

# Disclosure Information



## Physician Partnership and Compensation Overview

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**No Disclosures to Declare**

# Agenda

- ◆ **Welcome**
- ◆ **Overview of Physician Partnership**
- ◆ **Overview of Compensation Models**
  - **Employed Physician**
  - **Partner**
    - **Individualistic**
    - **Equal Sharing**
    - **Tiered**
      - **Internal benchmarks**
      - **External benchmarks**
- ◆ **Questions & Answers**

# *Partnership*

# Partnership Track

- ◆ **Length to partnership: Average 2-3 years**
  - **Some groups use 1 year for physician with established practice**
  - **Time to evaluate cultural and clinical fit with the practice**
    - **Partnership track of <2 years may not allow adequate time to assess cultural fit**
  - **Physician under employment contract during this time**
    - **Typically compensated at reduced level**
  - **Partnership is not guaranteed at the end of the employment agreement**

# Partnership Track

## ◆ Partner status

- **May have one or several levels of partnership**
  - **Senior/Managing Partner – founding physicians**
  - **“Junior” Partner – non-founding partner**
- **Voting rights may be impacted by partner status**
  - **Senior/Managing partners may have voting rights that junior partners do not**
- **Compensation is typically not affected by partner *status***

# Partnership Track

## ◆ Buy In Calculation

- Compensation is often reduced during employment period as a component of the buy-in while a new physician builds his/her practice
- Additional buy-in often includes assets, A/R and goodwill
  - Assets appraised at book value with a floor of 10-20% of costs
  - A/R equals practice collections over a pre-determined period of time
  - Goodwill can be valued as a percentage of collections

# Partnership Track



## ◆ Buy-In Cont.

### ➤ Payment of buy-in

- Can be paid by calculating a set amount and paying that amount out over a finite period of time
  - E.g. If the A/R and goodwill are calculated to be \$500,000 combined, the new partner could pay \$125,000 a year to the partners for four years
  - With this methodology the buy-in is *not* tied to the current and near future success of the practice
- Can be paid for by a new partner over a period of time through a reduction in his/her net income
  - E.g. New partner receives 70% of his/her equal share in year 1, 80% year 2, 90% year 3, etc.
  - With this methodology the buy-in amount is tied to the current financial metrics of the practice

# *Compensation*

# Compensation Plans

- ◆ **Thousands of variations**
  - **No two systems exactly the same**
    - As many plans as group
  - **Typically different plans for employed physicians and partners**
- ◆ **No “perfect” plan**
  - **Only alternatives that are more or less imperfect**
- ◆ **Key characteristics of good ones**
  - **Linked to group goals**
  - **Has productivity component**
  - **Cash/collections and productivity are primary measures**
  - **Understandable and simple**
  - **May monitor and reward other activities**

# Compensation Plans

- ◆ **All relate to the following:**
  - **Goals**
  - **Values**
  - **Culture**
  - **Data**
  - **Historical ways of doing things**
  - **Strategy**

# Fundamental Principles

- ◆ **KISS**
- ◆ **Group culture vs. individualism**
  - You get what you incentivize
- ◆ **Money can be a negative motivator**
  - Seldom a long-term positive motivator
- ◆ **The right players/team can accomplish almost any goal**

# *Employed Physician Compensation*

# Employed Physician Compensation



- ◆ **Typically has a salary component, often has an incentive component**
  - **Yearly salary may be established for the duration of the employment contract**
  - **Incentive often based upon productivity**
    - **E.g. Once collections double salary the physician is paid a percentage of additional collections**
    - **E.g. Once a productivity threshold is met (measured by wRVUs) a bonus is paid**
  - **Incentive may also include non-clinical activities**
    - **E.g. Starting a peripheral vascular program within the practice**

# Employed Physician Compensation

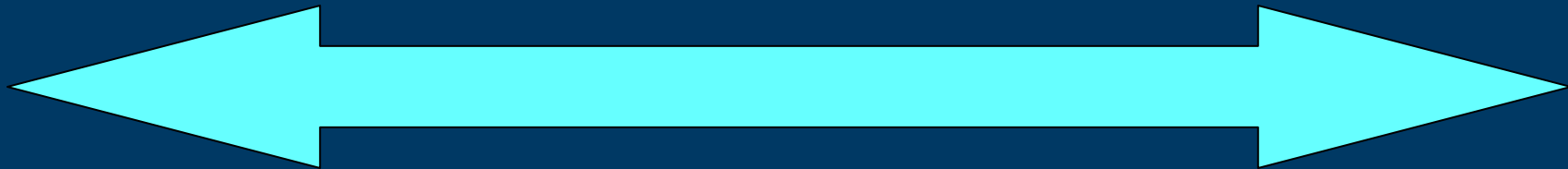


- ◆ **Employed physicians not on a track to partnership may have a different compensation**
  - **E.g. Flat rate per wRVU**
  - **E.g. Sliding scale compensation based upon productivity**
    - **Productivity related to other practice physicians**
    - **Productivity related to national benchmarks**
  - **Etc.**

# *Partner Physician Compensation*

# Compensation Models

## The Compensation Spectrum



**Equal Sharing - Multi-tiered - 100% Productivity**

*Group Culture*

*Individualism*

# ***Individual Focused Models***

# Individualistic Models

- ◆ **Each physician is a separate economic unit**
  - **The “eat what you kill” model**

# Individualistic Models

## ◆ Pros

- Promotes individual responsibility for costs and compensation
- “Eat what you kill” format rewards work
- Possibly easy to administer

## ◆ Cons

- Can have allocation disputes concerning costs and expense allocation
- Inter-group rivalry and competition can deter cohesive group performance (scheduling; sub-specialization)

# *Equal Sharing Models*

# Equal Sharing Models

- ◆ **Each physician is paid the same irrespective of productivity or group responsibilities**

# Group Oriented Models

## ◆ Pros

- Promotes group culture and group cohesiveness
- Simple and understandable
- Doesn't exclude productivity component

## ◆ Cons

- Difficult where large variations in productivity and work levels (e.g., part-time physicians)
- No direct responsibility for costs, resource usage, expenses
- May allow "coasting"
- May not provide sufficient reward for working harder

# ***Multi-Tiered Plans***

# Tiered Compensation Plans



## ◆ Overview

- Includes a base salary and an incentive component
- Designed for:
  - Allowing internal benchmarking
  - Maintaining group culture with the application of productivity
  - Rewarding high-end producers

# Tiered Compensation Plans

- ◆ **One example: 3 Tier Model**
  - **Combines productivity with equal sharing**
  - **Income increases as productivity thresholds are surpassed**
    - **Productivity thresholds are established in relation to the group's mean productivity level (internal benchmark)**
  - **Compensation pools are split equally among those who achieve the specified thresholds**

# 3-Tier Compensation Plan

- ◆ **3-Tier Model Example (percentages may vary)**
  - **Tier I (Base Compensation)**
    - All physicians must achieve Tier I at a minimum for participation in the plan
      - Physicians not achieving Tier I status will be removed from the plan and paid a percentage of Base Compensation
    - Tier I Pool = 85% of compensation pool
    - Tier I Productivity Threshold: 85% of group mean
  - **Tier II**
    - Tier II Pool = 10% of compensation pool
    - Tier II Productivity Threshold: 85% - 110% of group mean
  - **Tier III**
    - Tier III pool = 5% of compensation pool
    - Tier III Productivity Threshold: >110% of group mean

# 3-Tiered Compensation Plan

- ◆ **Measurements of Productivity**
  - **Gross charges**
  - **Collections from professional services**
  - **Patient visits (total volumes)**
  - **Total RVUs**
  - **Work RVUs (\*preferred)**
  - **Time Units**
  - **Etc.**

# 3-Tiered Compensation Plan



- ◆ **Total RVUs = Work RVUs + Practice Expense RVUs + Malpractice Expense RVUs**
  - **Work RVU (wRVU):** Relative number of units involved in the work performed by the physician or provider
  - **Practice Expense RVU:** Cost to operate a medical practice
  - **Malpractice Expense RVU:** Relative risk of each CPT code

# 3-Tiered Compensation Plan

- ◆ **Example: Practice of 7 physicians using wRVUs**
  - **Physician A: 13,668 (Interventionalist)**
  - **Physician B: 12,325 (EP)**
  - **Physician C: 8,930 (interventionalist)**
  - **Physician D: 10,832 (Interventionalist)**
  - **Physician E: 10,380 (Noninvasive)**
  - **Physician F: 13,255 (Invasive)**
  - **Physician G: 9,290 (Noninvasive)**
- ◆ **Total Group wRVUs: 78,680**

# 3-Tiered Compensation Plan

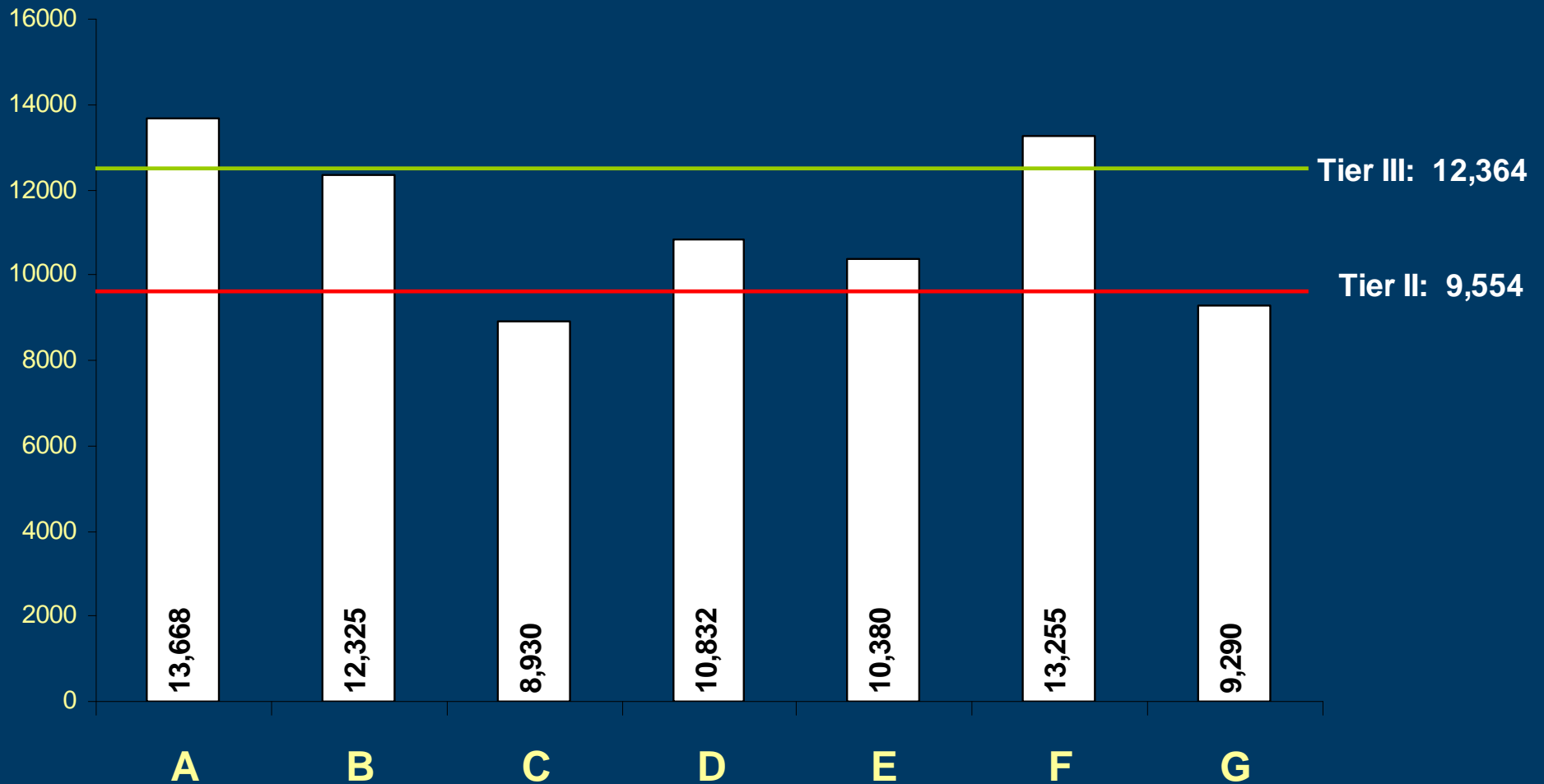
## ◆ Determination of Physician Tiers

- Total Group wRVUs: 78,680
- Mean: 11,240
- 85% Mean: 9,554
  - Tier I:  $\leq 9,554$  wRVUs
- 110% Mean: 12,364
  - Tier II: 9,555 to 12,363 wRVUs
  - Tier III:  $\geq 12,364$  wRVUs
  
- Physician A: 13,668 *Tier III*
- Physician B: 12,325 *Tier II*
- Physician C: 8,930 *Tier I*
- Physician D: 10,832 *Tier II*
- Physician E: 10,380 *Tier II*
- Physician F: 13,255 *Tier III*
- Physician G: 9,290 *Tier I*

# 3-Tiered Compensation Plan



## Physician wRVUs



# 3-Tiered Compensation Plan

- ◆ **Funds for distribution: Group revenue minus group expenses**
  - Total group revenue: \$8,731,796 -
  - Total group expenses: \$4,225,585 =
  - Funds for comp plan: \$4,506,211
- ◆ **Tier I funds:  $\$4,506,210 * 85\% = 3,830,279$**
- ◆ **Tier II funds:  $\$4,506,210 * 10\% = 450,621$**
- ◆ **Tier III funds:  $\$4,506,210 * 5\% = 225,311$**
- ◆ **Each physician that achieves Tier II shares in Tier I and Tier II**
- ◆ **Each physician that achieves Tier III shares in Tiers I, II and III funds**

# 3-Tiered Compensation Plan

## ◆ Physician Compensation

- Tier I:  $\$3,830,279 / 7 = \$547,183$
- Tier II:  $\$450,621 / 5 = \$90,124$ 
  - Tier II Comp:  $\$547,183 + \$90,124 = \$637,307$
- Tier III:  $\$225,311 / 2 = \$112,655$ 
  - Tier III Comp:  $\$637,307 + \$112,655 = \$749,962$
  
- Physician A: \$749,962
- Physician B: \$637,307
- Physician C: \$547,183
- Physician D: \$637,307
- Physician E: \$637,307
- Physician F: \$749,962
- Physician G: \$547,183
- Total: \$4,506,211

## 3-Tiered Compensation

- ◆ **Note: This method worked well for the group represented because they implemented a block schedule along with the tiered compensation. Therefore, the noninvasive physicians had the potential to produce at wRVU levels equal to those of the interventionalists.**

# 3-Tiered Compensation Plan

- ◆ **External Benchmarks may also be utilized**
  - **Benchmarks each physician to an external benchmark i.e. MGMA Median for cardiology practices**
    - **Benchmark ratios are utilized to determine tier status**
    - **Allows each physician to be benchmarked against his/her sub-specialty**
  - **Physicians given “shares” based upon their ration**
    - **Total income is divided by the shares for distribution to the partners**

# 3-Tiered Compensation Plan

- ◆ **MGMA Medians (2005 Physician Compensation and Production Survey)**
  - **EP** **9,770**
  - **Invasive** **8,310**
  - **Inv-Interventional** **9,661**
  - **Noninvasive** **6,564**
- ◆ **Determine each physician's productivity in relation to his/her sub-specialty median**
  - **Physician A: 12,226 (Interventionalist) / 9661 = 1.27**
  - **Physician B: 10,858 (Interventionalist) / 9,661 = 1.12**
  - **Physician C: 10,345 (interventionalist) / 9,661 = 1.07**
  - **Physician D: 7,760 (EP) / 9770 = 0.79**
  - **Physician E: 9,528 (Invasive) / 8,310 = 1.15**
  - **Physician F: 7,488 (Noninvasive) / 6,564 = 1.14**
  - **Physician G: 6,738 (Noninvasive) / 6,564 = 1.03**

# 3-Tiered Compensation Plan

## ◆ Determination of Physician Tiers

➤ Total Group Ratios: 7.57

➤ Mean: 1.08

➤ 85% Mean: 0.92

• Tier I:  $\leq 0.92$

➤ 110% Mean: 1.19

• Tier II: 0.93 to 1.18

• Tier III:  $\geq 1.19$

➤ Physician A: 1.27 *Tier III*

➤ Physician B: 1.12 *Tier II*

➤ Physician C: 1.07 *Tier II*

➤ Physician D: 0.79 *Tier I*

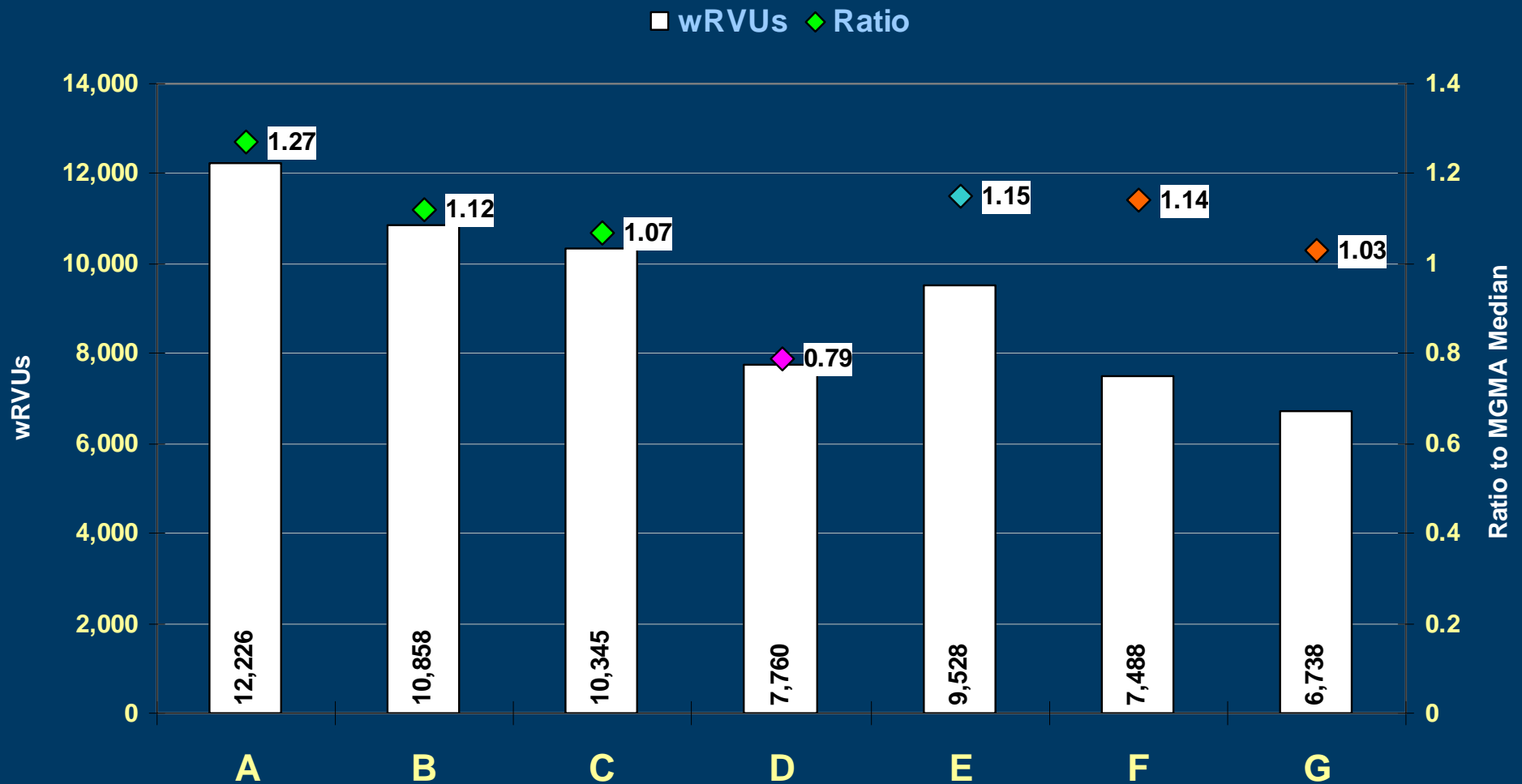
➤ Physician E: 1.15 *Tier II*

➤ Physician F: 1.14 *Tier II*

➤ Physician G: 1.03 *Tier II*

# 3-Tiered Compensation Plan

## Physician Tier Status Based on External Benchmark Ratio



# 3-Tiered Compensation Plan

## ◆ Physician Compensation

- Tier I:  $\$3,830,279 / 7 = \$547,183$
- Tier II:  $\$ 450,621 / 6 = \$75,104$ 
  - Tier II Comp:  $\$547,183 + \$90,124 = \$622,286$
- Tier III:  $\$225,311 / 1 = \$225,311$ 
  - Tier III Comp:  $\$622,286 + \$225,311 = \$847,597$
  
- Physician A:  $\$847,597$
- Physician B:  $\$622,286$
- Physician C:  $\$622,286$
- Physician D:  $\$547,183$
- Physician E:  $\$622,286$
- Physician F:  $\$622,286$
- Physician G:  $\$622,286$

# ***Time Units***

# Time Units

- ◆ **Based upon the actual time involved in performing a task**
  - **Assumes all activity is of equal importance to the practice**
    - i.e. a new patient visit is as important as an intervention
  - **Developed internally**
    - Practice determines the *average* amount of time involved in performing an activity
      - E.g. an established office visit takes 15 minutes, diagnostic cath 30 minutes, etc.
    - Efficiency will increase a physician's time units

# Time Units



lc	CPT Code	wRVU	TU
<b>New Patients</b>			
Level 1	99201	0.45	0.250
Level 2	99202	0.88	0.333
Level 3	99203	1.34	0.500
Level 4	99204	2.30	0.750
Level 5	99205	3.00	1.000
<b>Established patients</b>			
Level 1	99211	0.17	0.083
Level 2	99212	0.45	0.167
Level 3	99213	0.92	0.250
Level 4	99214	1.42	0.333
Level 5	99215	2.00	0.500
<b>Consults</b>			
Level 1	99241	0.64	0.250
Level 2	99242	1.34	0.333
Level 3	99243	1.88	0.500
Level 4	99244	3.02	0.750
Level 5	99245	3.77	1.000

# Time Unit Comparison

<b>lc</b>	<b>CPT Code</b>	<b>wRVU</b>	<b>TU</b>
<b>Treadmill</b>			
<b>Complete TM</b>	<b>93015</b>	<b>0.75</b>	<b>0.417</b>
<b>TM Supervision</b>	<b>93014</b>	<b>0.45</b>	<b>0.250</b>
<b>TM Interp</b>	<b>93018</b>	<b>0.30</b>	<b>0.167</b>
<b>EKG</b>			
<b>EKG Interp</b>	<b>93010</b>	<b>0.17</b>	<b>0.033</b>
<b>Echocardiogram</b>			
<b>2D Mmode Interp</b>	<b>93307</b>	<b>0.92</b>	<b>0.167</b>
<b>Doppler Interp</b>	<b>93320</b>	<b>0.38</b>	<b>0.000</b>
<b>Color Flow Interp</b>	<b>93325</b>	<b>0.07</b>	<b>0.000</b>
<b>Holter Monitor</b>			
<b>24 hour</b>	<b>93224</b>	<b>0.52</b>	<b>0.125</b>
<b>Nuclear</b>			
<b>Single Study</b>	<b>78464</b>	<b>1.09</b>	<b>0.167</b>
<b>Multiple Study</b>	<b>78465</b>	<b>1.46</b>	<b>0.167</b>
<b>Wall Motion</b>	<b>78478</b>	<b>0.50</b>	<b>0.000</b>
<b>Ejection Fraction</b>	<b>78480</b>	<b>0.30</b>	<b>0.000</b>

# *Other Issues*

# Special Issues



- ◆ **Part-time status**
- ◆ **Call**
- ◆ **Administrative time**
- ◆ **Partnership and new employees**
- ◆ **Research**

# Part-time Status

- ◆ **No solid data on number of part-time MDs**
  - Estimates 16%-25% of MD work force
- ◆ **Three major trends**
  - Increase in semi-retirements in an aging work force
  - Young physicians desire flexible work schedules
  - More physicians are women who are balancing career with family commitments
- ◆ **Benefits and advantages to the group should be modeled and understood by both part-timers and full-timers**
  - Some part-timers play key roles in group practice infrastructure
  - Part-timers have higher overhead per dollar collected than full-timers
  - Many malpractice carriers charge the same for full and part-timers
  - Many benefits (health insurance) cost the same regardless of the time worked
  - **Costs of serving patients are largely fixed**

# Call

- ◆ **The most onerous part of clinical practice**
- ◆ **Valued by various methodologies**
- ◆ **In some groups worth up to 1/3 of total compensation**

# Herding Cats...

**Not so hard if you have the tuna!**