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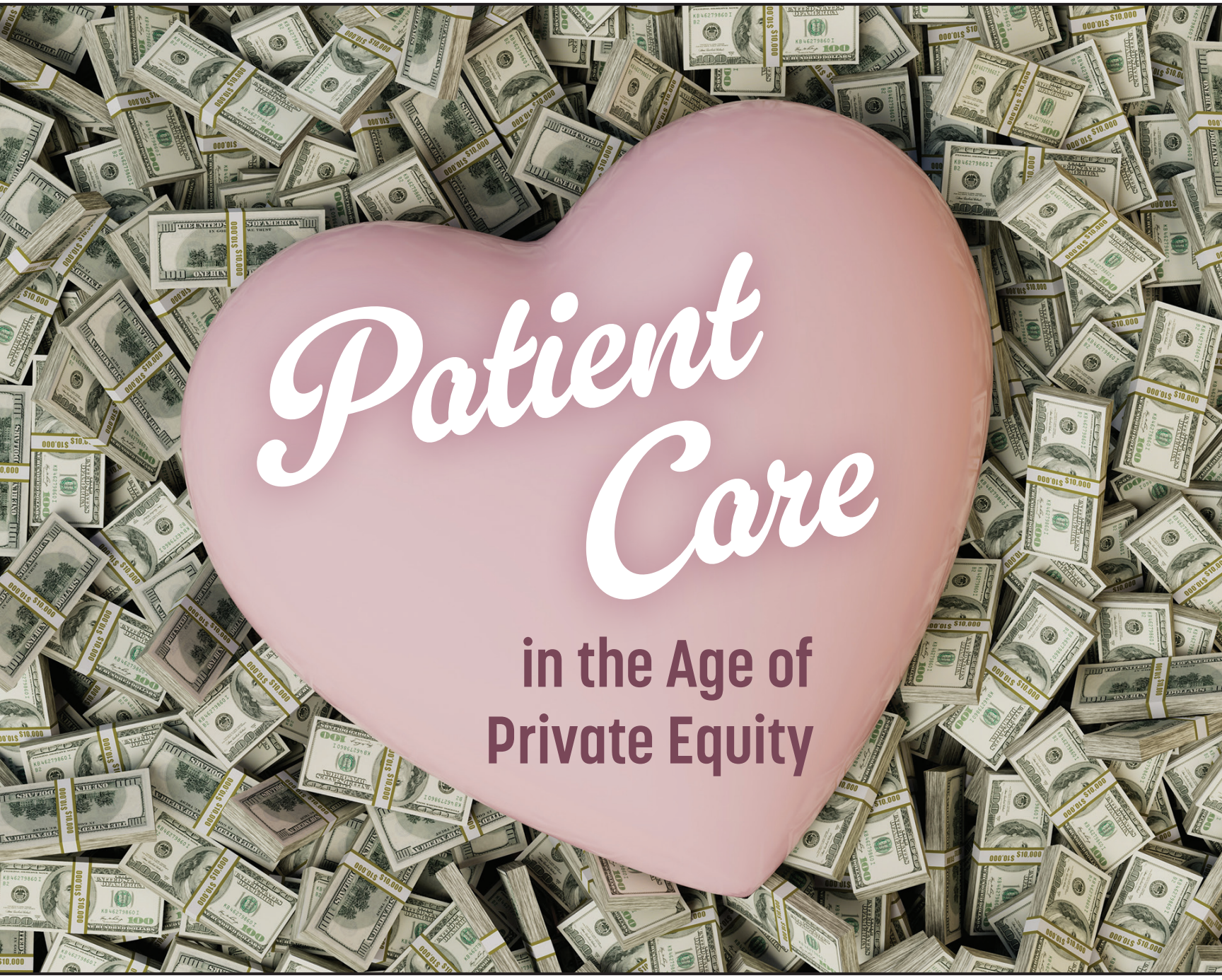

Patient Care in the Age of Private Equity

EDITORIAL

Eyes on the Prize: Saving Vision

Private equity (PE). We would be remiss if we didn't cover this topic periodically because it remains a prominent part of the retina community. Although soaring interest rates slowed PE acquisitions in 2023, reports suggest a resurgence in 2024. The S&P Global Market Intelligence 2024 Private Equity and Venture Capital Outlook found that 60% of PE executives expect improved acquisition rates this year—only 34% said the same last year.[1]

With this in mind, it's a good time to revisit PE in retina. The debate about the benefits and drawbacks of PE rages on (as evidenced by the sessions at this year's Vit-Buckle Society meeting in Miami, for any who attended), and most have strong opinions one way or the other. If you want to go down that rabbit hole, the July 2023 issue of the *Journal of VitreoRetinal Diseases* provided a rather succinct summary worth checking out (see *The Private Equity Debate in the Literature*). Two invited editorialists, Joel Pearlman, MD, PhD, and John T. Thompson, MD, shared their perspectives on PE in retina, each covering the same ground but with a different conclusion.[2,3] Note that Dr. Pearlman is a co-chair of Retina Consultants of America's Medical Leadership Board, while Dr. Thompson is a partner at his independent private practice.

Rather than rehash their talking points, this issue of *Retina Today Business Matters* focuses on what matters most: patient care. Regardless of your practice setting, the patient always comes first. Jordan Nelson, with BSM Consulting, shares how PE-backed practices can preserve clinician autonomy and maintain a patient-centric approach—two keys to keeping the patient front and center.

If you're tired of the PE discussion, skip right to the other articles in this issue. Joy Woodke, COE, OCS, OCSR, discusses strategies for avoiding buy-and-bill drug mistakes, our financial gurus focus on tools to secure your retirement, and members of Austin Clinical Research explain how they built their independent research center—and why you should consider creating one, too. ■

ALAN RUBY, MD
SECTION EDITOR

1. Private equity and venture capital industry shows resilience and optimism in 2024 amidst shifting market dynamics according to S&P Global Market Intelligence survey [press release]. PR Newswire. April 29, 2024. Accessed April 30, 2024. bit.ly/4aUKmOR
2. Pearlman J. Private equity: a punctuated equilibrium in retina. *J Vitreoretin Dis*. 2023;7(4):273-274.
3. Thompson JT. Private equity purchases of retina practices: their focus on profit is a threat to healthcare. *J Vitreoretin Dis*. 2023;7(4):271-272.

The Private Equity Debate in the Literature

Private Equity: A Punctuated Equilibrium in Retina
By Joel Pearlman, MD, PhD

Private Equity Purchases of Retina Practices: Their Focus on Profit is a Threat to Healthcare
By John T. Thompson, MD

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CODING ADVISOR
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HOW TO AVOID BUY-AND-BILL DRUG MISTAKES

Address claim issues as they arise to avoid disruption to your revenue cycle.

BY JOY WOODKE, COE, OCS, OCSR

Even a streamlined billing process for retina drugs can be sabotaged by a few mistakes and oversights. Due to low margins, neglecting even a handful of claims or underpayments from payers can significantly and quickly reduce your practice's profitability. A shared commitment to monitoring and addressing claim issues requires constant attention from all practice stakeholders. Included here are common pitfalls that can dramatically disrupt the revenue cycle.

PAYER CONTRACTS

Within insurance payer contracts, practice managers can find the agreed-upon terms for the fee schedule. Properly reviewing and understanding the terms of these agreements is essential because they can significantly affect the practice's reimbursement.

Often, medication reimbursement is a separate clause and is paid as a percentage of the CMS average sales price payment limit. Alternatively, some contracts will assign a unique fee schedule or pay a percentage of the invoiced cost. Some agreements state that the payment will be a percentage of the billed fee. This term is often specified when a not-otherwise-classified (NOC) HCPCS code is billed, which is the initial code used for new drugs until a permanent HCPCS code is assigned.

For example, let's say your practice purchases a newly FDA-approved drug for $2,000 and you bill a payer with an NOC HCPCS code with the usual and customary fee of $2,500. If this specific payer's contract states that it pays 60% of the billed fee, the practice will be grossly underpaid $1,500 for the drug. This payment is correct according to the agreed terms, and the remaining balance is a contractual write-off. Carefully review the terms of all payer contracts, and determine an appropriate billed fee to ensure appropriate reimbursement.

WE ALL MAKE MISTAKES, BUT SOME ARE MORE COSTLY THAN OTHERS.

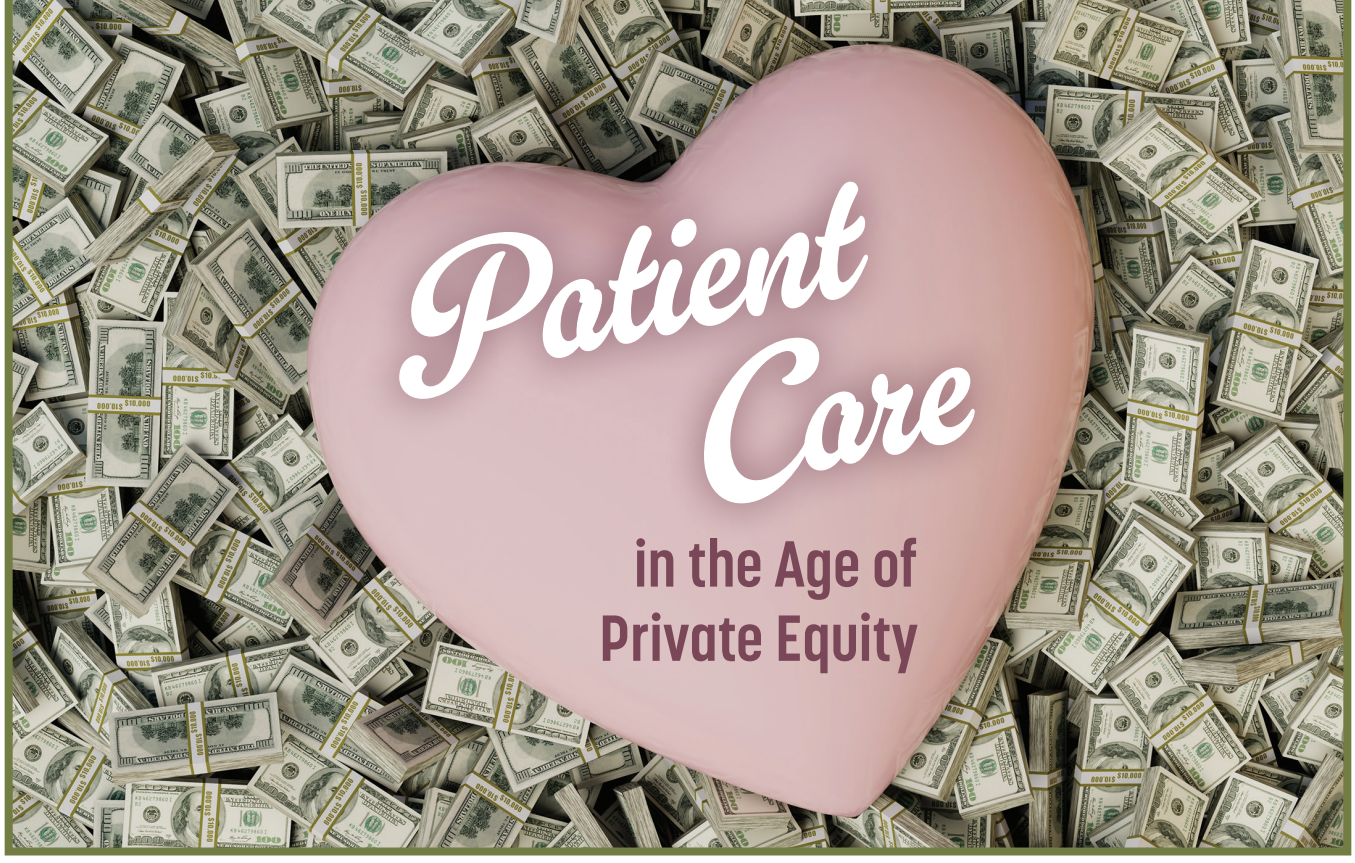
CODING MISTAKES

We all make mistakes, but some are more costly than others. Identifying and promptly correcting coding errors related to drug billing is a critical component of managing the revenue cycle in a retina practice. Possible errors can include billing for 1 unit instead of 2, 3, 5, or even 60 units. This expensive mistake is not only an underpayment, but if not corrected, can also be highlighted during a payer audit as a failure. At that point, options to correct the claim may be fairly limited due to timely filling limitations.

Additionally, billing for the incorrect medication will also dramatically affect the bottom line.

To avoid these types of errors, create internal audit reports that target these and other coding mistakes. Once you identify mistakes using the internal audit process, you can submit a voluntary refund followed by a corrected claim.

(Continued on page 7)



Patient Care in the Age of Private Equity

Retina practices can implement these strategies to ensure they maintain the highest standards of care, regardless of their ownership structure.

BY JORDAN NELSON

In recent years, the field of ophthalmology, including the subspecialty of retina care, has witnessed significant transformations driven by private equity (PE) investments. This trend has led to a multitude of changes, both positive and challenging, in how retina practices are structured, managed, and perceived. As these investments continue to shape the landscape, it becomes crucial to examine their effect on patient care. Doing so will help health care providers navigate these practice management changes to ensure that patients continue to receive the highest quality care.

RECENT INVESTMENTS IN RETINA

PE firms have become increasingly interested in investing in medical practices, including those specializing in retina care. These PE investments are typically structured through the creation of a Management Services Organization (MSO) that acquires the assets of medical practices while keeping practice entities in place for regulatory purposes.

MSOs provide a range of services to medical practices, such as human resources (HR), revenue cycle management, finance, and accounting. The MSO also provides capital for expansion, while implementing operational changes to improve profitability. Typically, physician owners who sell their practice assets to an MSO reinvest a portion of

AT A GLANCE

- Nearly 40 private equity (PE)-backed eye care Management Services Organizations (MSOs) operate in the United States, and nearly all partner with and employ retina specialists.
- PE ownership often has an investment horizon of 5 to 7 years to produce a +25% return for investors.
- MSOs can establish a Medical Executive Committee to represent the general mind of the physicians and ensure clinical considerations remain a top priority.
- Corporate-owned practices should establish quality metrics that prioritize patient outcomes and satisfaction.
- To ensure that patients receive great care under corporate ownership, PE-owned practices should prioritize patient welfare, preserve physician autonomy, and maintain high standards of care.

MORE ON PRIVATE EQUITY IN RETINA

Still have questions? See what other experts have to say about the wave of investment in the retina space:

What Is PE and Is It Right For Me?
By Dena Jalbert, MBA, CPA

Making the Leap to Private Equity
By David F. Williams, MD, MBA

A Day in the Life: Retina Edition
By Adrienne W. Scott, MD; Katherine E. Talcott, MD; Rebecca Soares, MD, MPH; Homayoun Tabandeh, MD, FASRS; Brandon Johnson, MD; Ryan A. Shields, MD; and Alan Ruby, MD

their sale proceeds into the MSO entity, thus becoming co-investors and part owners alongside the PE firm.

Nearly 40 PE-backed eye care MSOs operate in the United States, and nearly all partner with and employ retina specialists, many of whom are part of general ophthalmology groups. Hundreds of millions of dollars have been invested in these platforms, which has created a significant shift in how corporate-owned retina practices are managed and operate, with implications for both physicians and patients.

POTENTIAL CHALLENGES

While PE investments can bring financial benefits and operational efficiencies, they also pose several challenges for medical practices. PE ownership often has an investment horizon of 5 to 7 years to produce a +25% return for investors. New management is often hired, bringing business management tools that smaller practices may not be accustomed to using, such as annual budgets and board approval for strategic initiatives. PE also requires uniform information systems, leading to significant changes to accounting, practice management, and health record systems.

An MSO's C-suite executives are incentivized by profitability and enterprise growth. If not careful, an MSO may begin to prioritize process, systems, and profitability over patient experience and outcomes. Administrative burdens and standardized protocols may not align with the personalized approach associated with medical specialties such as retina. Downward financial and administrative pressure on physicians can also lead to a lack of clinical excellence.

Despite these challenges, there are strategies physicians and practices can employ to ensure that patients continue to receive excellent care under corporate ownership. Here, I discuss two of them.

NO. 1: PRESERVE PHYSICIAN CLINICAL AUTONOMY

Medical Executive Committee

It is not feasible for every physician in a practice that employs dozens (or even hundreds) to have clinical control over the organization; as an alternative, MSOs can establish a Medical Executive Committee (MEC). This is a committee comprised strictly of physicians and has direct access to the MSO's board of directors.

The committee is tasked with representing the general mind of the physicians and ensuring that clinical considerations remain a top priority. The MEC works with management to establish annual budgets for new equipment or other technology investments. The MEC is charged with establishing clinical best practices and


VISIONARIES IN PRACTICE

SELLING TO PRIVATE EQUITY

Realistic expectations and strategic planning are essential.

BY TONY STERRETT

ADVICE FROM COLLEAGUES

Anterior segment surgeons are having similar conversations. Take a look at a cover story that ran in the February issue of *Cataract and Refractive Surgery Today*:

Selling to Private Equity
By Tony Sterrett

WATCH IT NOW

A Look at Private Equity in Retina
By John T. Thompson, MD

protocols, monitoring quality metrics, and addressing HR situations that affect clinical care. The goal is to ensure that physicians have independent representation at the highest levels of the organization and the clinical autonomy of providers remains sacrosanct.

In some MSOs, the board of directors has physician representation, which is good, but not a substitute for a MEC. Within general ophthalmology practices, specialties like retina should be appropriately represented. Geographic representation should also be given consideration, and as MSOs grow, geographic sub-MECs could be useful.

Regular Physician-to-Physician Interaction

Physicians' interaction with each other can create a culture of collaboration and accountability. Collaboration often leads to innovative solutions to the challenges physicians face as part of a PE partnership model. Establishing a regular cadence for collaboration can facilitate the open exchange of ideas among care providers. Monthly or quarterly conferences and video calls allow providers to share ideas around clinical quality, new technology or techniques, hiring and staffing best practices, and a general forum to discuss treatment plans for uncommon or difficult patient situations.

In-person collaboration and meetings can also be a positive addition to the practice. While far more expensive than a conference call, face-to-face meetings offer a more personal and concentrated format for physicians to engage with each other.

Continuing Education

Corporate-owned practices should support physicians' continuing education to ensure they stay abreast of the latest advancements in retina care. This can help maintain high standards of care and physician clinical autonomy. At a minimum, practices should include a budget for providers to attend conferences and other educational events.

COLLABORATION OFTEN LEADS TO INNOVATIVE SOLUTIONS TO THE CHALLENGES PHYSICIANS FACE AS PART OF A PE PARTNERSHIP MODEL.

In addition, company management can coordinate with the MEC to create internal education opportunities and training. This might include inviting internal experts to share their knowledge with the broader group or inviting outside industry participants such as academia, health systems, or technology companies to collaborate.

NO. 2: MAINTAIN A PATIENT-CENTRIC APPROACH

The initial success of most independent practices is due to their dedication to creating a great patient experience. This standard, regardless of ownership, should always be the primary focus. Not only is this the right thing to do for patients, but also for the business.

Dedicated Time for Patient Care

Building and maintaining a patient-first culture is done by setting the example at the top of the organization. Board of director and shareholder meetings should allocate as much time to patient-related matters as they do to financial and strategic items. For example, in a 1-hour board of directors meeting, it is reasonable to expect 20 minutes of the agenda to focus on items such as quality metrics, patient satisfaction surveys, and clinical innovation. Much of this can be addressed by the MEC in board meetings.

Focus on Quality Metrics

Corporate-owned practices should establish quality metrics that prioritize patient outcomes and satisfaction. This will likely require investment in staff and technology to collect and analyze data. If knowledge is power, data can be the key to understanding how a practice is succeeding or failing and where those successes or failures are happening across the platform. Regular monitoring and assessment of these metrics can help identify areas for improvement and ensure high-quality care.

Emphasize Communication

Open and transparent communication between physicians and their local practice administrators is crucial. Just as physicians need dedicated access to the board of directors, local practice operators need direct access to the

IN THE LITERATURE

A recent study published in *Ophthalmology* found that, after retina practices are acquired by private equity (PE), their Medicare spending increases.[1] The researchers looked at a total of 82 practices that were acquired by PE during the study period (2015 – 2019) and matched control practices. In the PE-acquired practices, they found a 22% increase, per practice-quarter, in the use of higher-priced anti-VEGF agents (ie, aflibercept [Eylea, Regeneron]), compared with non-PE practices. This increased usage, averaging an extra 6.5 injections, led to an increase in overall Medicare spending of $13,028 per practice-quarter, or 21%.

1. Singh Y, Aderman CM, Song Z, Polsky D, Zhu JM. Increases in Medicare spending and use after private equity acquisition of retina practices. *Ophthalmology*. 2024;131(2):150-158.

physicians in the practices they are charged with operating. Local practice administrators are on the front line when identifying problems and effectively rolling out new programs. Without effective and open communication, much can get lost between the siloed roles in which administrators often operate.

Patient Advocacy

Practices should empower patients to advocate for their own care. This includes educating patients about their condition, treatment options, and how to navigate the health care system to ensure they receive the best possible care. Patients should have the ability to provide feedback about their experience. Technology can play an important role in patient advocacy, but having dedicated staff tasked with patient advocacy is often the best approach to ensure patients have what they need to feel their experience is the priority of the practice.

WEIGH THE PROS AND CONS

PE investment in retina practices is here to stay, and it represents a significant shift in the health care landscape. While these investments bring opportunities for growth and efficiency, they also pose challenges for patient care. By prioritizing patient welfare, preserving physician autonomy, and maintaining high standards of care, practices can navigate these changes and ensure that patients continue to receive great care under corporate ownership. ■

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(Continued from page 3)

INADEQUATE DENIAL MANAGEMENT

Ideally in a retina practice, the appropriate staff are assigned to denial management with a priority focus on drug reimbursement. Nearly 17% of claims are denied initially, which can dramatically affect the accounts receivable and cash flow, especially when considering the volume of drug claims submitted in a retina practice.

A calculated internal process should facilitate the management of each denial to identify if the cause is internal (eg, coding error, incorrect payer, registration mistake) or external (eg, payer not following their own policy, underpayment). When an internal cause is identified, a corrected claim should be submitted promptly, and the encounter should be tracked internally until the full payment is received. Alternatively, when the denial is an external payer-related cause, take immediate action, including sending an appeal or working directly with a provider representative to resolve it.

Here are a few of the most common claim denials caused by internal mistakes:

- using a drug with an off-label frequency or for an off-label diagnosis;
- lacking prior authorization or not following a payer's step-therapy policy;
- missing the necessary anatomical modifiers (eg, -RT, -LT, or -50) for an intravitreal injection, CPT code 67028;
- not reporting modifiers -JW or -JZ appropriately;
- billing the incorrect HCPCS code for bevacizumab (Avastin, Genentech/Roche) per the payer policy (eg, J9035, J7999, or J3490); and
- for commercial and Medicaid payers, not reporting the unit of measure in item 24 following the National Drug Code or incorrect reporting (eg, UN1 instead of ML0.05). ■

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- Financial disclosure: None

Learn more about managing medication coding, billing, and profitability through the AAO's Medication Inventory Management.

For other practice management tools, visit the AAO's Practice Management for Retina website.

Cultivate Your Best Practice Culture

Insights from a private practice owner.

BY JOHN A. HOVANESIAN, MD

Ophthalmology is a highly competitive specialty. Our private practice has built a competitive advantage in our community by concentrating on the five Ps: *pace*, *position*, *potential*, *performance*, and *power* (see the sidebar for definitions).[1] Of these, a focus on position—specifically our practice culture—has differentiated our practice from others.

LEAD WITH GRATITUDE

A practice's position and reputation extend beyond the clinical expertise of its surgeons and eye care professionals. Although state-of-the-art technology and exceptional medical knowledge are important, patients often notice a practice's culture more than the technology it uses.

Leading with a positive attitude and gratitude is the first step to cultivating a strong practice culture. This approach has a ripple effect throughout the practice that resonates with staff and patients alike and helps create an environment where everyone feels valued and cared for.

Another way to nurture a positive practice culture is through small acts of kindness. It is crucial to express gratitude to staff members, including those in the billing department and at the front desk and others who may not regularly interact with physicians. For instance, we send out a weekly email to the entire practice that highlights positive comments about staff members submitted by colleagues and patients. This creates a continuous loop of recognition and appreciation.

AT A GLANCE

- Although state-of-the-art technology and exceptional medical knowledge are important, patients often notice a practice's culture more than the technology it uses.
- Acts of appreciation require time and resources, but they also demonstrate that we value our staff, boost morale, foster a sense of community, create a collective sense of purpose and fulfillment, and contribute to the overall success of the practice.
- Personalities can significantly influence practice culture. We hire for attitude and train for skill.
- Conflict is inevitable in any practice. When it arises, we assume good intent and strive to align staff with the common purpose of resolving conflicts to provide quality care.

THE FIVE PS*

PACE The timing and intensity of a practice's strategic action

POSITION Conveying a unique and appealing image to patients

POTENTIAL The provision of superior capabilities and resources

PERFORMANCE Delivering and implementing superior actions and strategies

POWER Creating a successful collective organization

*Adapted from Luke RD et al.[1]

Beyond verbal gratitude, we incorporate incentives such as surprise gift cards, regular holiday celebrations, and theme days such as "Wear Your Favorite Sports Team Jersey to Work." These seemingly simple tactics have helped build a fun and enjoyable practice culture, which patients appreciate as much as staff.

Acts of appreciation require time and resources, but they also demonstrate that we value our staff, boost morale, foster a sense of community, create a collective sense of purpose and fulfillment, and contribute to the overall success of the practice.

CHOOSE STAFF WISELY

Staff personalities can significantly influence practice culture. We hire for attitude and train for skill. A candidate with a positive outlook is always preferred over one with prior eye care or medical experience but a poor attitude. This approach has proven to promote a positive practice culture and enhance staff satisfaction and engagement.

Some of our employees, particularly technicians, are between college and medical school. Although their time with us may be limited, their great attitudes and eagerness make training them worth the investment because they contribute positively to our practice culture.

This article originally ran in the February issue of *Cataract and Refractive Surgery Today*.

We also emphasize diversity and inclusion to create a welcoming culture for both staff and patients. We celebrate our differences and are committed to maintaining an inclusive and accepting environment.

Conflict is inevitable in any practice. When it arises, we assume good intent and strive to align staff with the common purpose of resolving conflicts to provide quality care. Simon Sinek's book *Start With Why* serves as a compass for our practice.[2] We begin every conflict resolution conversation by asking the following questions: (1) Why are we here? and (2) What are we trying to accomplish? Not every conflict can be resolved, but most dissipate when addressed with a positive attitude from the start.

CONCLUSION

In the competitive field of ophthalmology, emphasizing a supportive and nurturing practice culture has been crucial to our success. We express gratitude, carefully consider staff personality, and embrace diversity and inclusivity to optimize practice culture.

The interconnectedness of these elements enhances the sustainability of our practice and creates a supportive environment for our staff and patients. ■

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2. Sinek S. *Start With Why : How Great Leaders Inspire Everyone to Take Action*. Portfolio/Penguin; 2011.

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- Financial disclosure: None acknowledged

PRACTICE MANAGEMENT

INDEPENDENT RESEARCH CENTERS: A VIABLE CAREER OPTION

Consider this alternative to a traditional retina practice.

BY LUKE C. HECKMANN, BS; BRIAN B. BERGER, MD; AND IVANA GUNDERSON, BS

A dedicated ophthalmology research site independent from a clinical practice is a viable business model with the potential to yield numerous advantages for the physicians, site, patients, and research sponsors (Figure 1). The design of a retina research center in tandem with a clinic has been previously described.[1] Here, we discuss the benefits of taking the next step to separate clinical practice and research.

BENEFITS TO PHYSICIANS

The most obvious benefit to working at an independent, research-only retina center may be increased efficiency and time management in conducting research that is only possible at an independent site. At such a facility, physicians can focus their attention solely on research; there are fewer patients because research visits are longer due to the number of required protocol assessments. Seeing fewer patients allows more face time with each person, and physicians have time to thoroughly understand each patient and their social milieu; thus, an independent site can be conducive to providing more holistic care. In addition, seeing fewer patients also means fewer after-hours calls and emergencies.

A research-only environment also eliminates many logistical nuances that often require personnel to manage. For example, prescriptions and refills are non-existent, as all investigational products and protocol-required medications are either provided or reimbursed by the study and dispensed by the research office. Similarly, because health insurance is not a factor at an independent research site, there is no need for credentialing, verifications, authorizations, or time spent coordinating care for patients through assistance programs. Deductibles and copays are obsolete in this setting, along with patient statements and explanation of benefits, saving significant time and effort.

Figure 1. Austin Clinical Research is an independent, research-only retina center.

In addition to these benefits, a research-only setting provides intellectual stimulation by allowing physicians to work with the latest treatments in a controlled environment. The diagnoses and treatments for enrolled patients require less decision making, as care is guided by the study protocols, and the final diagnostic eligibility decisions are made by central reading centers.

Overall, physician dissatisfaction is at an all-time high, and, consequently, they are working fewer hours and retiring at an earlier age.[2,3] A large portion of this dissatisfaction can likely be explained by the rules imposed by the government/insurance complex; physicians are constantly being pressured to see more patients for less reimbursement and expend increasing resources to collect their proper compensation from insurance companies.

Figure 2. You can optimize the space in a research-only center by designating a separate drug storage room (A), laboratory (B), and imaging suite (C).

With manageable patient volumes across an appropriate number of ongoing studies, physician compensation at an independent research site can be comparable with or even better than traditional clinical practice.

IMPROVED ACCESS FOR PATIENTS

Clinical trial participation is an incredible opportunity for most patients and is further enhanced at a site that only focuses on research. We often hear that the biggest complaint of patients today is the lack of face time with their non-research doctor, as they are often unable to ask their questions or get complete explanations of their disease and treatment; as mentioned previously, an independent research setting is a viable solution not only for physicians, but also for the patients in their care.

Because only clinical trial participants are seen at an independent research site, they benefit from a dramatically reduced wait time. At a typical clinic, patients often wait in various clinic locations to be helped by front-office staff and then seen by technicians and the physician. In contrast, patients visiting a research-only site can be welcomed upon arrival by a dedicated staff member who completes all assessments with minimal downtime. Despite the large number of assessments required for protocol visits, the duration of research visits at an independent site can be comparable with that of a typical clinic appointment in our experience, and is potentially much shorter than if a research visit were squeezed into a busy clinic day.

With shorter wait times, patients can spend more time with their physician and staff, resulting in a stronger relationship and better rapport. The patient feels they are receiving comprehensive care alongside their dedicated coordinator, rather than going through extensive protocol assessments with little explanation. Because a site dedicated to research can participate in more studies than an already busy clinic, patients also have a larger selection of studies to participate in and, thus, have better access to the latest treatments.

Lastly, financial stress is an increasing concern for patients, with constant changes and increasing costs from medical insurance. By participating in a clinical trial, uninsured or underinsured patients can receive cutting-edge treatments for a condition that may otherwise go untreated or undertreated, simply due to cost. Patients are also compensated for their time, and transportation can be provided for appointments, which further promotes compliance with treatment and yields better outcomes.

BOOST IN RESEARCH SITE PRODUCTIVITY

By shifting the focus solely to clinical research, the site itself will see a boost in efficiency, as its entire workflow becomes reoriented around the research patients, including scheduling, staffing, office layout, and equipment. Scheduling is not constrained by the physicians' time being shared with clinic patients, and the site can have dedicated research staff, which leads to more accurate, personalized, and comprehensive care. The physical layout can be further optimized to include a space for an ETDRS vision lane, investigational product storage and preparation room, laboratory, and imaging suite (Figure 2).

Another factor is that recruitment is focused entirely on patients eligible for clinical trials. This can be directed toward the entire community with direct-to-patient advertising, which, when done correctly, is quite effective. Potentially, all physicians within the community can send referrals, as there is no competition from non-research clinical physicians. Patients can enroll in a clinical trial and still maintain relationships with their other physicians; it's

AN INDEPENDENT CLINICAL RESEARCH CENTER PROVIDES THE OPPORTUNITY FOR PHYSICIANS TO PRACTICE MEDICINE WITH MANAGEABLE SCHEDULES, PROFICIENT STAFF, AND SATISFIED PATIENTS.

worth noting that participation in a trial is not indefinite, and, thus, patients will resume routine care with their referring physicians when the trial ends. Patients may also choose to continue seeing their regular eye care provider between study appointments, as study physicians will not be managing eye conditions unrelated to the trial.

BENEFITS TO THE SPONSORS

Sponsors that conduct studies at a dedicated research site will experience key benefits across all areas of study conduct, including start-up, recruitment, enrollment, and quality of data. A dedicated research site can complete start-up and host a site initiation visit within 6 weeks of site selection, based on our experience. This is attributable to having a dedicated point of contact who can complete start-up documents, such as contracts and Institutional Review Board and Institutional Biosafety Committee submissions, concurrently, as well as experienced staff who can transfer certifications between all study vendors. Thus, sponsors do not have to spend time following up on document requests or waiting on various approvals from internal committees. An efficient start-up leads to on-time site activation and prompt participant enrollment, which allows sponsors to meet their study timelines.

Because research staff at independent sites can be trained across all areas of clinical trial conduct, they have a comprehensive understanding of protocol assessments. They can maintain certifications for all study vendors, such as those related to visual acuity, imaging, data entry, and international quality standards in which the relevant site staff are required to be certified (eg, Good Clinical Practice and Integrated Approaches to Testing and Assessment). The ability to focus solely on research can be attractive for staff, as it is intellectually stimulating and offers endless potential for growth, long-term employment, and stability.

FIRSTHAND EXPERIENCE

An independent clinical research center provides the opportunity for physicians to practice medicine with manageable schedules, proficient staff, and satisfied patients. For patients, clinical trial visits at a dedicated research site offer access to novel treatments in a friendly and professional environment; for sponsors, this setting offers confidence in the data obtained in a timely manner.

We implemented the independent research site model at the end of 2021. Our site is frequently the first one activated in many studies. The practice employs five part-time physicians, six clinical research coordinators, two imaging technicians, and a site director. Our staff have experience in more than 200 clinical trials in phase 1 to 4, enroll an average of 168 patients per year, and maintain an average of 39 ongoing studies per year. When our patients exit one study, they are usually eager to enroll in another. Our experience has demonstrated that happy physicians, patients, staff, and sponsors can generate a great work environment that is beneficial for all parties. ■

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FIVE TOOLS TO BUILD WEALTH FOR A SUCCESSFUL RETIREMENT


Physicians have many ways to secure their finances and ensure a happy retirement.

BY DAVID B. MANDELL, JD, MBA, AND JASON M. O'DELL, MS, CWM

Securing a comfortable retirement is a leading financial goal for most physicians, including retina specialists. To reach this goal, many physicians use a variety of different planning tools throughout their careers. In this article, we examine the five most common retirement planning tools used by physicians.

1 QUALIFIED RETIREMENT PLAN (QRP)

Retina specialists who receive a W-2 can often participate in their employer's retirement plan, which allows them to defer income by contributing to the plan.

A classic example of a QRP is a 401(k), which is the most common retirement plan option offered to physician employees of for-profit entities. Government and nonprofit health care organizations offer 403(b) plans, which work the same as 401(k)s.

For retina practice owners, a QRP can also be an attractive option, although they need to be aware of the financial ramifications (ie, what it will cost them to fund the plan for employees). Working with an experienced advisor can help practice owners determine which type of plan(s) make the most sense (eg, 401(k), defined-benefit plan, profit-sharing plan, money-purchase plan); they can also run various funding formulas so that owners get the lion's share of the benefits while also meeting the requirements for employee contributions.

Properly structured plans offer a variety of benefits: plan participants can fully deduct contributions to a QRP, funds within the QRP grow tax-deferred, and (if non-owner employees participate) the funds within a QRP enjoy superior asset protection.

In our experience, we find that nearly all physicians in private practice participate in QRPs. The tax deduction is hard to resist. However, for physician practice owners, QRPs come with a few downsides, such as the cost of contributions for employees, potential liability for mismanagement of employee funds, and the ultimate tax costs on distributions. Because of these, it often makes sense for owners to investigate another type of plan (that hedges the QRP) as an additional savings vehicle. For many, the next tool provides that tax hedge.

2 NON-QUALIFIED PLAN

Many private practice physicians want to save significantly for retirement but are limited by the QRP funding rules. In addition, practice owners are interested in a plan that hedges against their QRP and can be accessed tax-free in retirement. Non-qualified plans can be the solution for many. Because these plans are not subject to QRP rules, non-qualified plans do not have to be offered to employees. Further, even among the physician owners, there is absolute flexibility. For example, one physician can contribute a maximum amount, the next partner could contribute much less, and a third physician could opt out completely.

The main drawback to non-qualified plans is that contributions are never tax deductible. However, like a Roth IRA, they can be structured for tax-free growth and tax-free access in retirement. As such, non-qualified plans can be an ideal long-term tax hedge against a QRP. Beyond these general ground rules, there is tremendous flexibility and variation with non-qualified plan designs.

3 BENEFIT PLAN FOR SELF-EMPLOYED AND OUTSIDE BUSINESSES

Self-employed physicians and physicians who receive income reported on Form 1099 (including those who "moonlight," work locum tenens, or consult in the health care industry) have other options to help save for retirement.

A SEP-IRA is a traditional IRA established under a Self-Employed Pension (SEP) Plan document (often the Form 5305-SEP). Under the 2024 limits, physicians can contribute the lesser of $69,000 or 25% of their compensation. In addition, physicians with a SEP may still be able to contribute to a separate traditional IRA or Roth IRA. Like other traditional IRAs, SEP-IRA account balances grow tax-deferred and are taxed at the ordinary income rates when distributed.

UNDER 2024 LIMITS, AN INDIVIDUAL'S TOTAL CONTRIBUTIONS TO TRADITIONAL AND ROTH IRAS CANNOT EXCEED $7,000 PER YEAR ($8,000 PER YEAR IF OLDER THAN 50 YEARS OF AGE).

4 AFTER-TAX (ROTH) IRA

Under 2024 limits, an individual's total contributions to traditional and Roth IRAs cannot exceed $7,000 per year ($8,000 per year if older than 50 years of age). Physicians who are not covered by a workplace retirement plan may deduct pretax contributions while those covered at work can make non-deductible or partially deductible contributions, depending on their earned income and filing status.

Many physicians implement a "backdoor Roth IRA" by first contributing to a traditional IRA and then converting the traditional IRA to a Roth IRA. (Note: This tactic requires careful planning to avoid unnecessary taxation. Work with an experienced advisor on this.)

5 PERMANENT (CASH VALUE) LIFE INSURANCE

If managed properly, a permanent life insurance policy can provide the same benefits as a Roth IRA (ie, contributions are made after-tax and balances grow tax-free and can be accessed tax-free). The category of permanent or "cash value" life insurance includes whole, universal, variable, and equity-indexed life insurance policies. While the differences among these policies are significant, a deep dive into these distinctions is beyond the scope of this article (to learn more, see *Further Reading*). Regardless of the type of insurance, the cash value of permanent policies grows tax-free and can be accessed tax-free during the insured's life.

SECURING THE FUTURE

The top financial goal of nearly all physicians is retirement on their terms, and the five retirement tools discussed here can play significant roles in achieving this goal. If building your retirement wealth is an important goal for you, an experienced advisor can help you investigate retirement planning alternatives and determine the best option(s) for you, your family, and your practice. ■

FURTHER READING

Consider Two Assets With Special Tax Benefits
By Carole C. Foos, CPA, and David B. Mandell, JD, MBA

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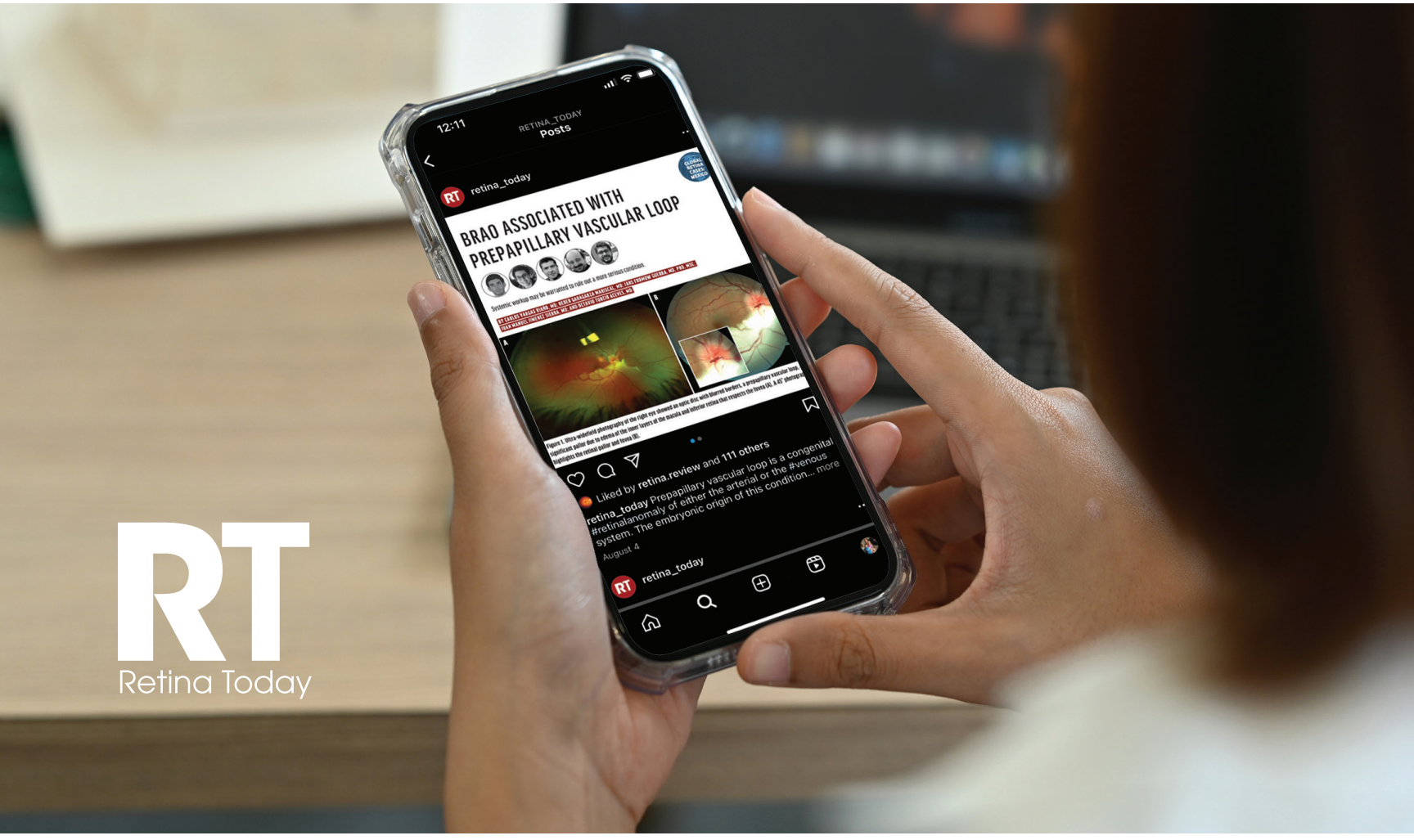

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Reference: 1. Data on file. Regeneron Pharmaceuticals, Inc.

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