Compensation 201
Thinking Beyond the WRVU

Let’s talk money.

For those of you integrated with a hospital, one of your chief concerns likely centers on what your compensation structure will look like in the next round of negotiations. Those of you still in private practice are probably wondering what will be left of your ever-dwindling revenue once you deduct operating expenses. A confluence of factors—including physician integration efforts, a focus on population-based health, and value-based payments—is leading both hospitals and private practice groups to reexamine how to pay their cardiologists. Compensation conversations rank among the most difficult in which hospitals and physicians engage, and there is no one-size-fits-all solution. In my experience, however, the most effective compensation methodologies incorporate incentives that are balanced and, more than ever, include metrics that are not productivity-based. While no silver bullet exists for how compensation should be structured, we do know that compensation plans should reflect the practice’s culture, encourage clinical productivity, and emphasize quality/care coordination.

Measuring Success Beyond Productivity

Most health systems and providers are thinking about future payment reform, but in the current fee-for-service environment, productivity-based compensation plans still dominate. Enter the WRVU or “work relative value unit,” the familiar measure of the relative time and intensity associated with each CPT code. In their basic form, WRVU plans tie compensation to work effort, rewarding high producers. However, many hospitals want greater cardiologist involvement in broader service line performance efforts. The problem: productivity models do not directly incentivize you to perform nonclinical work. Forward-thinking organizations are incorporating specific service line performance incentives that reward quality, citizenship, and other non-productivity-related efforts. This entices you, the physician, to become more invested in service line performance while also advancing hospital objectives. Additionally, for private practices, these incentives can help shape the culture of the group by promoting patient experience and coordination of care, and paving the way for more value-based payments. This evolution in compensation plan methodologies has already begun. The latest data from the 2013 ECG National Provider Compensation, Production, and Benefits Survey shows that 52% of all physicians in 2012 had quality-based metrics incorporated into their compensation, up from 25% in 2011.

For the majority of these arrangements, service line incentives make up a small percentage of total compensation (i.e., 5-10%). When I speak with cardiologists about this growing trend, many express skepticism as to how attainable performance targets actually are and about a hospital’s ability to effectively capture the data. What’s interesting is that when I talk with cardiologists who work for organizations that utilize these types of incentives, I hear that the performance of the cardiology service line is improved—due largely to greater physician engagement, better care coordination, and substantial cost savings. Not coincidentally, each of these benefits aligns closely with the triple aim of health care reform. As the conversation moves away from being entirely about productivity, often clinicians see a positive impact on cardiology group culture. Due to the benefits that have been realized, these performance incentives are being weighted more heavily by some systems, sometimes making up as much as 25% of total compensation.

How You Might Be Measured

So what types of performance measures are being incentivized? This varies by organization, but specific metrics that mirror programmatic objectives and payer contracting strategies will likely have the greatest impact. Performance goals that are manageable in number, achievable, easy to measure, and under your control will be the most meaningful for both physicians and the hospital. Examples of some cardiology service line metrics I often see are found in the Table.

This is not an exhaustive list, nor should all of these measures be incorporated into every compensation plan. Additionally, determining how performance will be paid is a pivotal piece of the compensation puzzle. Give some thought as to what payments will be made if and/or when performance targets are only partially achieved.

Set Your Expectations

Do not expect the wholesale incorporation of performance incentives into compensation plans to happen overnight, but it should happen eventually. Data suggest that the weight given to performance incentives, relative to total compensation, is growing, particularly as reimbursement shifts toward value-based methodologies, physicians gain trust in this approach, and data availability improves. While we still live in the world of WRVUs, adding non-productivity based metrics to compensation plans (for both integrated hospitals and private cardiology practices) starts to bridge the gap between the fee-for-service past and the value-based future.

For more information, Sue can be reached at sanderson@ecgmc.com.