together to create value for the patient by leveraging and optimizing the performance of a single unified entity.

The creation of trust must be at the center of alignment and fully integrated systems in order to achieve value. Well-designed compensation plans will promote the clinical, organizational and cultural objectives of the system. By contrast, a poorly designed plan will erect a barrier or can even destroy trust over time.

4. You must be able to withstand emerging market forces

While the future track of health care reform is still uncertain, several key trends are already emerging. These trends will likely predominate and should therefore be considered when developing a compensation plan:

A. Cardiologists are going to be asked to do less per patient, but care for more patients per physician. One measure that is emerging to consider population management is patient panel size. Patient panel size is defined as the number of unique patient visits in an 18-month period of time.

B. Downward pressures on reimbursement will continue. Therefore, healthcare systems and cardiologist will partner to drive costs out of the system, including lowering supply costs, reducing length of stay, improving quality, and improving workflow efficiencies.

C. With increased partnerships and integration, there will be more need to develop physician leaders.

D. The implementation of appropriate use criteria (AUC) in cardiology imaging and device implants will lead to an increase in consistency and standardization of care.
E. With a growing focus on outcomes-based medicine, practices will need to move to a Clinical Integration model, where care is viewed as multi-disciplinary disease management across a continuum, rather than the traditional delivery of episodic care.

F. To achieve innovative healthcare delivery, such as virtual care or multi-disciplinary care, organizations of all sizes will need to invest in emerging technologies in order to gain and maintain a competitive advantage. This will be increasingly important, especially as more patients rely on Internet portals, both government- and privately-based, for information about costs and quality of care.

Physician compensation plans must consider that doctors will be doing less clinical work over time. Figure 4 is a graphic of a compensation design that shows a reduction in pay related to productivity, with a corresponding increase in “other” incentive measures aligned with organizational goals. Note that as the percentage of compensation at risk increases, so does the potential total compensation available.

5. You must meet Fair Market Value, Legal and Compliance standards

For groups and organization that have aligned or integrated with hospital systems, recent court rulings (e.g., the $277 million Federal fine levied against Tuomey Healthcare System and Marion General Hospital) challenge previously accepted compensation architecture, requiring deeper examination of the models and design.

Regardless of the ownership model, organizations must consider best practices when taking a compensation redesign under consideration. It is also much more efficient to have a representative responsible for Fair Market Value review and Legal and Compliance involved from the beginning.

The healthcare landscape is changing rapidly, with greater pressure to reduce costs. At the same time, physicians are seeing more patients per day than ever before and being called upon to deliver higher quality care. Despite this, most physicians are still paid predominantly on a volume basis, even as groups are actively considering a move toward the Accountable Care Organization model, assuming risk for patients with chronic disease such as heart failure or coronary artery disease.

All these factors are converging during a time when some predict there will be a shortage of practicing cardiologists within the next dozen years. A well-designed compensation plan is mandatory for cardiology groups to continue to retain and recruit the physicians they need to serve their patients. These plans, however, must be internally equitable and external competitive while aligning the physician group with the strategic goals of the larger organization. Cardiologists who adopt the above principles in their coming negotiations will be seen as better understanding the larger picture, and will be considered as more valuable “team players,” thus entitled to compensation that both sides consider to be equitable.

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1 (For the purposes of this article, we define “integrated” as an employment, professional service agreement or management service agreement between a hospital or health system and physicians.)