Rethinking Production Based Compensation Plans

By Thomas A. Lerner*

Negotiations regarding compensation are one of the primary reason that physicians consult lawyers for non-medically related matters involving their practices. The issue arises in the context of hiring or association, the merger or separation of practices or simply when a member of a group practice seeks a change. Because the common compensation structure is set up to define one's economic worth, and by extension, value to the practice, the negotiations carry with them an inherent tension, even when the goals of all involved are substantially the same.

The default compensation system tends to be a production based plan. The premise of this article is to encourage consideration of a simpler and less formulaic approach, that may add cohesion to a group practice, relieve administrative burdens and contribute towards a less stressful and more satisfying work experience. The dynamics of each group will be different, of course, but the discussion may be worth having.

Compensation plans have two primary purposes: to reward work, and to motivate certain behaviors. In the conventional corporate business setting these two purposes are served with the use of an established salary, combined with an opportunity for a bonus or salary increase. In an environment where revenue is less predictable, such as a service business that is dependent upon the productivity of its employees, cash flow fluctuations tend to mitigate in favor of a more flexible structure.

Production based compensation systems individualize the risk/reward associated with revenue generation. A common form of compensation plan within group practices involves some method of overhead allocation as a direct cost charged to each physician, combined with individualized tracking of revenue received for services provided by each physician. The net compensation received by the physician is generally based upon the amount of funds collected for that physician's services after the deduction of the allocated costs. In group practices where some of the physicians are owners and others are non-owner employees, the owner compensation may also include a component of profit earned from the services provided by employees, or from ancillary services.

Variations exist with regard to the manner in which overhead is allocated. For some groups, certain fixed recurring costs are divided among the physicians on a per capita basis, while other costs may be allocated proportionally in accordance with revenue generated. Thus, the highest producer bears the highest proportion of the overhead, but that system also roughly reflects higher usage. Like all formulaic systems, this has its analytical flaws, as it assumes that the higher revenue relates to consumables or depreciation, when in fact it may simply reflect the nature of the procedures involved. Other practices will use a simpler "per capita" allocation for overhead. There are still other variations on the theme.

The effect of this kind of production based/overhead allocation plan is to make each physician an individual profit center. It is a "group practice" only to the extent of shared call, shared overhead and collegiality. Unless the group practice establishes systems that address the allocation of new patients who come to the practice generally (as opposed to a referral to an individual doctor) the system also places each physician in direct competition with the other members of the group. While this competitive aspect may be of little significance among full or growing practices, it will become increasingly noticeable where the practice's patient population is static or shrinking. Tracking and allocating the practice's costs, and tracking the individualized revenue adds additional accounting complexity when all medical practices are already endowed with tremendous billing and accounting chores as a result of the extraordinarily inefficient and cumbersome third-party payor system with which American health care is burdened.

In multi-specialty practices that include both specialists and primary care, a production based compensation system invites conflict. The compensation received by the specialists' will typically be significantly higher than primary care, without regard for the fact that many of the specialists

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* Thomas A. Lerner is an attorney with the Seattle firm of Stokes Lawrence, P.S. Mr. Lerner regularly represents physicians in their business affairs.

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patients will be direct referrals from the primary care physicians in the group. A compensation plan for such a multispecialty group where all of the physicians believe that the plan is fair is the ever elusive "holy grail" for those who work with physician compensation plans. Proposing such a plan is beyond the ambitions of this article.

Because of the manner in which production based compensation plans operate, their effect can be to discourage cohesion within the group. Rather, a production plan invites an inherent tension. The group cohesion comes from a commonality of interest and (often but not always) practice styles—and the necessity of finding others with whom to share overhead and call. A production plan is not one where a "rising tide lifts all boats." Rather, it will be an array of peaks and troughs. To carry the metaphor further, the visual image is of stormy seas.

There is, of course, another perspective that may explain why production based plans have such widespread currency. Individualizing the risks and rewards frees each physician to make independent judgments about how they spend their time (subject to the limitations of shared resources, and the requirement that the practice be adequately staffed and call covered). Thus, a physician who prefers a more abbreviated schedule has the independence to make that call, as only that physician will bear the financial consequences. That independence may outweigh any of the negative factors inherent in a production based plan. Which considerations prevail is a matter of personal preference for the physician and the group.

In reconsidering the production based structure, let us again reflect upon the twin purposes of a compensation plan: to reward and motivate. Consider a compensation model for a group practice where the physicians are all of the same specialty and the costs and net revenues are equally (or substantially equally) shared among the physicians. For example, among four physicians, each may receive twenty-five percent of the net revenue. In such a setting, the burden of the work can be equitably managed through scheduling, where each physician is equally motivated to share resources so that their partners can be as productive as possible. If a physician prefers to work a shorter schedule, their percentage of revenue can be adjusted accordingly. Thus, the physician who prefers a thirty hour week to a forty hour schedule receives 18.75% of the net revenue, with the other three physicians (who pick up the load) each receiving slightly more than 27% of the revenue. There are endless variations on this system, and it frees the physicians to design a compensation system based on common values and experiences rather than competition. By contrast, a production based system encourages competition for resources, so that each individual physician can maximize their revenue, without regard for the effect on others within the group.

For one form or another of a shared compensation plan to succeed, it cannot ignore the disparities that the production compensation plans involve. A shared compensation system also does not automatically mean that all revenue received is divided equally. There must be a consensus among the participating physicians with regard to job expectations, in terms of the amount of effort to be devoted to the practice, and time away from the practice. Variations in revenue sharing can be agreed upon, based upon different personal preferences or traits. Thus, such a system can accommodate the passionate workaholic, along with the physician who is drawn to their interests away from the practice.

By eliminating the economic basis for competition among partners within the same group, and implementing an economic model that can be mutually supportive (beyond shared call and a collegiality) the financial condition of the group as a whole need not be diminished. Instead, some of the stress associated with attaining that financial condition should be relieved.

Where the advantages to a departure from the production based model are readily apparent, why has the production model maintained such vitality? It is one of the few remaining mechanisms for an established practitioner to realize value from the goodwill developed through years of practice. Where third-party payors determine payment rates, that goodwill value is a reflection of continuity with a good reputation. A production model does

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not reward that reputation beyond a certain level of patient volume, which at some point will exceed the physician's capacity. A shared compensation model maintains the same rewards of a good reputation, while sharing the burden of performing the work.

There are readily available alternative economic models by which an experienced practitioner can bring on a junior associate without having to inordinately subsidize the junior associate while their practice develops and grows. Those models are commonly in place, in one form or another, for "new hires." The challenge, and tension, arises depending upon when the new physician transitions from salary based compensation to the production model. The gradual growth and development of a new practice can be appropriately addressed in a graduated entry into a shared compensation model.

Additionally, the production model provides a quantifiable mechanism by which individuals can measure their worth. Regardless of one's profession, in a society without royalty, income has become a surrogate for societal significance. Professional athletes, for example, are highly regarded as much for their extraordinary contracts as they are for their exploits on the field, regardless of how boorishly they may behave off the field. We look not so much to the quality of one's contribution to society as we do to how it is economically valued. Abandoning a production based system requires that one find a greater level of satisfaction from the whole, rather than just one's own constituent part.

In recent years, there has been much discussion of physician satisfaction with their careers, as doctors are caught in the crosshairs between health insurance costs and health insurer profits, and pressure to serve higher patient volume. There is room within each practice to reassess the effects of the economic structure on which the practice is based, and whether some of the wear and tear on individual physicians can be relieved by employing a different economic model. This article may provide a basis for beginning discussions to that end. ■