Physician Compensation: Evolving Trends

Cathleen Biga
President/CEO Cardiovascular Management of Illinois
cbiga@cardiacmgmt.com

ACC Practice made Perfect Podcast

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Agenda

- Environmental trends in compensation
- Comp design
- Practice setting and comp distribution
- Real world examples

Key Questions for FIT's

- Is salary guaranteed or not?
  - Year 1 or 2 would suggest guarantee for ramp up
- Base pay consistent or productivity dependent?
- What is call? How is it compensated? Is it the same for all?
- How do senior physicians transition out of call?

What is included in Physician Comp

- Guaranteed or not?
- Base pay consistent or productivity dependent?
- Benefits
  - Health, dental, LTD (is there a cap?), Short Term (how long before eligible? Is there a cap?)
  - Med Mal – if I leave is there a tail?
  - Pension: Profit sharing, 401K, 403B, 457B's
- Direct patient revenue, admin time, at risk $
- CV SL monies (?)

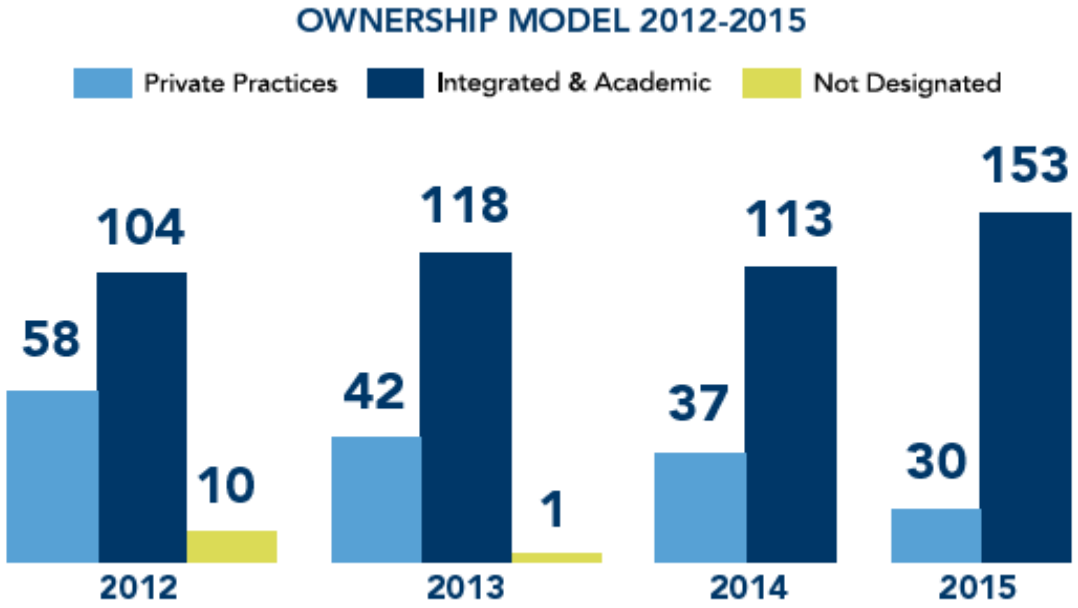
What is Changing

- Will be paid and graded on:
  - Coordinated Care / Preventative Care
  - Efficiency
  - Outcomes
  - Quality metrics
  - Patient Engagement
- Payment will be achieved thru:
  - Episodes of care
  - APM's

What stays the Same (sort of)

- Volume still matters:
  - From providing a Lot services to patients
  - To providing services to a Lot of patients
  - The more patients you do/can service the more attractive you will be to insurers, employers, etc.
  - Larger Patient Panel = dilution of risk
    - Utilization analyzed via patient panel
  - Scale matters to insurers
    - Single point of contact & coordination of care

Ownership Trends



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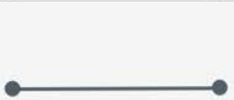
10 Year Picture

Evolution of Practice Ownership: Increase in Hospital Ownership; Decrease in Physician Ownership

Practices that are owned by a Hospital/IDS have nearly quadrupled since 2007 while there are half as many Physician owned practices now as in 2007. In addition, 4.5% of practices today did not exist 10 years ago.

% of Practices 0.3% 64.1%

	2007	2017	Evolution of Practice Ownership
Hospital/Integrated Delivery System (IDS) owned	11.7%	45.0%	
Physician owned	64.1%	34.2%	
Medical school/University owned	10.6%	11.6%	
Government owned	4.3%	4.9%	
Insurance company / HMO owned	0.3%	0.7%	
Other	2.5%	3.2%	
Not sure	1.9%	0.4%	

Q. What is the ownership structure of your practice? I Ten years ago (in 2007), who was the majority owner of your practice?

Source: 2017 ACC Practice Census Study

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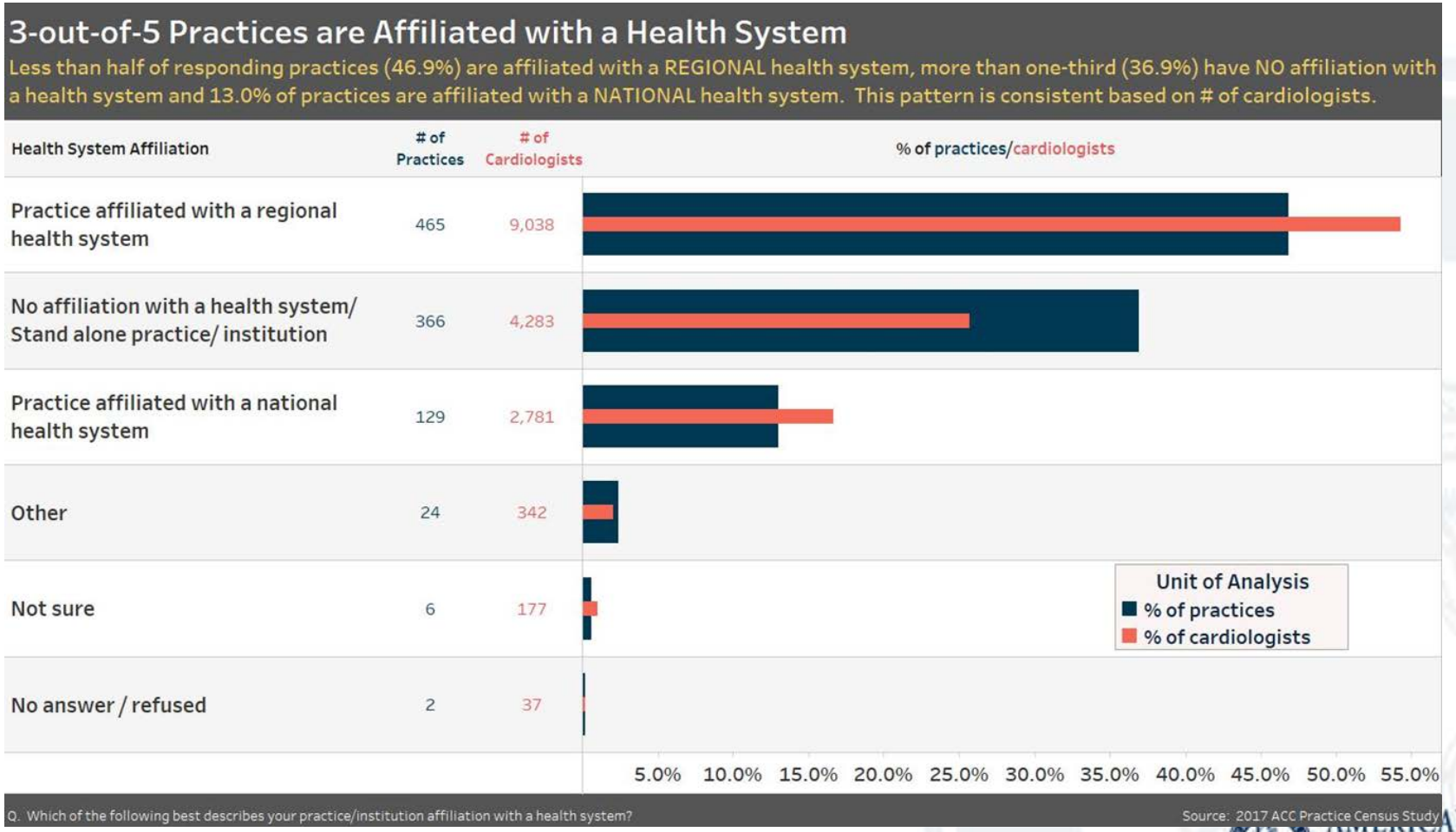
Ownership Trends…..



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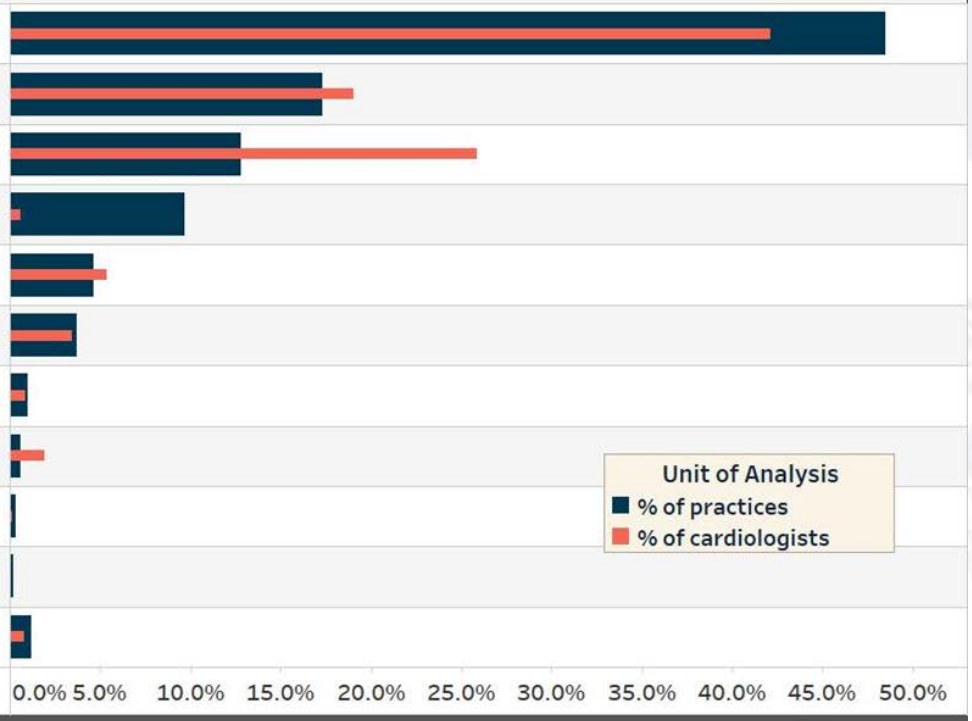
ACC practice Survey: 2017 Report

CV Group is the Predominant Practice Type

Roughly half of responding practices, 481 out of 992 (48.5%), indicate their practice is part of a CV Group, 17.3% are part of a Multi-Specialty Group and 12.8% are part of a Med School/University. Med School jumps to second most popular practice setting based on # of cardiologists.

Practice Type	# of Practices	# of Cardiologists
Cardiovascular Group	481	7,012
Multi-Specialty Group	172	3,166
Medical School or University	127	4,309
Solo Practice	96	96
Non-Government Hospital	46	895
Gov't Hospital or Agency - VA	37	570
Government Hospital or Agency - Other	10	139
HMO	6	319
Government Hospital or Agency - Military	3	18
Industry	2	2
Other	12	131



Q. To begin, how would you best classify your practice?

Source: 2017 ACC Practice Census Study

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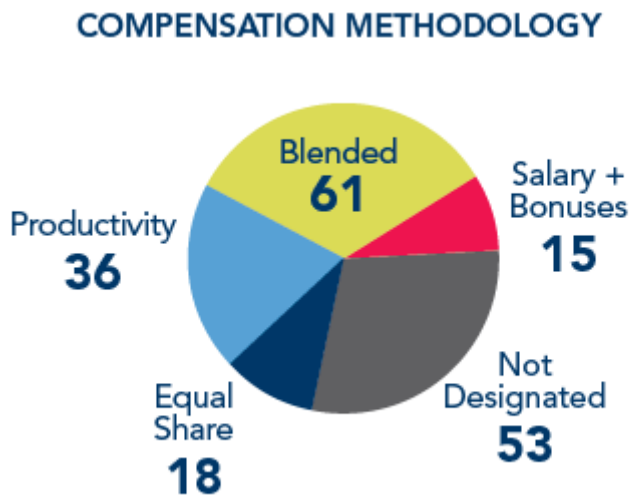
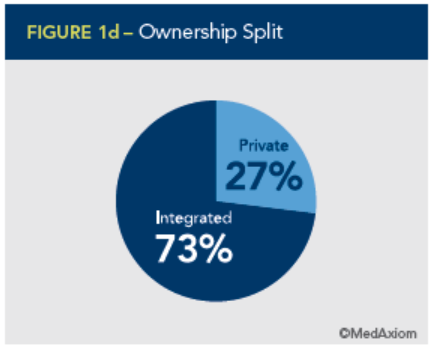
Across the country:





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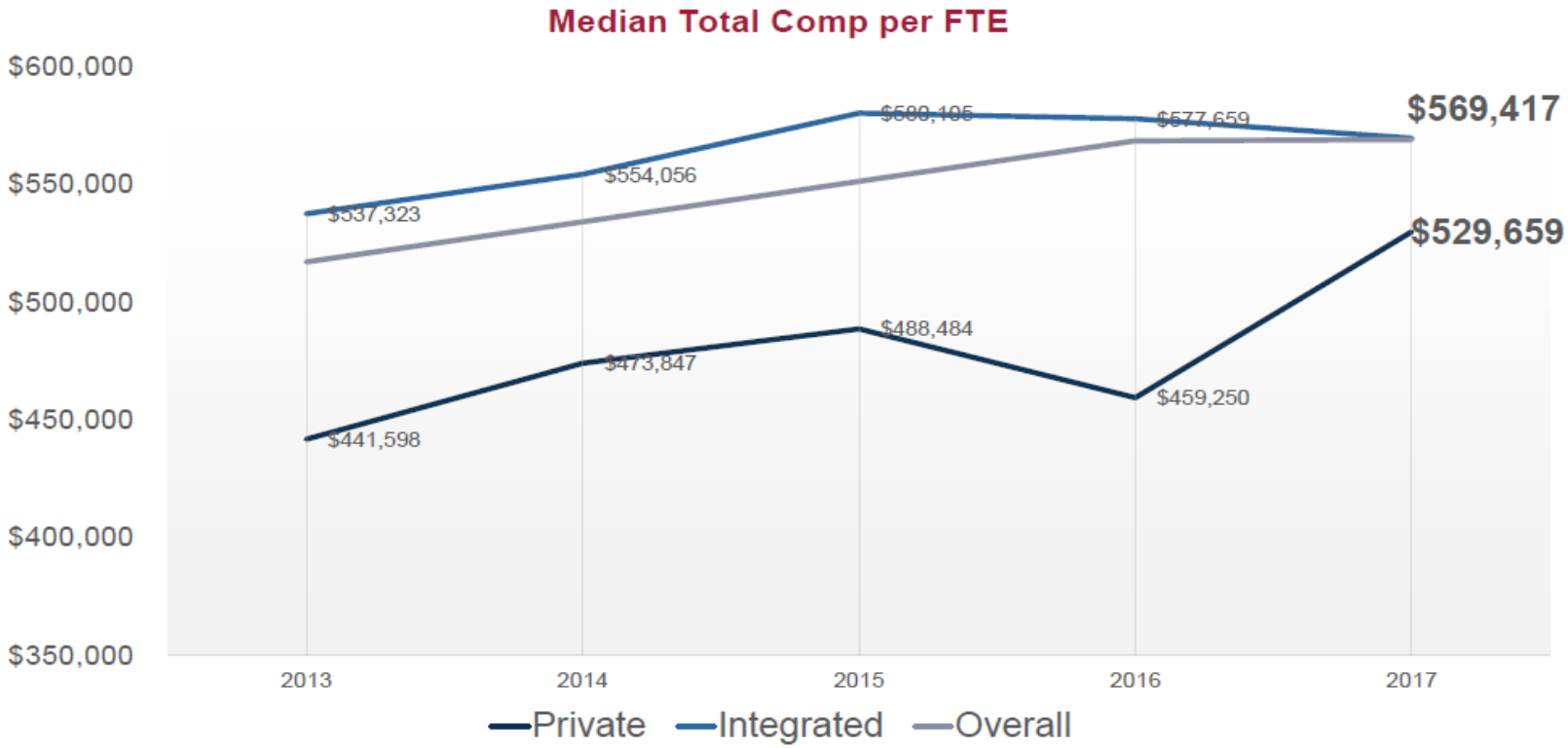
Trends in Compensation



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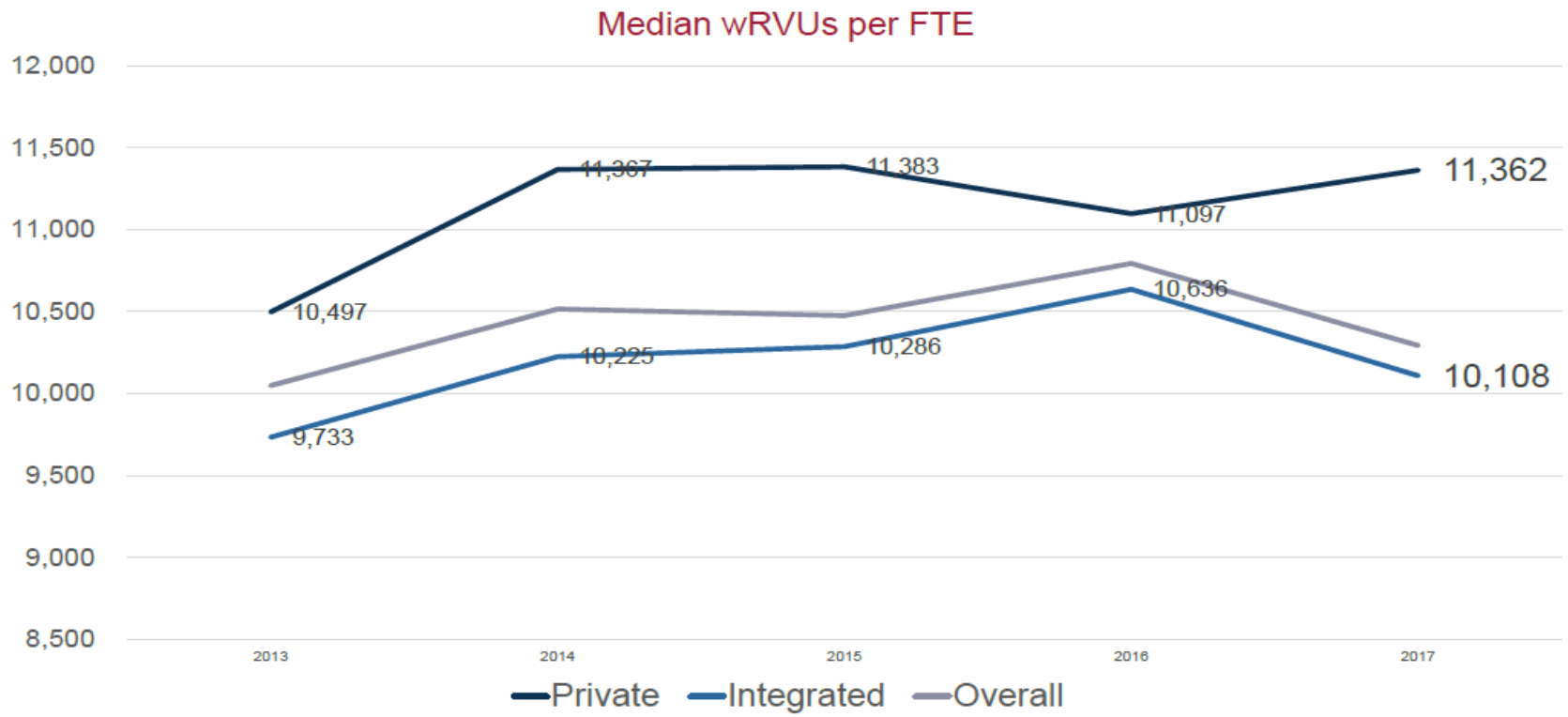
Median wRVU's



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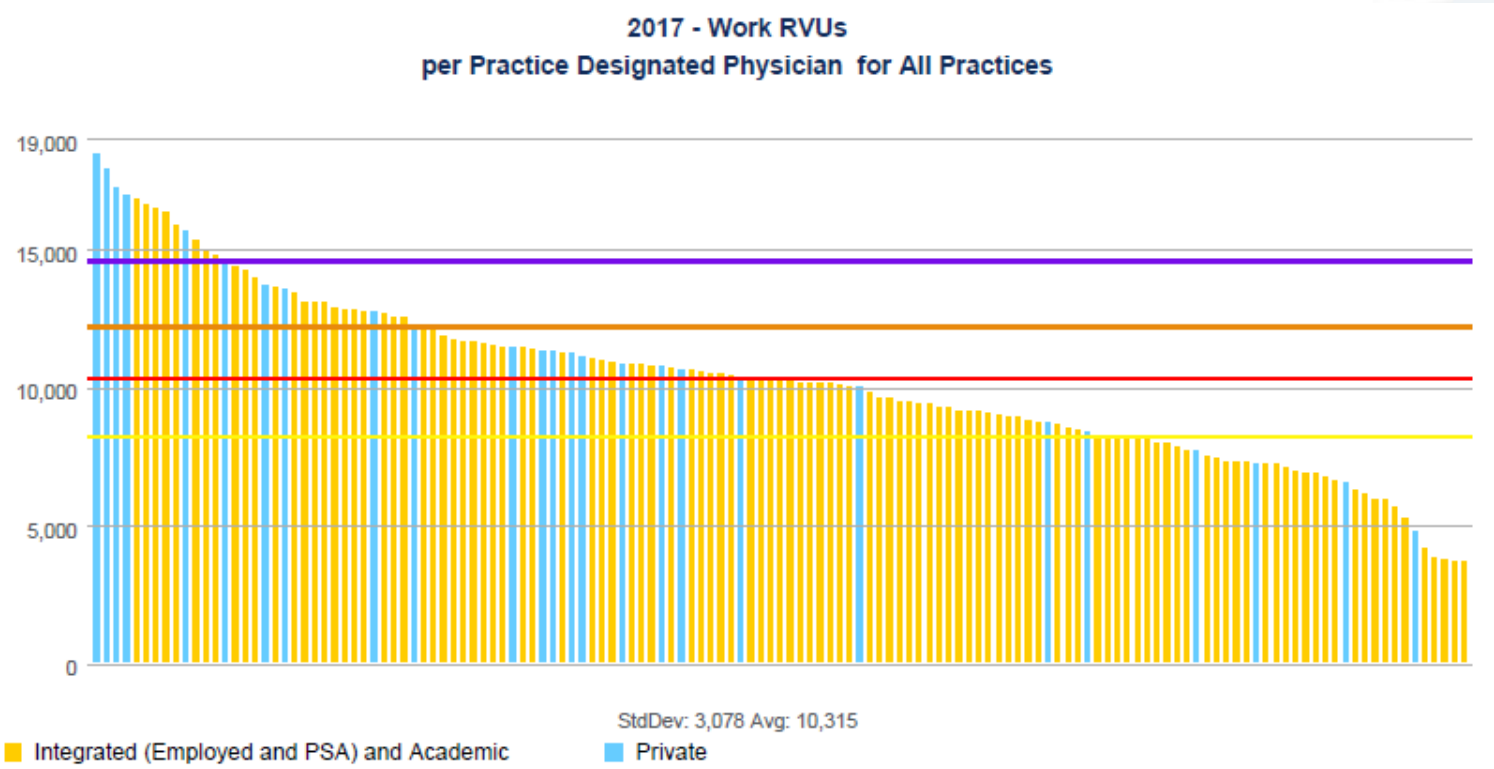
Total wRVU's



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Overview

- Keep the new Value agenda in mind
- Compensation plan is not a distribution plan
- There are no guarantees
- The plan has to have relevance & facilitate goal alignment
- It must migrate to a common platform
- Set a “take home” amount that is sustainable
  - Provide physicians with stability

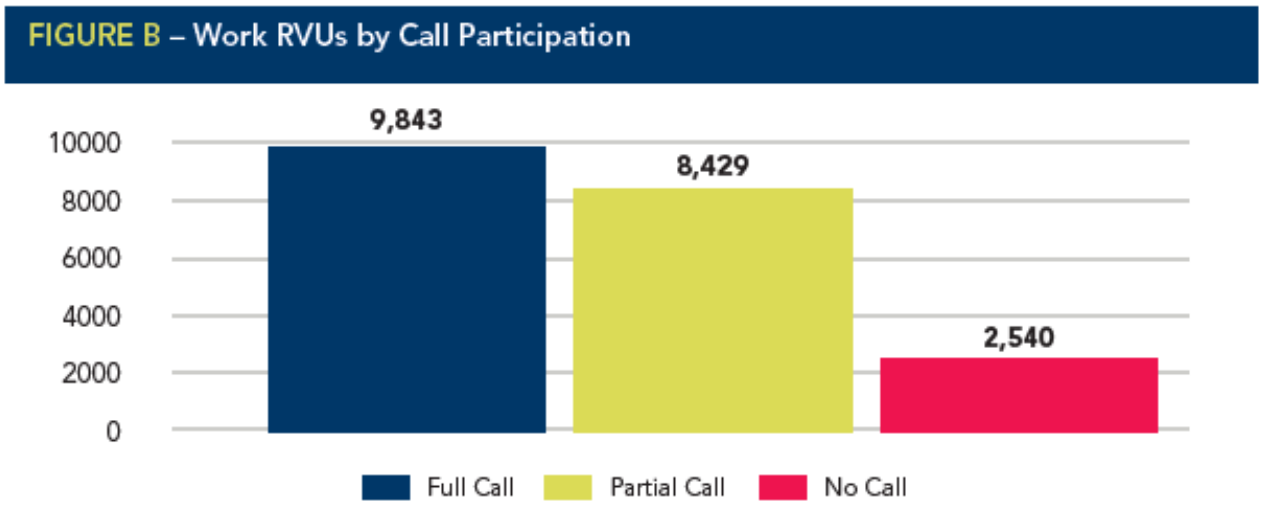
Critical Elements

- Identify key call elements
  - EP call
  - Interventional
  - Call in when not on call
- Value it
- Define call wind-down
- Define retirement path
- Define disability

Wind-down

- Open to all?
- Limited by age/years with group?
- How long ?
- Loose voting rights?
- How many can be in wind-down?
  - Who decides?

Call Wind-down



MedAxiom 2016 survey

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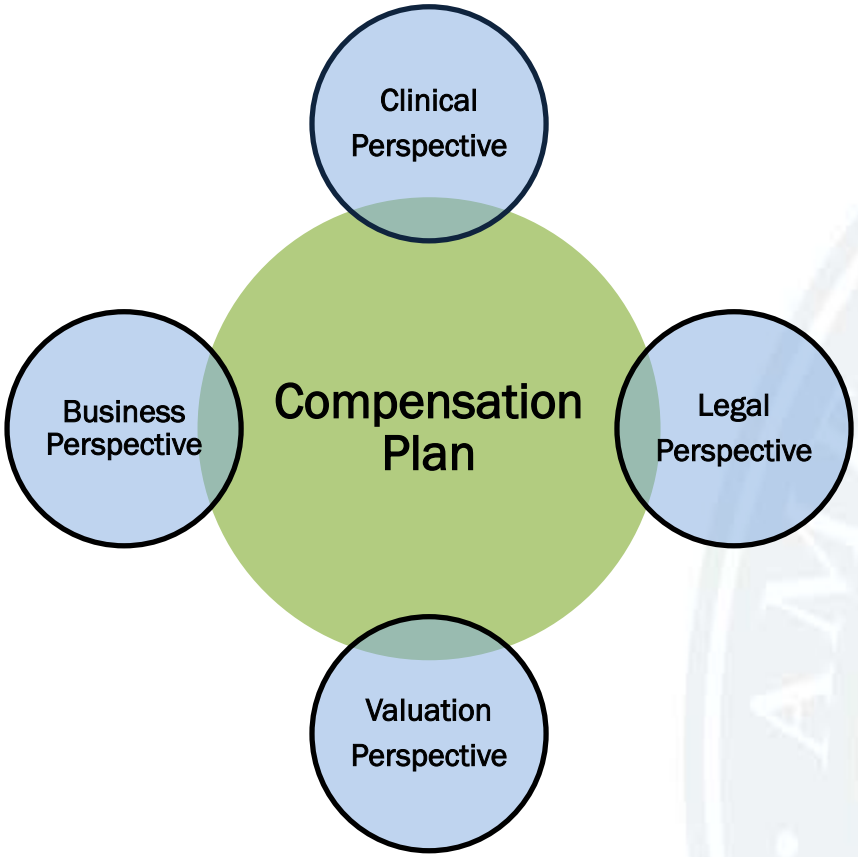
Key Design Elements

- Predictability, stability for physicians
- Conducive to alignment
- Conducive to anticipated payment structure
- Acknowledgement of current income
- Base + call compose “take home”
  - Evaluated and set annually
  - Quarterly “true ups”

Designing a Comp Plan



Compensation Components

- Base – Show up for work
  - Minimum threshold (# of clinics, min. panel size, etc.)
- Call
  - May become more or less onerous in this new value world
  - See MIPS CPI for patient access
- Non-Clinical / Administrative
  - Will increase in the value world
  - MUST pay for intellectual property
  - MUST pay for non wRVU (care coordination)
- Value incentives
- Productivity Incentives
  - Patient panel size, wRVU(?), other
  - Physician shortage + aging population = someone needs to see patients
  - Value is not less care, but right care at right time

What do we Incentivize

- Be Careful = You will get the behavior you incentivize
- Weigh or prioritize what is important
  - Efficiency (cost)
  - Outcomes
  - ACO Performance – care coordination
  - Outreach / Growth (still a numbers game)
  - Meeting MACRA/QPP criterion
  - Bundle readiness
  - Top 50 hospital
- Select things that can be measured

Measure and Reward

- Put in place mechanisms to measure
- Frequency for measurement and feedback
- Assign value to each incentive
- For example: Incentivize Efficiency & Quality
  - Compliance with AUC standards for graphics
  - Use of AUC tools (FOCUS, etc.)
  - Lab turn over times
  - Use of radial approach

Pooled or Individual

- Groups attainment of incentives put into pool and then distributed to physicians via compensation model
- Can we Pool (Tuomey, Halifax, etc.)?
- We have to Pool Compensation for Value
  - Value requires a “Team Effort”
  - Value takes a “Village”
  - Value needs -----“a change in law”

What is Pooled Compensation

- Monies from all sources come into pool
- Comp model is negotiated
  - How you are paid for work done
    - Receipts
    - wRVU rate
  - Incentives – CIN, MU, programmatic
  - CV SL monies
- Comp distribution
  - Different from Comp model

Balance FFS and Value

- FFS will not go away (entirely)
  - 9% Penalty still means that 91% FFS (potentially)
- Focus has to be on Value to compete
  - Closed networks, bundles, national competition, etc.
- Can't change on a dime - migrate to Value
  - Value will be more important than productivity
- Incremental changes
  - Start before need to
  - Add value component tied to meaningful longer term quality / process goal
  - Employer / System may not realize return on Value proposition in near term; need to have longer term focus

What Does Your Group Value

- Sub-specialization
  - Who should be doing what
  - Skill gap vs market dynamics
- Call
- Part time
- Physician burn out
  - Quadruple aim

wRVU vs. TVU

wRVU

- Uniform, defined by CMS
- Not necessarily reflection of work or time spent
- Rigid, Doesn't incent goals
- Developed by complex survey mechanism
- Universally considered unequal across sub-specialties

TVU

- Customized to practice
- Easily to define and modify
- Reflects time spent
- Customize to incentivize activity
- Common denominator (minutes)
- Can equalize across sub-specialties

Time Value Units

- Each CPT code has a TVU value
- Based on Time Motion studies
  - Informal national comparisons
- Used for Clinical and Non-Clinical work
- TVU value based on
  - Time to perform work
  - Incent what we decide is best to incent
  - Separate work or integral part of larger procedure
- Each TVU = one minute
- On Average 10 TVU's per wRVU

Non-clinical TVU's: Travel

TRAVEL TVU

	ABMC	SAMC	GSH	GOH	ELGIN	NCH	LEXINGTON	MANOR	C'MONT	C' OAKS	Frnd Vil	Asbury C.
ABMC		18	40	20	30	18	15	6	18	18	12	10
SAMC	18		30	30	18	18	10	18	18	18	18	20
GSH	40	30		40	40	40	20	0	0	0	0	0
GOH	20	30	40		30	30	20	0	0	0	0	0
ELGIN	30	18	40	30		30	20	0	0	0	0	0
NCH	18	18	40	30	30		20	0	0	0	0	0
LEXINGTON	15	10	20	20	20	20		0	0	0	0	0
MANOR CARE	6	18	0	0	0	0	0		0	0	0	0
CLAREMONT	18	18	0	0	0	0	0	0		0	0	0
CLARE OAKS	18	18	0	0	0	0	0	0	0		0	0
FRIENDSHIP Village	10	11	0	0	0	0	0	0	0	0		0
ASBURY COURT	12	18	0	0	0	0	0	0	0	0	0	
LUTHERAN HOME	10	20	0	0	0	0	0	0	0	0	0	
	10	20										

Notes:

- No Travel TVU while on call
- No Travel TVU while on weekend
- No Travel TVU from home

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Non-clinical TVU's:

LECTURE TVU	TVU
Departmental & Hospital Grand Round full lecture including prep (40 - 60 min lecture)	200
Community Lecture (approved by POC or Marketing) including prep time	60
Lunches (approved by Marketing Committee **ONLY**)	60
Going to a Lecture	0

RESEARCH ENROLLMENT	
Referring physician	50
PI	50

MEETING TVU	TVU
Partner meeting (monthly)	120
Dept. of Cardiology (any hospital)	60
General Staff Meetings	60
M&M / Peer Review	60
CVA Quality	60
CVA Marketing	60
CVA EMR	60
CVA Operations	60
Lab Quality (ICACTL, ICANL, ICAEL, ICAVL)	60
Sub-Committee (non chair / Admin stipend)	60
MSQOC - contract	Actual
ABMC Quality - contract	Actual
Hospital Credentialing - contract	Actual
Hospital Quality - contract	Actual

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Clinical TVU Examples

CPT	Description	wRVU	TVU
33308	Pacemaker Implant	8.77	65
33349	ICD implant	15.17	100
93653	Ablation	15.00	180
93283	Device Check	1.15	3
92928	Stent w/ ptca major artery / LAD	11.21	85
93458	L hrt artery/ventricle angio	5.85	60
93000	EKG - Global	0.17	1
93010	EKG - Pro	0.17	0.6
93016 / 18	Treadmill	0.75	7
93306	Echo	1.30	10
93320	Doppler	0.38	0
93351	Stress Echo	1.75	12
99203	Office New - Level III	1.42	30
99204	Office New - Level IV	2.43	37
99205	Office New - Level V	3.17	37
99213	Office Est. - Level III	0.97	15
99214	Office Est. - Level IV	1.50	20
99215	Office Est. - Level V	2.11	20
99222	Hospital New - Level II	2.61	30
99223	Hospital New - Level III	3.86	35
99232	Hospital Follow-up - Level I	1.39	20
99233	Hospital Follow-up - Level III	2.00	20

TVU / Productivity

- TVU / Productivity Decisions
  - Credit for Incident to / Shared visits
  - Reduction for multiple procedures
  - Minimum Threshold
  - Productivity Tiers and value

Plan Assumptions

- Base = $200,000 (Threshold 7,000 wRVU)
- Call = $161,000 (33% total compensation)
- Productivity Compensation = ___% of total Comp.
- Productivity Threshold = 90% MGMA Median
- Productivity Tiers
  - < 15% = 2 points
  - 15% - 30% = 4 points
  - 30% - 45% = 5 points
  - > 45% = 6 points

Plan Assumptions (cont.)

- Quality incentives split equally
- Equal Share Threshold = 7,000 wRVU
- You MUST decide on the model ***BEFORE*** you see individual numbers
  - ***Philosophy is critical***
  - ***Call wind-down is critical***
  - ***Part-time/time share***

Components of Value-Based Compensation

Base Compensation
+
Call
+
Production Value Compensation
+
Group Performance Based At-Risk Compensation
=
Physician Total Compensation

Aligned Incentives Reward Results

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Perfect Compensation Model

- Remember that “The perfect compensation model is the one that the physicians (and employer) hate the least”

Steve Gornik Austin Heart (paraphrased)

Example of Allocation

Allocation depends on what stage group is at:

	Group A	Group B	Group C	Group D
Base	20%	20%	20%	15%
Call	30%	25%	35%	25%
Non-clinical	10%	15%	20%	15%
Value	15%	25%	10%	35%
Productivity	25%	15%	15%	10%

Guiding Principles

- The compensation plan must have ***relevance*** in the currently emerging Value Based Economy payment model
- The compensation plan must ***facilitate goal alignment*** of the physicians with each other, as well as the physicians with the health system
- The compensation plan will ultimately ***incentivize physician performance required to execute the cardiovascular service line strategic plan***
- The compensation plan will, to the extent possible given the current transformational nature of the healthcare industry, provide ***physician's economic stability***

Service Line or at Risk $

Non-Clinical Compensation

- Leadership Positions
- Medical Directorships
- Call Coverage
- Hospital/Health System Incentive Earned
- Hospital/Health System Incentive Available
- Non-Governmental Payor Incentives Earned
- Non-Governmental Payor Incentives Available

TABLE 4 – Median Non-Clinical Comp per FTE ©MedAxiom

	2014	2015
Leadership Positions	$6,667	$9,632
Medical Directorships	$11,869	$8,481
Call Coverage	$22,853	$22,856
Hospital/Health System Incentives - Available	$30,000	$41,667
Hospital/Health System Incentives - Earned	$22,046	$22,463
Total Non-Clinical Compensation Earned	$45,457	$37,685
Percentage of Available Non-Clinical Comp Earned	80%	88%

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Questions?

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