Compensation Principles in Cardiology Practices – Beyond Productivity: Rewarding Leadership and Creating a Return on Investment

Background

As the population ages, the need for cardiovascular services generally, and cardiologists in particular, increases. It is estimated that for every 100,000 people, there are 6.3 cardiologists, and these cardiologists are unevenly distributed geographically throughout the country. With the dramatic growth in the older population, and the technological advancements in the early detection, diagnosis, and treatment of disease, most pundits portend an uneven but sure short-term shortage of cardiologists.

Unfortunately, this increase in the demand for cardiologists has come at a time when our programs are training fewer cardiologists than before. This mismatch between supply on the one hand, and demand on the other, has led to increase in the starting salaries for new physicians and physician assistants.

Lately, current estimates are that approximately 2 out of every 5 vacant positions went unfilled, particularly in high demand areas The pressure to fill these still open positions has driven starting salaries for new physicians to the point of jeopardizing the current staffing of existing groups. Disillusioned and unhappy practicing cardiologists are making moves. Conversely, some practices are simply struggling to retain current cardiologists. (Why stay where you are as an unhappy partner if you can leave and join another group, and not see a dramatic dip in income?)

However, simply retaining current cardiologists is not the answer for most practices. With our aging population comes an increased demand for *additional* associates to see group patients. Add the necessity to bring on the best trained in the newest technology in the subspecialty, and it becomes clear that cardiology groups must grow in number. To afford the necessary human and capital investments, the practices must spread the per capita investment over more providers.

Historically, cardiology practices have labored over how to compensate their physicians. With the shortage of cardiologists, some practices have raised the bar for starting compensation so high that those salaries may approach what owners are earning in other groups. And, with starting salaries so high, a conflict within groups, especially between senior and associate physicians, is bound to develop.

Equal versus Productivity Income Division

On the one hand, if your group utilizes a Compensation Plan that pays on productivity, then the senior physician who invested their time, money and "sweat equity" to grow the patient base and earn the position of senior physician in the group has the greatest fear of being left behind in the formula. Compensation based on productivity definitely favors the recently trained interventional and nuclear cardiologist, for they will be most rewarded, based on the payor driven formula.

On the other hand, an equal division of income is not necessarily fair. While the equality of the model navigates the physicians around the legal quagmire of Medicare Fraud and Abuse and Stark Regulations, it makes no attempt to measure objectively or subjectively, any work effort. If money talks, and is to motivate at all, then a productivity division of income is at least rationally equitable, assuming you can negotiate the legal issues. Yet even a productivity division of income fails to allocate resources properly, as it both creates a disincentive to inter-refer (a main criteria for group practice growth), and it fails to address the intangible contributions of management mentoring or "rain making."

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The trend in many cardiology groups over the past few years was to divide the income more or less equally with some small differentials. In part this was the result of new legislation, and equal ownership, investment, and group incentives that were recognized and encouraged. Stark laws (now on hold on this issue) required that income from designated health services (most imaging services) not be credited to a physician based on the value or volume of referrals. Why should a physician receive extra income for ordering a test that someone else performed, even if that test was medically necessary? The "equal – split" method still does have its drawbacks. Friction develops if pay is equal but effort is not. The reality is that the usual result is that overall effort slows down and stabilizes somewhere around the collective perception of the group's "expectation" for production.

Productivity models have historically served as the structure for how physicians were compensated. The productivity model directly rewards individual effort, with income self-adjusted for the work patterns of the physician. Unnecessary competition can be created from this type of compensation model, and the competition may lead to hostility among the physicians since the only method of being financially rewarded results from patient activity. Inter-group referrals are ignored, and each physician's resource utilization is treated as the same.

Mixed Equal / Productivity Income Division Models

Most cardiology practices currently have a hybrid form of compensation, including both productivity and equal components. There are many issues to consider with both the productivity model and the equal-split method. How overhead is to be allocated and how productivity will be measured (by charges, collections, RVUs or other measures) are typical questions that arise.

Even currently common equal and/or productivity income methods do not fully compensate physicians for those activities that benefit your group, such as coordinating local cardiovascular care, and maintaining market-share through staff, facility and technological development. If you decide to expand by developing new offices, the effort may actually be penalized under any form of productivity. Likewise, there are no incentives to implement cost controls or develop care protocols.

Many practices do not move beyond the equal / productivity debate, because they do not move from income division, (whacking up what remains after paying overhead) to compensation planning (planning to pay themselves fairly). To do this, they must squarely consider the basic dilemma for any practice in developing a compensation plan: how to balance all of the goals of the practice including: (1) retaining and attracting new physicians, (2) encouraging increased productivity, (3) overcoming the competition among your providers, and (4) adding new, technologically advanced services.

"Compensation 101"

Most medical practices "Divide the Pie." This implies that the practice takes in all its income, pays all the non-physician operational expenses, and then pays all remaining amounts to its physicians. This principle remains the same whether the entity is a partnership or a professional corporation. If you are in a partnership, this method of income division might be written in the partnership agreement. However, if you are part of a professional corporation, the compensation plan is typically stated in a legally binding agreement among the shareholders. Note that under this method, any investment of income back into the practice is *in lieu of* compensation to physicians.

Physician Compensation Model – A Three Tier Approach

Consider a new model for compensation that brings your Compensation Plan more in line with a typical "business" approach. Think about how the non-physician business actually runs. The business generates income from many revenue sources. The income collected pays for (basic) salaries, sales commissions, bonuses for effective management and successful attempts to grow. Then, assuming it at least met its financial projections (which include investment in the business and goals for profit), it pays dividends – returns on the investment in its stock to its stockholders who took the risk to help capitalize the company.

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Look at the basic "tiers" of payment. There are three: (1) base pay, (2) management or incentive pay earned for fulfilling a stated business objective, and (3) return on investment, which is paid to those who capitalized the company. Put this in the context of your practice. There is base pay, which for your professional staff pays basic salaries for a range of production levels. This is not materially different from your new associates wanting a guaranteed minimum for some level of performance. (Below minimum production employees should be released!)

Then there is incentive pay for achieving stated goals. Those goals, may be (solely) "excess" production, or better, may include other stated goals, which can be quantified objectively or subjectively. They could include other talents in management skill, or achieving group goals. You should state those goals, but consider the following range of desirable activity you could encourage:

- Running a "hospital" or "group" clinic (heart failure, pacemaker, lipid, etc.) or in running a laboratory service (interventional, nuclear, etc.)
- Working with physician extenders (and implementing / following protocols for the service)
- Achieving certain financial targets
- Opening new offices
- Integrating a new service or technology
- Successfully managing a practice through a period of change
- Etc.

Demonstrating The Model

Third, and too rarely considered is a financial return for the investment each of your owners made in the business when they decided to take less cash from the business so the business could purchase a piece of equipment that would make the practice better, or more efficient or competitive in some way. Although that was always the theory, unless you divided the income equally, did that ever really happen? Probably not, because you did not have a mechanism to make it happen. So, beyond simply a return on capital investment, this third tier also offers a return on the human capital investment in your infrastructure, which is so difficult to quantify.

So, how would this work for you? Let's keep this math simple. After all, your model is already in existence at the practice (on an Excel spreadsheet or other).

Say you have a practice of ten physicians each bringing in an average of $800,000 per physician collected Gross Income. Assume your overhead is high at fifty percent (50%). Subtracting the overhead from the total gross income of all ten physicians, you come up with the Net (Physician) Income - essentially the Income Available for the Compensation Plan. (This model actually works somewhat in reverse, but is presented this way for simplicity.)

Base (Worker) Pay.

All Gross Income All Sources (cash basis, 10 physicians)[1]	$8,000,000
All non-physician operational overhead expenses[2]	$4,000,000
Available for Compensation Plan (Net Income)	$4,000,000

[1] Average income per cardiologist in a group setting is $700,000 – 900,000 per physician, total professional and technical components.
[2] Average operational overhead, exclusive of physician salary and benefits and semi-personal expenses is +/- 50% of Gross Income.
[3] Base Pay does not have to be equal across the Board. This is done to keep the Model simple.

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First, separate the roles that individuals take on. The first role in this compensation model is the "worker." Effectively, you set the work expectation (in RVUs, number of patients seen, etc.) and then pay everyone a "base pay" to achieve that level. For example, if Base Pay[3] for a full time cardiologist is $200,000, with an expectation of the physician generating at least 7,400 RVUs (Medicare work value RVUs), and you have ten such physicians, $2,000,000 would be devoted to Base Pay. Depending on the hypothetical practice finances, 50% of your projected available Net (Physician) Income is now tied up (committed) to base pay.

Tier One: Base Pay Income Available for Tier 1:				$2,000,000
Physician	**Range of**	**Expected RVUs**	**Actual RVUs**	**Base Pay**
1	6,500.00	7,400.00	7,100.00	$200,000
2	6,500.00	7,400.00	7,000.00	$200,000
3	6,500.00	7,400.00	7,000.00	$200,000
4	6,500.00	7,400.00	6,800.00	$200,000
5	6,500.00	7,400.00	6,600.00	$200,000
6	6,500.00	7,400.00	6,500.00	$200,000
7	6,500.00	7,400.00	7,100.00	$200,000
8	6,500.00	7,400.00	6,900.00	$200,000
9	6,500.00	7,400.00	6,600.00	$200,000
10	6,500.00	7,400.00	7,400.00	$200,000
Total		**74,000.00**		**$2,000,000**

The first tier must clearly state the work effort production. You should also provide certain other factors should clearly be "given" for continued employment. Clearly stated; they should include (at least the following:

- The employee must be able to get along with others and function in a group setting;
- The employee must be clinically proficient;
- The employee must maintain adequate performance with an accepted tolerance range

Executive Pay

The second tier of pay is a little tricky, because you are forced to state the desired (rewarded) objectives[4]. And, let's assume you can rate behavior.

While you may use this tier to deter (punish, or fail to reward) work not done (e.g. drop call, lose $40,000), this example focuses on positive reinforcement. Assume you have three goals. (Too many only serves to confuse.) And, while they may vary over time, they need to be clearly communicated at any given time, and in place long enough to motivate behavior.

For example, lets say that you have the following three objectives:

[4] Assuming you contribute in other non-financial ways, and depending on the group philosophy, *associates* may or may not be entitled to an additional (second) tier of income.

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	Goal	Action	Target
1.	Increase overall physician productivity	Subspecialty targets are established	General - $650,000 Interventional $750,000 Nuclear $1,000,000
2.	Management Participation	Reward Meeting Attendance	Payment $ per Dr. per meeting
3.	Reward Management/Officer Time	Create Pool of Management Income	Target 10% of Tier 2 for Management

Let's say that you allocate fifteen percent (15%) of Net Income to Tier Two evenly distributed. Using this model, you might see the following Tier 2 bonus amounts:

Tier 2: Incentive Pay

Income Available for Tier 2: $600,000

Goal One: Productivity* 60% of T-2

or $360,000

Physician	**Sub Spec. Target**	**Actual Production**	**"Excess" Production**	**Relative "Excess" Production**	**Bonus**
1	650,000	640,000	-	-	-
2	650,000	700,000	50,000	7.5%	26,866
3	650,000	760,000	110,000	16.4%	59,104
4	650,000	800,000	150,000	22.4%	80,597
5	650,000	600,000	-	-	-
6	650,000	660,000	10,000	1.5%	5,373
7	950,000	940,000	-	-	-
8	950,000	1,000,000	50,000	7.5%	26,866
9	1,100,000	1,400,000	300,000	44.8%	161,194
10	1,100,000	1,000,000	-	-	-
TOTAL	**8,000,000**	**8,500,000**	**670,000**		**360,000**

** Note that because some people failed to meet "minimum" bonus targets, this is not equal to (B-A). That is why we used "Relative Excess" Production times the available bonus pool.*

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Tier 2: Incentive Pay				
Income Available for Tier 2:			$600,000	
Goal Two: Meeting Attendance			30%	of T-2
	or		$180,000	
Physician	**Number Attended**	**Meetings**	***Bonus***	
1	22		$26,939	
2	12		$14,694	
3	8		$9,796	
4	15		$18,367	
5	16		$19,592	
6	12		$14,694	
7	20		$24,490	
8	14		$17,143	
9	10		$12,245	
10	18		$22,041	
TOTAL	**147**		**$180,000**	
Max Potential Meetings			24	
	per period:			
Value of one Meeting:				
Tier Two Meeting Bonus:			$180,000	
Total "Meeting" Points				
available:			147	
Points per meeting:			$1,224	

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Tier 2: Incentive Pay			
Income Available for Tier 2:		$600,000	
Goal Three: Actual Management		10.0%	of T-2
	or	$60,000	
Physician	**Management Role**	***Allocated Fee***	
1	Sec/Treasurer	15,000	
2	President	30,000	
3			
4			
5			
6			
7			
8	Vice President	15,000	
9			
10			
TOTAL		**60,000**	

Putting all the Tier 2 bonus payments together would look like this:

Tier Two Bonus Pay				
Physician	***Goal 1***	***Goal 2***	***Goal 3***	***Total T2 Pay***
1	$0	$26,939	$15,000	$41,939
2	$26,866	$14,694	$30,000	$71,560
3	$59,104	$9,796	$0	$68,900
4	$80,597	$18,367	$0	$98,964
5	$0	$19,592	$0	$19,592
6	$5,373	$14,694	$0	$20,067
7	$0	$24,490	$0	$24,490
8	$26,866	$17,143	$15,000	$59,009
9	$161,194	$12,245	$0	$173,439
10	$0	$22,041	$0	$22,041
TOTAL	**$360,000**	**$180,000**	**$60,000**	**$600,000**
	60.0%	30.0%	10.0%	

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Last, at the third level, reward your owners for their equity. Beyond a dividend, but still along the lines of a return on human and capital investment, pay the remainder of the Net Income on the basis of return on investment. Depending on your practice philosophy, this "equity" return could be a combination of actually held equity or equity plus number of years co-ownership (up to some maximum number of years.) This category is flexible, and is the pool from which money can be either reinvested in the Practice and/or returned to its original investors.

Tier 3: Equity Pay		
Income Available for Tier 3:		$1,400,000
Physician	**Ownership Status***	***Bonus Share***
1	1	$175,000
2	1	$175,000
3	1	$175,000
4	1	$175,000
5	1	$175,000
6	1	$175,000
7	1	$175,000
8	1	$175,000
9	0	$0
10	0	$0
TOTAL		**$1,400,000**
* (1 = Yes, 0 =	No)	

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Our example is summarized here:

All Gross Income, All Sources *(Cash Basis, 10 Physicians)*		$8,000,000		
All non-Physician operational Overhead		$4,000,000	Estimated @	50% of GI
Available Income for Compensation Plan: *(Net Income)*		$4,000,000		
Tier 1: Base Pay		$2,000,000	50.0%	of Available Income
Tier 2: Incentive Pay		$600,000	15.0%	of Available Income
Goal 1: Productivity		360,000	60.0%	of Tier 2
Goal 2: Meeting Attendance		180,000	30.0%	of Tier 2
Goal 3: Actual Management		60,000	10.0%	of Tier 2
Tier 3: Equity Pay		$1,400,000	35.0%	of Available Income
Physician	**Tier 1**	**Tier 2**	**Tier 3**	**Total**
1	$200,000	$41,939	$175,000	$416,939
2	$200,000	$71,560	$175,000	$446,560
3	$200,000	$68,900	$175,000	$443,900
4	$200,000	$98,964	$175,000	$473,964
5	$200,000	$19,592	$175,000	$394,592
6	$200,000	$20,067	$175,000	$395,067
7	$200,000	$24,490	$175,000	$399,490
8	$200,000	$59,009	$175,000	$434,009
9	$200,000	$173,439	$0	$373,439
10	$200,000	$22,041	$0	$222,041
TOTAL	**$2,000,000**	**$600,000**	**$1,400,000**	**$4,000,000**

In actually implementing this Program, a practice budgets and commits to pay Base Pay. It then usually commits to an amount of budgeted Net Income for Equity Pay, therefore leaving the Tier Two Pay to "float" somewhat (1.0 - % T –1 - % T – 3 = T – 2%). What makes this different from simply Income Division is the advance planning and commitment to stated objectives, which if fulfilled, shall be compensated. The practice faces the likelihood of being either over or under budgeted projections. So it must decide – in advance – how it will handle that problem.

Conclusion

There are at least as many compensation formulas as your practice has shareholders. The idea of a discretionary salary and bonus might be what your practice decides to utilize. Perhaps you will subscribe to the logic of a Three Tier Model. In either event, bear in mind that some relationship to the market and to objective standards must be maintained. Also, the Model must be capable of simple explanation and modeling. It is generally a good idea to form a compensation committee representing a directory of physicians in the practice to set annual salaries and determines any bonuses. A formal system for peer evaluation is also helpful as well.

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What We Can Learn

The viability of your compensation plan will depend on the physician complement, goals and mission of your group. Your chosen plan will also vary from time to time among your practice. The best way to evaluate which plan is best for your group is to discuss, perhaps at a group retreat, what kind of plan everyone feels is objective and fair. It is also important to realize that change is inevitable, and your practice must be flexible to successfully deal with any changes. You may want to hire a professional consultant to help your group determine its goals and concerns, and then ultimately design the right income-division plan for your practice.

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