Compensation Opportunities in Physician-Hospital Integration

By William T. Carlson Jr.

After talking to dozens of cardiology groups about their interest in hospital integration, I find one element common in every discussion — their interest is the result of falling payer reimbursements and their impact on physician compensation. As a result, while compensation is not the most important element of these integration discussions, it is the most visible. If you are considering integration, these principles should guide the discussion on compensation.

Principle #1: Understand the economics of physician-hospital integration

Cardiologists frequently ask how hospitals can afford to purchase their practices and increase their compensation. The answer is provider-based reimbursement (PBR). PBR is the method by which hospitals are paid more for diagnostic tests than what physicians receive. The diagnostic tests must be provided in hospital space (which can be structured within physician offices), use hospital personnel (who usually are former group practice personnel) and must be within 35 miles of the hospital provider. However, if these requirements and others can be met, it can mean millions of dollars in additional revenue without any increase in use.

The existence of PBR does not mean that cardiologists can expect to receive every dollar of additional revenue produced. The limiting concept of Fair Market Value still exists for both practice valuation and physician compensation.

One additional consideration is that PBR raises the cost of health care to the patient because patient co-payments and deductibles are often higher. While providers typically do not walk away from PBR because of the revenue enhancement it represents, cardiologists should be prepared to explain the cost increase to their patients.

Principle #2: Select your preferred compensation system

I regularly tell cardiologists they should choose a compensation system based on what behavior they want to reward. In considering this issue, the three primary systems are: productivity, equal split and the corridor system. The good news is that if you can explain your rationale, most hospitals permit cardiologists to select the system that best fits the group.

The productivity system rewards clinical activity. It is often referred to as the "Eat What You Kill" system because the more you do, the more you are paid. This system works best for those groups that have more work to do than there are physicians to do it, thereby avoiding intra-group competition. In this system, compensation is calculated by multiplying a productivity measure (usually Work Relative Value Units [WRVU] or Time Value Units) times a negotiated dollar figure (referred to as the Conversion Rate).

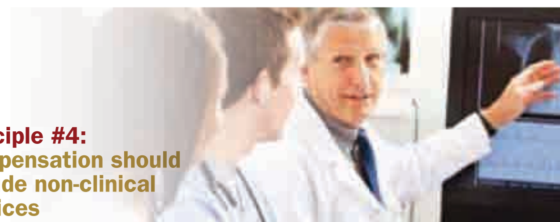
The equal split system rewards collegiality. Groups that have had an equal split system prior to integration tend to retain that system because they have found it promotes group harmony. A compensation pool is created based on a WRVU formula, and funds are then distributed equally among the cardiologists.

The corridor system is best suited for mature markets in which there is equilibrium between the supply of cardiologists and the demand for their services. In this system a specific W-2 compensation rate typically is negotiated, and the rate will not vary as long as the cardiologists maintain their productivity within a corridor of 5 percent up or down. For example, if a group is producing 100,000 WRVUs annually, their compensation would not vary as long as their productivity stayed within a range of 95,000 to 105,000 WRVUs. If their productivity did vary outside the range, the cardiologists would experience a compensation penalty below 95,000 and would receive incentive compensation for productivity above 105,000.

Principle #3: Understand productivity versus predictability

Cardiologists often want to know what kind of compensation they should expect their hospital will "guarantee." Compensation guarantees are as rare as cost-based reimbursement. The reason is that hospitals learned a lesson 15 years ago when they employed primary care physicians without productivity requirements. When no incentive existed for physicians to maintain or increase their productivity, physician productivity declined.

Each of the compensation systems described here has some productivity element. The good news is that typically cardiologists will not have to increase their productivity in order to increase their compensation, but there will be additional compensation available if they do so.

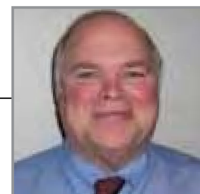


Principle #4: Compensation should include non-clinical services

It is important to include non-clinical services in your negotiations. Said another way, if cardiologists are compensated only for clinical services, what happens to medical directorships, developing new outreach sites or participating in hospital-based teaching programs?

Compensation for non-clinical services typically follows one of two paths. First, you can develop separate contracts for these services and pay the participating cardiologists separately from the compensation for their clinical services. Second, you can supply RVU credit based on the time spent in providing these services, and the resulting amounts are included in the regular compensation system.

You have noticed by now there is no mention of how much compensation is typical in these integration deals. The reason is the figure varies based on numerous factors such as: physician productivity, diagnostic testing levels and the hospital administration's understanding of the potential patient care benefits. Initial offers generally are in the $500,000 – $600,000 range, but those numbers often increase based on the cardiologists' current compensation, the revenue generated by PBR and whether there are multiple hospitals interested in the group. Your negotiating ability will have a direct impact on the final number.



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Cuts to Nuclear Cardiology Payments Likely

The cuts proposed to Medicare payment for cardiology services under the Medicare Physician Fee Schedule have caused enormous concern among practices. Unfortunately, even if the Centers for Medicare and Medicaid Services (CMS) does not finalize the cuts as proposed, substantial changes in payments to other services could occur. Most notably, myocardial perfusion imaging/SPECT testing has been subject to review by the CPT Editorial Panel to create a new code that combines the reporting of the SPECT test with the wall motion and ejection fraction services that are now reported as separate codes for the vast majority of SPECT studies. ACC anticipates that the changes made to these codes could result in considerable reductions in payment for this service.

CMS does not release a final fee schedule until Nov. 1, so it is uncertain how much of a decrease in payment this service may receive. The examination of services that are performed together but coded separately has been of strong interest to policymakers. Other services that require the reporting of multiple codes for a single service may be subject to similar review and potential payment reductions in the future. More information from the CPT Editorial Panel will be available in coming months.