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Group Practice Income Division: Current Trends in Dividing the Pie

Income division/physician compensation has always been a subject of intense interest to ophthalmologists. However, recent pressures on ophthalmologists' income -- from reimbursement cutbacks and cost increases -- have caused even more practices to revisit their formula, and evaluate whether it meets their needs. There also is growing recognition that income division is not just an approach for "dividing the spoils" of medical practice. It is a tool for incenting desired physician behavior, and discouraging unwanted behavior.

Typical Income Division Models

Traditionally, ophthalmology practice compensation models have been production – oriented. The typical practice collects receipts, pays non-doctor overhead expenses and then distributes the remaining net income among the physicians in proportion to their relative productivity as measured by collections. In other words, if Dr. A accounted for 20% of the net collections of the group, Dr. A would receive 20% of the practice's net income.

This method certainly encourages productivity, which is beneficial to the group. However, it may lead to overutilization, upcoding, and "cherry-picking," where physicians seek the patients with the highest paying coverage. These negative behaviors in turn hamper quality patient care and increase the likelihood of payor audits.

To alleviate some of these issues, some ophthalmology practices divide a portion of the net income (usually 20-30%) equally among the doctors. The remainder is divided based on productivity. While this is a step in the right direction, there is still heavy emphasis on production (70 – 80%), with the attendant negative consequences described above.

Some groups use relative value units (RVUs) to measure productivity. This solves the problem of cherry picking based on payor reimbursement rates; a cataract for high-paying payor A has the same RVU value as a cataract for low-paying payor B. However, this still does not address concerns with overutilization or upcoding.

A few groups divide all monies equally. In some cases, this is appropriate. However, in such groups there is no incentive for physicians to work efficiently and increase productivity. And if there are subspecialists in the group, this method generally will not work, since the economics of subspecialty practices are generally significantly different from those of the general ophthalmology practice.

The methods discussed so far allocate overhead in the same proportion as receipts. A few groups hold to traditional notions that overhead should be categorized, with "fixed" expenses (primarily rent and utilities) divided equally and "variable" expenses divided in proportion to productivity. Typically, this is combined with a strict "eat what you kill" division of receipts (each doctor is allocated 100% of the monies that he generates).

In our view, none of these methods is fully satisfactory for the modern ophthalmology practice. This is because there are no rewards for important activities such as providing proper chart documentation or improving patient satisfaction.

The Traditional Business Model

Non-physician businesses provide a good example for ophthalmology practices to follow. They establish reasonable financial and operational goals and expect management and staff to work together to achieve them. Base salaries reward basic work effort, and bonuses and commissions are used to

reward exceptional effort or talent. Assuming that business and financial objectives are met, dividends are paid to the stockholders, to reward their investment.

This tiered approach is a traditional business model in most industries. Yet for many ophthalmology practices, it is a novel concept. Most ophthalmology practices only get as far as compensating basic work (via base salaries) and high work effort (via production bonuses). There is no considered approach for rewarding other desirable efforts or contributions, such as administrative effort, business development, patient satisfaction or simple "good citizenship" (arrive for hours on time, timely completion of charts, good relations with staff, etc). There is no considered method for rewarding shareholder investment.

The Tiered Approach to Income Division

Tier One

First you must compensate your physicians as "worker bees." This is the base salary. The first tier must clearly state the work effort required. Set work expectations (in RVUs, number of patients seen, etc.). Allow some flexibility by specifying a reasonable range of acceptable production, rather than a flat absolute minimum. Otherwise, as soon as a physician achieves the minimum threshold, he or she may expect extra compensation; such extra compensation should not be available until performance has reached an exceptional level. Certain other factors, such as clinical proficiency and the ability to work well with others, should also be a "given" for continued employment.

Tier One may be applied to owner and associate physicians alike. You may establish a single base salary per physician per year, or you may set base salaries based on years of employment. If you choose the latter, you should allow for standard increases in base salary for the first three to five years. You may also cycle up the basic performance expectations in line with the salary to indicate to associates the progression of expected goals. After five years or so, you should expect that your newer physicians will be achieving the same productivity as more senior members. Thereafter, the base salary generally stays the same (with cost of living increases as appropriate).

Tier Two

Tier Two is used to encourage and reward desired behaviors. Traditionally, medical practices have rewarded doctors for high productivity levels but not for much more. Yet there are many other behaviors you may want to encourage beyond pure production.

In Tier Two, you must establish objectives above and beyond the basic requirements. These will vary based on the needs of the particular group. Examples include:

1. The physician's documentation supports the CPT code billed for at least 90% of the patient charts randomly selected by the practice's Compliance Committee.
2. The physician participates in management by attending at least ten monthly physician meetings per year.
3. The physician begins office sessions on time at least 90% of the scheduled sessions.
4. The physician exceeds the established base range of RVU production.

You may use this tier to deter (punish, or fail to reward) work not done. However, it is preferable to focus on positive reinforcement. Also, to the extent possible, objectives should be measurable, leaving little room for subjectivity. Next, select only three to five criteria. Having too many only serves to confuse. Finally, although the objectives may change over time, they must be clearly communicated at the start of each compensation year and be kept in place long enough to motivate the desired behavior.

Depending on your practice, you may want to include associate physicians in Tier Two. While some Tier Two criteria may not be applicable (e.g. attending shareholder meetings), others will be (e.g. accurate and timely chart preparation, good coding, prompt arrival for office hours).

Tier Three

This tier is reserved to the owner physicians who have invested in the practice and take the risk on liabilities. Tier Three represents the return on investment in lasers, diagnostic equipment, and human capital, all designed and acquired to make the practice more efficient. The owners either borrowed the money or used a portion of their compensation to acquire these items.

Hypothetical Example

Let's say you have a practice of ten physicians, with annual gross receipts of \$8,000,000. Assume a 50% non-physician overhead rate. That leaves \$4,000,000 of net income available for physician compensation. Of the ten physicians, eight are owners and two are associates.

Gross Income from All Sources:	\$ 8,000,000
All Non-physician Operational Overhead Expenses:	\$(4,000,000)
Net Income Available for Compensation Plan:	<u>\$4,000,000</u>

Tier One

Along with the expectation of clinical competence and general good work behavior, you establish an acceptable production range of 7,000 to 7,800 work RVUs. You determine that for this basic work effort, the appropriate pay rate is \$260,000. This represents 65% of the net income available for physician compensation. This amount is paid to the physicians, \$220,000 in salary and the balance in physician expenses, such as dues, subscriptions, CME and retirement plan contributions.

Physician	Expected RVUs	Base Pay and Expenses
1	7,400	\$260,000
2	7,400	\$260,000
3	7,200	\$260,000
4	8,400	\$260,000
5	8,280	\$260,000
6	8,100	\$260,000
7	8,280	\$260,000
8	7,600	\$260,000
9	8,100	\$260,000
10	8,040	\$260,000
Total	78,800	\$2,600,000

In this example, all of the physicians met the minimum target. If one had not, the group may have chosen to reduce his or her base salary in proportion to his or her production. For example, suppose the delinquent physician produced 6,300 work RVUs, which is 90% of the minimum. The base salary would be reduced to \$198,000, or 90% of \$220,000. One practical problem here is that the delinquent physician may have already been paid the full salary in the year of delinquent performance. In this case, the base salary in the coming year would be reduced to recover the overpayment.

Tier Two

In the example, the group has established the following three objectives:

<u>Goal</u>	<u>Measure</u>
1. Increase overall physician productivity	Exceed 7,800 work RVUs
2. Management participation	Credit given for more than 6 meetings
3. Improve documentation	90% accuracy in documentation supporting CPT code billed

The group has allocated twenty percent (20%) of the net income, or \$800,000, to Tier Two. Additionally, they have decided that half (\$400,000) of the Tier Two allocation should go to Goal 1, a quarter (\$200,000) to Goal 2 and the balance (\$200,000) to Goal 3. Tier Two Compensation would look like this:

Tier Two Incentive Pay: Goal 1

Income Available for Goal 1: \$400,000

Goal 1 Measurement: Exceed 7,800 work RVUs

Physician	Target	Actual Production	"Excess" Production	Relative "Excess" Production	Bonus
1	7,800	7,400	n/a	n/a	n/a
2	7,800	7,400	n/a	n/a	n/a
3	7,800	7,200	n/a	n/a	n/a
4	7,800	8,400	600	25.00%	\$100,000
5	7,800	8,280	480	20.00%	\$80,000
6	7,800	8,100	300	12.50%	\$50,000
7	7,800	8,280	480	20.00%	\$80,000
8	7,800	7,600	n/a	n/a	n/a
9	7,800	8,100	300	12.50%	\$50,000
10	7,800	8,040	240	10.00%	\$40,000
TOTAL			2,400	100%	400,000

** Note that the group used "Relative Excess" Production times the available bonus pool rather than dividing the pool evenly between those who had met the required work RVUs for participation. Dr. 9 and Dr. 10 are non-owner physicians, but were permitted to participate in this part of Tier Two Bonus.*

Tier Two Incentive Pay: Goal 2
 Income Available for Goal 2 \$200,000
 Goal 2 Measurement: Attend more than 6 meetings

Physician	Number Meetings Attended	Relative Attendance	Bonus
1	10	15.625%	\$31,250
2	12	18.750%	\$37,500
3	12	18.750%	\$37,500
4	8	12.500%	\$25,000
5	4	n/a	\$0
6	6	n/a	\$0
7	10	15.625%	\$31,250
8	12	18.750%	\$37,500
9	n/a		\$0
10	n/a		\$0
		100%	\$200,000

For this portion of Tier Two Bonus, the non-owner physicians (Drs. 9 and 10) were not included as the meetings were for shareholders. The Tier Two Bonus allocated to Goal 2 was divided based on relative attendance with no credit given if 6 or fewer meetings attended.

Tier 2 Incentive Pay: Goal 3
 Income Available for Goal 3:
 Goal 3 Measurement: 90% accuracy & documentation

Physician	Objective Achieved?	Bonus
1	no	\$0
2	yes	\$40,000
3	no	\$0
4	no	\$0
5	yes	\$40,000
6	yes	\$40,000
7	yes	\$40,000
8	no	\$0
9	yes	\$40,000
10	no	\$0
TOTAL		\$200,000

The Tier Two Bonus allocated to Goal 3 is divided equally among those who met the threshold. Non-owner physicians were included.

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

Tier Two Bonus Pay

Physician	Goal 1	Goal 2	Goal 3	Total Tier Two Bonus
1	\$0	\$31,250	\$0	\$31,250
2	\$0	\$37,500	\$40,000	\$77,500
3	\$0	\$37,500	\$0	\$37,500
4	\$100,000	\$25,000	\$0	\$125,000
5	\$80,000	\$0	\$40,000	\$120,000
6	\$50,000	\$0	\$40,000	\$90,000
7	\$80,000	\$31,250	\$40,000	\$151,250
8	\$0	\$37,500	\$0	\$37,500
9	\$50,000	n/a	\$40,000	\$90,000
10	\$40,000	n/a	\$0	\$40,000
TOTAL	\$400,000	\$200,000	\$200,000	\$800,000

Tier Three

Last, at the third level reward the owners for their equity. This category is flexible, and is the pool from which money can be either reinvested on the Practice and/or returned to its original investors. Any return is divided among the owners equally. Hence, each of the eight owners would receive one-eighth of the remaining \$600,000 as a Tier Three Bonus.

Summary

Our example is summarized here:

Physician	Tier 1	Tier 2	Tier 3	Total
1	\$260,000	\$31,250	\$75,000	\$366,250
2	\$260,000	\$77,500	\$75,000	\$412,500
3	\$260,000	\$37,500	\$75,000	\$372,500
4	\$260,000	\$125,000	\$75,000	\$460,000
5	\$260,000	\$120,000	\$75,000	\$455,000
6	\$260,000	\$90,000	\$75,000	\$425,000
7	\$260,000	\$151,250	\$75,000	\$486,250
8	\$260,000	\$37,500	\$75,000	\$372,500
9	\$260,000	\$90,000	\$0	\$350,000
10	\$260,000	\$40,000	\$0	\$300,000
Total	\$2,600,000	\$800,000	\$600,000	\$4,000,000

What About Associate Physicians?

While the example included non-owner associates in the income division plan, this may be too generous. For associates, consider replacing Tier 1 pay with a lower amount, and perhaps discount the associate's Tier 2 participation. (e.g. the associate receives only 80% of his or her applicable Tier 2 amount.) These reductions to associate Tier 1 and Tier 2 allocations should then be moved over to Tier 3, for owners. Alternatively, use the traditional base pay plus bonus approach for the associate, and rely on performance appraisals and the prospect of future ownership to incent the associate to adopt the desired behaviors.

Conclusion

The tiered approach allows for greatly flexibility in determining what goals are most important to the individual practice. It takes the emphasis away from pure production and encourages behaviors needed to make your ophthalmology practice successful.

A version of this article was submitted for publication in Administrative Eyecare (January 2002 issue). It was reviewed and updated in 2006. Permission is hereby granted for the reprinting and use of this article provided that such distribution is free, and provided that the source and ownership of this material is acknowledged to be The Health Care Group, Inc.®. This article can be found online at www.healthcaregroup.com.