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Developing an Equitable Compensation Formula for Your Practice

wRVU compensation methods provide a measure of fairness.

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Whether a doctor is in private practice with a partner/associate, or is employed by a large group, HMO, or hospital, the formula utilized to determine the compensation for each doctor within the group is often one of the most passionately debated matters. The only doctors who are unconcerned about compensation formulas are those in solo practice. If, however, at some point, a solo practitioner decides that it would make sense to share office space and overhead with another doctor—or add an associate or partner—the long-term success of the contemplated arrangement will be highly dependent upon the perceived fairness of the compensation formula utilized along with any expense sharing arrangement.

There are pros and cons inherent in every type of compensation formula, with much depending on the "type of behavior" the physicians in a practice hope to encourage. Before embarking upon a discussion of these pros and cons, know that all formulas have three underlying constants. These include: 1) there is no single formula that is ideal or totally equitable for all participating physicians, 2) it is difficult to perceive formulas as being fair when all physicians are compensated the same, or when they are 100% productivity-based, and 3) compensation formulas should be reviewed for fairness every few years because no one formula works well forever.

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Before a group considers the various options for compensation formulas, it should first be ascertained that none of the physicians in the group harbor unrealistic income expectations or have lifestyles that exceed financial reality. There is definitely potential for both of these possibilities in merger situations where the doctors involved may have "overly

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rosy" projections for increased revenue and/or decreased costs. Keep in mind too that doctors also demonstrate different levels of efficiency when seeing patients, and some may see a group situation as an opportunity to cut hours or workload. Fortunately, both of these situations can be addressed by the type of compensation formula chosen.

Expense-Sharing Formulas

For some group practice situations, the doctors involved may, or may not, be true partners. A frequently utilized model is one in which the group's doctors are actually independent practitioners who simply share "name space" on the office door along with such expenses as rent, staff, and supplies. Although these doctors are not true partners, potential for conflict still exists when attempting to determine a formula for dividing expenses that will be considered equitable by all.

Another expense-sharing model consists of two independent doctors in different practice locations who form a partnership to share a third location where each will work part-time. Doctors in expense-sharing situations face challenges and benefits that are similar to what those in group practices face. These expense-sharing arrangements are particularly good for high producers who do not want to divulge, or share, their revenue. When considering this type of "merger," keep in mind that in such instances, it is common to see the doctor who is busier in his/her primary office want to allocate overhead on a half-day basis.

The problem with adopting this practice is that the doctor who is busier in his/her primary practice will often cram as many visits as possible into a half day—a strategy that enables him/her to increase revenue while disproportionately decreasing his/her share of the overhead (if the formula is based on "days in the office space"). Another negative for this "cramming strategy" is that it drives up variable costs such as supplies and third-party billing—shared costs which are driven by volume rather than by half day units. The result is that in this type of situation, the doctor who spreads a similar volume of patients over several half-days ends up paying a disproportionate amount of the overhead.

Generally, it is not a good idea to allocate expenses strictly on a productivity basis. When considering expense-sharing arrangements, expenses should be broken down into three categories: fixed, variable, and direct. The most commonly-used formula for determining percentages in expense-sharing situations incorporates an equal sharing of fixed expenses, splitting of variable expenses according to individual physician use, and considering each physician responsible for his/her direct expenses. Fixed expenses include such things as rent, telephone, equipment, and an office manager's salary; variable expenses include payroll for billing staff and medical assistants as well as medical and office supplies; and direct expenses include auto, CME/travel, and malpractice insurance. Some expenses fall into "gray" areas, requiring that the participating doctors come to agreement on their designation as fixed, variable, or direct. After going through each expense category and agreeing on its allocation, one option used for those expenses that fall into "gray" areas is to use a hybrid model whereby 50% of any of these costs are considered fixed and 50% variable. An example is a receptionist who greets patients as they arrive for doctors working in the practice and is making appointments for all doctors, at all times—whether or not a specific doctor is working in the office 100% of the time.

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Income Distribution Formulas

One of my favorite quotes comes from overhearing two physicians in conversation as they exited a hospital elevator. One said, "Why is it that all doctors are workaholics except for my partner?" When a doctor feels this way, his/her perception may, or may not, be correct, but if s/he believes it to be true, it is definitely time to re-evaluate the compensation formula for that practice. The challenge in such a situation is that this opinion is often based on productivity reports that do not take into account mitigating circumstances. For example, the lower-producing doctor may be working equally "hard" (i.e., seeing as many patients or working as many hours) but has been delegated a higher percentage of welfare patients—or ones with lower-paying insurance policies. All of these patients need to be "seen" by the practice—someone needs to treat them.

Today, it is rare to see distribution formulas where everyone gets equal pay. When all doctors receive the same compensation, there is little incentive for anyone to be more productive or work more hours. If a highly productive doctor is being paid the same as one producing substantially less, s/he may become disgruntled and decide to work less industriously. This, in turn, is bad for all doctors in the group. The result is that everyone's percentage of over-

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head goes up, and commensurately, everyone's compensation level is driven down.

Similarly, compensation formulas based 100% on productivity do not work well either. In the simplest form of production-based compensation, doctors are paid a fixed percentage of their individual collections. This is better known as "eat what you kill." The problem with this type of model is that it encourages unhealthy competition among doctors in the same group and works against achieving a well-functioning group that is able to compassionately and efficiently care for all patients referred to the group.

Because neither an equal distribution model nor a 100% productivity-based compensation brings out the physician behavior ideal for a practice and its patients, today's compensation plans often incorporate several elements. Because healthcare is becoming more complex, the elements to consider in compensation are likewise becoming more complex. Formulas considered by groups could include combinations of: 1) a base salary, 2) productivity pay based on collections, 3) work relative value units (wRVUs), 4) an incentive bonus based on productivity, 5) a stipend for any administrative services, 6) an incentive payment based on achieving quality of patient outcomes, 7) incentive payments for achieving certain cost savings and efficiencies, and 8) some type of profit-sharing for partners, based on each doctor's percentage of ownership.

One "simple" compensation method that has worked well in eliciting desired physician behavior involves paying a small base salary (which could increase, based on years in the practice), an amount based on productivity, and an amount based on profit-sharing (in turn, based on percentage of ownership), along with a provision of equivalent benefits that typically include contributions to retirement plans, automobile expense reimbursement, CME expenses, business-related travel expenses, and malpractice insurance coverage. The productivity portion could be based on wRVUs or on a percentage of individual collections. As with other formulas, quality measures, bonuses, and other elements can be added to this compensation formula. These would be utilized to encourage any behaviors that the group feels will help it achieve specific outcomes. It should be considered too that any physician spending time in management of the practice is likely to have lower productivity as a result. This too should be compensated with an agreed-to annual stipend or an hourly rate.

The reason that wRVU compensation methods are popular is that wRVU is a pure measure of work-productivity; it is not restricted by the type of insurance billed or the amount of payment collected, and it can be applied to any specialty in a multi-specialty practice. Because the wRVU method is not altered by the amount collected, calculation of the actual compensation received needs not only to be based on the number of wRVUs produced, but this number must then be multiplied by a factor that also takes collections, expenses, and profit into account. Because marginal profit increases with increased productivity (due to a greater volume of patients being spread over fixed expenses), the multiple should be increased for those doctors whose productivity falls in the higher percentiles.

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Since a group cannot pay out more in compensation than the "money collected, minus overhead paid", the wRVU method gives an incentive for everyone in the group to control expenses and increase efficiency. The more efficient the group, the higher the multiple that can be used—resulting in a higher-than-average compensation for all doctors in the group and greater profit for the group's partners. Because of the multiple factors that the wRVU method takes into account, applying it has been a good way of achieving productivity, efficiency, and value in ownership. More importantly, the wRVU method can also provide an incentive for quality achievement because future contracts will likely pay higher for achieving certain quality benchmarks. This, in turn, should increase the multiple used. High quality ratings will also attract more patients to the group, growing the practice.

Whether you are a partner in a group, opening a satellite office with another independent doctor, or employed by a group, the better you understand various compensation methods and how they can be used to encourage specific types of behavior, the better you will be able to offer suggestions for change in your practice's compensation formulas. Remember that these formulas should be re-evaluated periodically for fairness, and any changes should take into account the type of behavior needed to address healthcare delivery models and reimbursement methods as they evolve and change going forward. **PM**

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