Physician Compensation Plans

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Physician compensation in a private solo practice is simple: The physician receives any profits after expenses are paid as compensation. The physician generally takes a monthly draw and has periodic bonus distributions. When two or more physicians join the practice, the compensation variables change. Open communication and planning can help avoid conflicts that might arise from one partner feeling as though the compensation formula is unequitable.

Understanding the physician group culture is one of the most important elements when designing a compensation formula. How does the group communicate? Is there a shared vision, and what are the norms that help shape the way the group operates? This helps the group determine what is important and what they want to incentivize in a compensation formula. For example, Medical Practice Services consulted with a urology group that distributed everything equally. To learn more about the practice and culture, we interviewed each of the physicians to determine what was important to them. They had a strong team-based approach that they wanted to maintain, which tied into the equitable distribution of compensation.

Every group should spend some time assessing the financials and key performance indicators before addressing physician compensation. This includes reviewing each physician's productivity by assessing his or her charges and payments. It may also be helpful to review worked RVUs or encounters as a productivity measure. Additionally, every group should review their accounts receivable and collection ratios to determine if the revenue cycle is efficient.

Medical Practice Services consulted with a multispecialty group to assist with recommendations regarding compensation design. In this process, we learned that there were changes in their billing operations within the last year; they had outsourced their billing and then they brought it back in house. Their collection ratios were below industry benchmarks. We recommended that they spend more resources improving collections before attempting to redistribute compensation. Finally, we recommended that the group spend some time reviewing the income statement. The income statement should easily reflect the overhead, which is the expense before allocating physician expenses. If the financials and key performance indicators are not optimal, then variations in compensation design will not benefit the group.

Before developing a new compensation formula, it is important to spend some time assessing the physicians' understanding of the current formula and what they hope to

achieve with it. During this process, the group may identify any unique expenses or revenue associated with a provider in the group. Other considerations involve allocating profits from advanced practitioners, ancillary services, and value-based payments. Groups should consult with legal counsel to ensure that ancillary profit distributions comply with Stark regulations. Many payers reimburse value-based payments at the tax ID level. Some groups allocate the value-based payments internally based on their patient panel or on quality performance metrics. Some options for allocating advanced practitioner profits include distributing revenue after only direct salary and benefits are covered or including a percentage of the general overhead to the provider.

There are many different compensation formula structures. Most involve a distribution of physician compensation by allocating a portion of the expenses equally and a portion by productivity. Some groups may be very detailed in their approach, allocating all revenue and expense directly to the physician. The downside to this approach is that it takes more accounting resources to allocate everything at the physician level. On the other end of the spectrum is the group that pays every physician equally. This works well for a group where each physician has a similar expense and productivity structure. However, conflicts arise when one physician wants to slow down, work more, or utilize additional services. In larger groups with multiple departments and services, it is common to have a system of allocating shared administrative expenses equally, while allocating site expenses based on physician productivity and overhead at that site.

Some groups allocate expenses entirely on productivity. The downside to this approach is that the highest producer in the group pays more overhead expenses. Another option involves allocating a percentage of the expenses equally and a percentage based on productivity. In general, about 80% of the cost within a medical group is fixed cost or cost that does not change with patient volume. Some examples include rent, employees, and utilities. About 20% of the expense within a practice is variable which changes with volume. Supplies, both administrative and medical, are some examples of variable expenses. Groups can use this as a starting point for discussion.

Finally, it is best to keep the compensation formula simple and easy to understand. Keep in mind what you are trying to incentivize, as the formula will influence the group's culture. The more productivity-based the formula is structured, the less team-oriented the group will be. Conversely, an equal distribution of compensation in the group does not benefit the physician who wants to work more to earn additional income. Finding the right physician income distribution formula depends on the dynamics of the group. Once you have completed your compensation analysis, continue to evaluate but do not let the monthly financial minutia derail your strategic objectives. Focus on patient care, improving operations, and building your practice. In return, you will earn more compensation.

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