

On the Money

An in-depth look at interventional cardiology compensation trends.

BY JEFF OZMON AND JOEL SAUER

The current wave of health care change has hit almost every sector of the market, and physician salaries have not been immune. With downward pressure on cost and volume, along with more public scrutiny on quality reporting and transparency, we are starting to see the effect in the overall compensation and productivity of our physician providers. In cardiology, the move toward integration that started approximately 5 years ago has resulted in the fact that today, about 70% of cardiologists are now affiliated with a hospital or health system via employment or a professional services agreement. During the recent past, and into the coming few years, many of these affiliated contracts are due for renegotiation. Although we do not currently know what the net effect of the renegotiations might be, data suggest that the overall slowing of integration activity may have started to normalize the market.

COMPENSATION

A review of the 2014 MedAxiom Provider Compensation & Production Survey¹ (based on 2013 data) yields some interesting highlights. The overall compensation for a full-time interventional cardiologist decreased for the first time in more than 5 years (Figure 1) from a median of \$586,154 in 2012 to \$558,824 in 2013. However, interventional cardiology was not the only subspecialty affected. There was a pullback across all subspecialties, as shown in Figure 2. Whether this decline of nearly 8% is the beginning of a trend or simply a 1-year anomaly remains to be seen, but it is certainly noteworthy given the steady upward climb in prior years.

When considering compensation alone, a cardiologist will earn substantially more in an integrated model than in independent practice. Figure 3 shows the median compensation for an interventional cardiologist, comparing the private and integrated ownership models. The integrated cohort saw a median compensation of \$583,829

as compared to \$485,041 for private physicians, a 17% difference. Additionally, although the integrated cohort saw a nearly 9% decline from 2012 to 2013, the private cohort actually had an increase of 6% during the same time period.

Despite this drop, interventional cardiologists in the integrated model continue a 4-year stint of being the top earners among all cardiology physicians. This may be due in part to the proliferation of percutaneous coronary intervention (PCI) centers (specifically PCI programs without surgical backup) across the country, which has increased the need for interventional physicians to adequately cover “on-call” burdens. Increased competition in markets can also drive on-call coverage recruitment, which affects wages.

According to a 2013 analysis published in the *Journal of the American Heart Association*, 39% of all hospitals in the United States have interventional cardiology capabilities, representing a 21.2% growth from 2003 to 2011. This study indicates that this comes during a period of time when the population has only grown 8%, and the prevalence of myocardial infarction has actually declined.²

In an environment where the number of facilities needing coverage is increasing, and volumes (which in a fee-for-service world generate revenue) are declining, something or someone will need to make up the difference. The data suggest that hospitals and health systems are filling in this gap, based on the interventional compensation position.

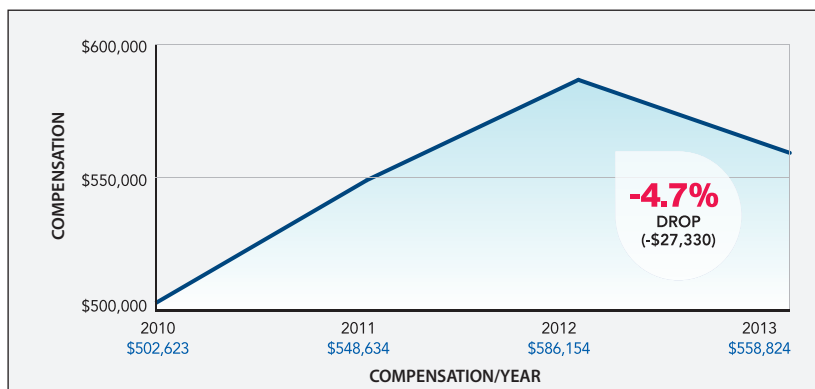


Figure 1. Interventional cardiology median compensation—all.

PRODUCTION

The standard currency for measuring physicians' work production is the relative value unit (RVU), as defined by the American Medical Association and used by Centers for Medicare & Medicaid and third-party insurers to pay for physician activity. Three components make up each RVU: the physician professional work (wRVU), the practice expense (often referred to as "technical expense"), and the professional liability (malpractice). According to the 2012 MedAxiom Integration Survey,³ the wRVU is the most often used (57%) production measure for cardiologist compensation in the employed or leased (purchased-services agreement) models.

When measured by wRVUs, production for all cardiologists decreased nearly 4% in 2013 as compared to 2012 (Figure 4), whereas interventional cardiology saw a 6% decline (Figure 5) during the same period. An overall decline in work production for cardiology correlates to the decline in physician production and may help explain the nearly 8% decline in overall compensation. When comparing the difference in ownership models, we find that private practice cardiologists reported 9% higher productivity than those in integrated models (Figure 6). Although the raw data may suggest that private physicians work harder, it should be noted that cardiologists in integrated systems are often asked to participate in more nonclinical work. However, because most of this work is paid outside of wRVUs, it may be another factor that helps explain why the integrated physician has a higher overall compensation.

Looking at total RVUs, which include all three previously itemized components, the delta between private and integrated groups widens (Figure 7). This 25% differential is not unexpected given that approximately 45% of integrated practices bill Provider Based (billed under a hospital outpatient department using POS 22), whereas technical (office expense) work is shifted out of the practice and

over to the hospital. This migration reduces the total RVU value without affecting the wRVU. The data also suggest that in addition to catheterization procedures, interventional physicians must perform a significant number of diagnostic and other technical services (and/or ancillary billing procedures) in the private setting.

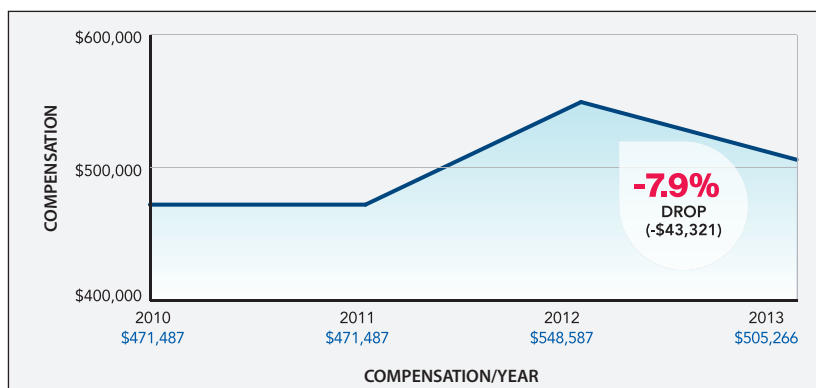


Figure 2. Cardiology median compensation—all blended.

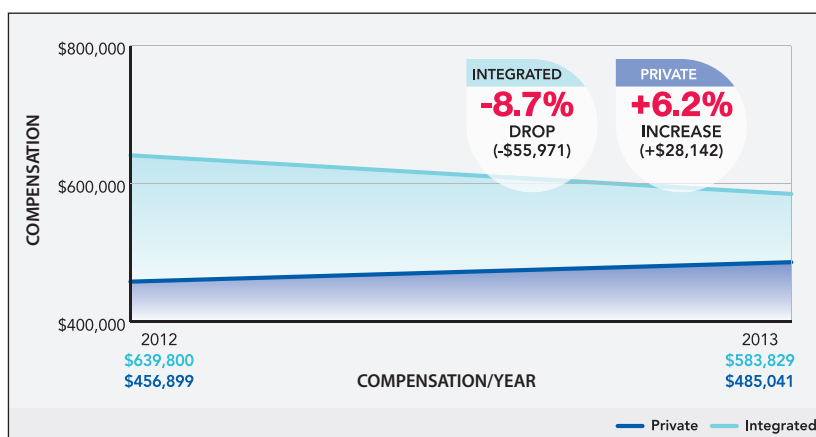


Figure 3. Median compensation—interventional cardiology ownership comparisons.



Figure 4. Cardiology median wRVU—all blended.

When looking at compensation per wRVU, the change from 2012 to 2013 was insignificant, which makes mathematical sense given that the compensation decline nearly paralleled the decline in work productivity. For interventional cardiology, the median compensation per wRVU was \$54 in 2013 compared to \$53.96 in 2014. When looking at the ownership model, integrated interventional cardiologists earned \$58 per wRVU compared to \$43 for cardiologists in private practice.

IT'S ALL ABOUT NEW PATIENTS

During the past 5 years, there has been a decline in catheterization volumes, which drives PCI volumes downward per cardiologist. With this downward pressure on volume from factors such as appropriate use criteria, the role of statins in treating coronary artery disease, the advent of drug-eluting stents, and economic pressures (eg, high-deductible plans), most health systems and physicians are looking at volume as a factor of increased patient population.

For cardiology, one of the best measures of a healthy practice is new patient volume. Using the data from MedAccess, we can compare the correlation between new patients per cardiologist to other key practice metrics, including compensation, productivity, and selected volume measures (Figure 8).

CONCLUSION

Groups that want to improve volumes are looking at how they can increase access, as well as the overall new patient volume, which translates into larger patient panel size per cardiologist. A key component in gaining market share to improve volumes going forward will be the ability to redesign around care teams and care coordination. These new models allow groups to make the transition from an individual patient relationship to a population relationship and some form of population-based reimbursement. Regardless, growing patient volumes inevitably translate to taking market

share from competitors, which will require tight integration between physicians and the hospital.

In the midst of the many and complex changes happening within health care, physician compensation is not at the center of transformation strategies, yet it is a factor that must be aligned with the overall goals and vision of every program's evolution; compensation should be a comple-

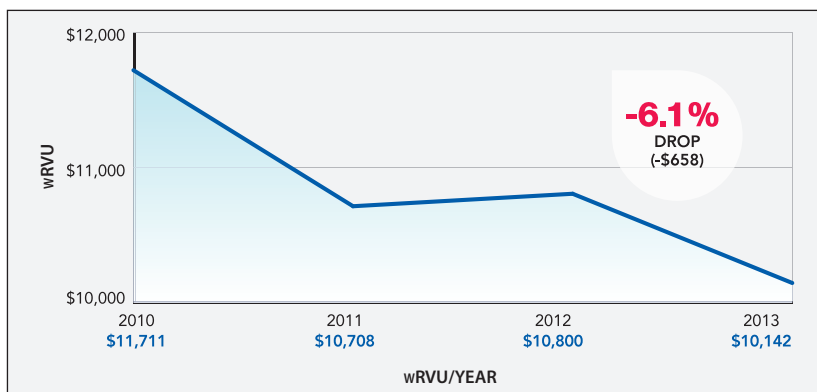


Figure 5. Interventional cardiology median wRVU—all.

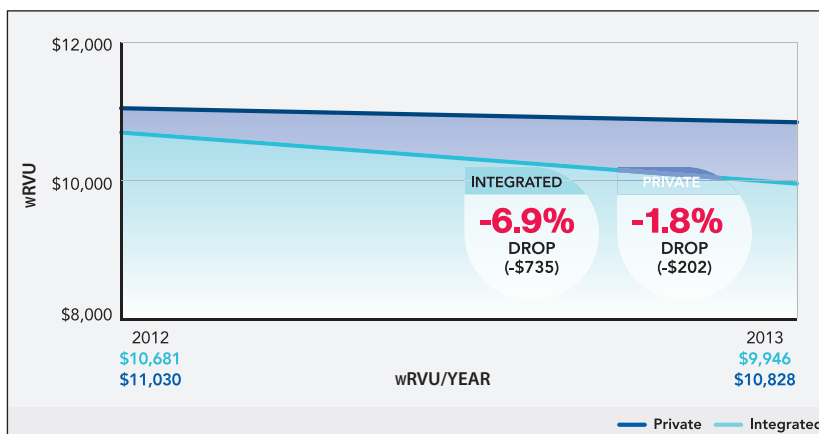


Figure 6. Median wRVU—interventional cardiology ownership comparisons.

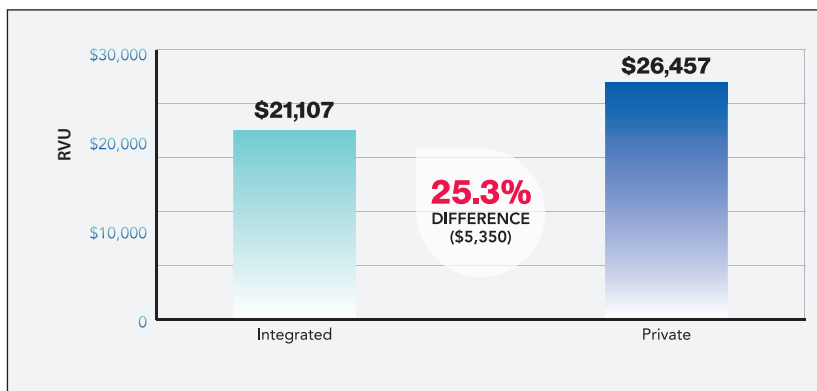


Figure 7. Median total RVU—interventional cardiology 2013.

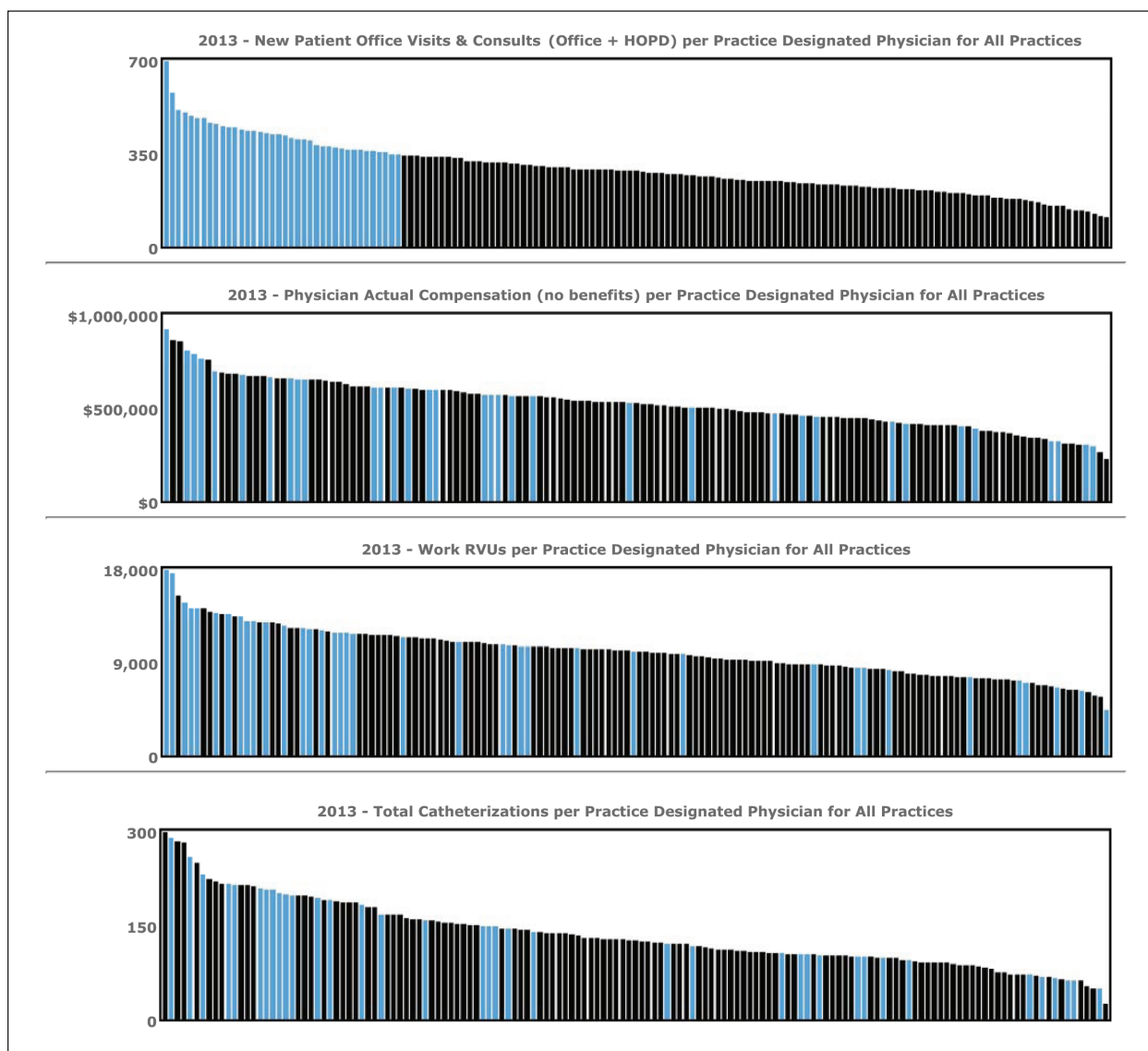


Figure 8. A comparison of new patients per cardiologist to compensation, wRVU, and total catheterizations. The graphic shows the top quartile for new patients (highlighted in blue) as the constant and then compares this cohort to the other measures. The data show that there is a relatively high correlation in new patients and other volume metrics, including compensation, as evidenced by the cluster of blue bars to the left-hand side of the additional metrics.

ment of, and not a barrier to, success. Programs that do not align physician compensation around broader organizational goals do so at their peril and, ultimately, will not be successful in re-engineering their product. Finding the appropriate financial rewards in a value-oriented reimbursement world is not an easy or quick process. Prudence suggests getting an early start. ■

Jeff Ozmon is Vice President, Consulting at MedAxiom. His areas of expertise include physician-hospital alignment, strategic and business planning, compensation plans, process

improvement, organizational development, and governance and leadership development. Mr. Ozmon may be reached at jozmon@medaxiom.com.

Joel Sauer is Vice President, Consulting at MedAxiom. His work includes full-service line development, comanagement arrangements, and integrations. Mr. Sauer may be reached at jsauer@medaxiom.com.

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3. Jaskie S. MedAxiom Integration Survey 2012.