Special Report

Physician Income Distribution Systems:

The Search for Perfection

Latham
Consulting Group
Make Decisions, Resolve Conflict, Move Forward

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Physician Income Distribution

Physician income distribution methods often attempt to recognize:

- Different earning power.
- Different work habits.
- Financial value of activities which may not be income producing in themselves.
- The affect of managed care reimbursement.
- Expense control.

Unfortunately, there is no perfect compensation system for group practices. In many cases, a fundamental goal in devising group compensation programs is to find the balance point at which the least compromise of conflicting objectives occur.

Key to any distribution plan is recognizing that the method must be objectively directed toward organizational rather than individual needs.

Almost all small to medium-sized groups use a strict, arithmetic formula to distribute their income. This allows them to avoid the discomfort associated with evaluating a peer physician (some larger groups are now adopting discretionary income systems in which the physician managers exercise some element of judgment affecting individual compensation).

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It is also important to note that compensation plans distribute net income which itself is a function of the group's revenues and costs. Accordingly, many distribution formulas are based not only on revenues, but also on the allocation of costs.

Most income distribution plans include one or more of the following methods:

1. ***Productivity:*** Where practice income is distributed in some relation to the physician's productivity in the group.
2. ***Equal Share:*** Where each physician receives an equal share of the income of the practice.
3. ***Cost Accounting:*** Under cost accounting, each physician is assigned his or her direct, and some or all of his or her indirect expenses.
4. ***Desirable Non-Income Producing Activities:*** The group may choose to reward certain non-income producing activities.
5. ***Seniority:*** Some groups' distribution plans recognize physician seniority in the practice.

In addition, there are several other possible considerations when developing a income distribution plan:

- Credit for Ancillary Services
- Fail Safe Points
- Bonus Pools

In recent years, the use of Productivity and Cost Accounting principles as part of a distribution formula have increased, the use of Seniority components has decreased, and the amount of Equal Share as a formula component has generally been reduced.

Recent studies show that 78% of groups are using a plan which includes a productivity component, while 7% use the equal share method exclusively.

Trends include recognizing the impact of managed care involvement, the use of board discretionary funds where some income is distributed based upon

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subjective factors, and negotiated salary-based income distribution (used by prepaid and university-based groups).

The following pages describe the major income distribution methods in more detail..

Productivity

The pace of their work, the ability to do work, and the value of the different types of work produced all tend to make individual doctors in a group produce services of different value to the consumer. This difference converts through normal economic process into different contributions to net earnings of the group which are used to pay doctors.

Knowledge of this difference and competitive alternatives for practice stimulates doctors' normal expectations for compensation in relationship to the value of their work.

Proponents of a productivity-based income distribution argue that such a plan does the best job of matching reward to work, and of motivating physicians to perform in a highly productive manner. They also point out that those who choose to be somewhat less productive do not take funds from those who are more productive. This can be an advantage if a doctor wishes to slow down because he or she is nearing retirement or for other personal reasons.

Few proponents of such system recommend that the group's distribution plan rely completely on productivity-based distribution. They believe that the productivity component of the plan should represent 40% to 60% of the distributable income - less than 40% tends to be inadequate reward for hard workers and more than 60% tends to create overly strong independent and competitive qualities.

Opponents of productivity based plans argue that such a plan can lead to the following problems:

- Limited internal referrals because of income concerns.

- Zero or minimal involvement in desirable non-income producing activities, although this can be overcome by setting requirements and standards.
- Members of the group can become reluctant to do anything that would not provide a direct contribution to their individual compensation. This can include a reluctance to bring in new, competitive physicians.

Productivity plans are normally based on dollar productivity. Proponents of using this basis argue that if production of net earnings in necessary to pay doctors for their services, then production of net earnings should be the measure of productivity for compensation purposes. They also feel that other methods of measuring productivity usually represent compromises for administrative convenience. Other methods which groups consider include patient clinic visits/surgical times, and relative value schedules.

Other groups use indexing methods where a certain amount is paid to the physician for stair-stepped levels of production. For example, a physician might received 40% of the first $100,000 of his production, 50% of the next $50,000, etc.

There are also groups which use a productivity index system in which each group member's income production is compared against a basic national average for his or her specialty. Each doctor would be paid a lower percentage, perhaps 35% to 40% of his production up to half that index figure, and then he would receive a higher percentage (maybe 50% or 55%) of his billings up to the index's second half total. If the physician's production exceeds the national index figure, he would be entitled to a still higher percentage share of that excess - perhaps 65% to 70%. Under this method, the percentages to be applied must be carefully developed so the income shares will actually be available. Normally, this system involves heated discussions about how much to award the "overproducers" vis-à-vis the "under producers."

There are also "Superbonus calculations," where high producing physicians are given a premium distribution for production in excess of a predetermined threshold. For example, a typical provision might be to pay a physician a higher percentage of all dollars produced in excess of $500,000 in addition to the distribution calculated by the formula for the first $500,000.

Equal Share

In almost every group practice, some shift of income from high-producing to low producing specialties or sub-specialties takes place. This shift is created to recognize the following factors:

- Values exist within a group practice that are not related exclusively to dollar production or profit generation. These values are usually intangible and are recognized through a component of income sharing that is equal.
- Many of the lower dollar producing specialties or sub-specialties provide a large, steady volume of referrals to the higher producing specialties.
- Many lower dollar producing specialties or sub-specialties have low production/high cost characteristics that will result in inadequate physician incomes in a group practice with strict cost accounting or production-intensive distribution systems.

In addition, proponents of the equal share method point out that it stimulates group values and unity and compensates for cross coverage and internal referrals.

Opponents of equal share, however, point out that if the equal share philosophy is pervasive, when it is applied to incremental increases in production, it produces a result that defies economic reality and actually results in a relative disincentive, especially for physicians in high dollar-producing specialties, to expand volume. They point out that there is little incentive for maximum effort by each physician. Finally, they point to the difficulty of dealing with less than fully productive physicians, either from partial retirement, disability or choice of life-style.

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Although the equal split component is usually explicit (i.e., a provision that 40% of distributable income is allowed equally), there are also indirect ways of equal allocation:

- Within a cost accounting system (discussed further below), indirect expenses are allocated, totally or substantially, in proportion to production (which means that the higher producers pay more expenses).
- Provisions are made for equal allowances for certain types of expenses, such as travel, meetings, automobiles, dues, subscriptions and entertainment.
- Provisions based on seniority, in which a large proportion of the owners qualify for the maximum allocation, are included.

Cost Accounting

Cost accounting recognizes the costs of generating service and holds the doctor financially responsible for all or part of his logistical support.

When a physician's share of the income is equal, he can totally ignore his own costs because he only pays for a fraction of any costs he adds. When income distribution is only based on productivity, he can receive compensation which is inconsistent with his contribution to the total amount available for distribution.

Under cost accounting, physicians are assigned direct, and some or all indirect expenses. The idea is to charge these costs to those who are responsible, thereby creating a system of built in checks and balances.

Proponents suggest that without such controls, physicians have no motivation to control costs.

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The counter argument is that the physician not only becomes concerned with controlling costs, but actually becomes obsessed with expenses to the extent it becomes an obstacle to growth and improving qualitatively. In addition:

- Allocation of shared costs cannot be precisely made.
- The use of cost centers penalizes the physicians in traditionally high cost specialties or sub-specialties. This process, purely quantitative in nature, fails to recognize material contributions that some specialties or sub-specialties contribute to the welfare of the organization.
- The implementation of cost accounting often requires staff increases and upgrading of data collection systems.

Desirable Non-Income Producing Activities

While it is difficult to place a dollar value on intangible physician responsibilities (such as board of directors, committee service or community relations), it must be recognized that such activities are beneficial to the group practice organization. Performing these duties often takes time which might otherwise be spent at clinical productivity, reducing a physician's capacity to earn income through a productivity-based system.

Quantifying compensation for non-income producing activities such as education, administration, research, public relations and civic activities is most difficult and often overlooked. Many groups use an equal share component in their compensation plan and take the opinion that non-income producing activities are accounted and compensated for in the percent allocated to equal sharing. Some groups, however, identify major components which either must be done (such as administrative functions) or are extremely desirable and establish a value for such activities.

Generally, a predetermined stipend, which is considered as part of the group's general overhead, is paid for these services. Some groups develop point systems for each activity, while others investigate what value the marketplace would assign to them.

Proponents of recognizing these activities point to the value the group receives if they are performed. Opponents note that it is difficult to accurately

value these activities, and the group can spend endless hours haggling about what they are worth.

Seniority

Proponents of a seniority component in an income distribution formula believe that:

- The more senior physicians provide certain benefits to the group that should be compensated.
- Longevity with the group is positive for the group's functioning.

Opponents note that these benefits are difficult to measure objectively.

In recent years, the use of a Seniority component is normally used to "stair-step" new physicians compensation up to the amounts they will receive as a "senior" physician.

Fail Safe Point

Groups that divide at least some proportion of their income equally struggle with what to do with:

- Low producers
- Disabled physicians
- Those who choose to lower their productivity for life-style purposes
- Retiring physicians

Many groups develop some sort of "fail-safe point" in which a member is no longer provided an equal share of income production once his or her production falls below a specific point. That "under-producing" doctor's income would then have to be reduced automatically when the situation arises, thus avoiding confrontations and/or negotiation.

For example, a member might no longer receive an equal share if the member's total charges for a year becomes less than 75% of an equal load. The member would thereafter be entitled only to his or her actual production percentage of income until the member brings back his or her share of the total workload back over the "fail-safe point" for some period of time. The other partners would divide the remaining amounts as usual.

Some groups provide for a "one-year lag" in applying the fail-safe principle. The lag tends to give a doctor some extra benefit before knocking down his or her share, and it also helps reduce the amount of continuing and current "score-keeping" which some doctors dislike.

The main argument for a "fail-safe point" is that it automatically identifies the production level at which a group member no longer deserves an equal income share - without the embarrassment and/or dispute of evaluating a member's worth and challenging his or her income right.

Other groups provide an "escape clause" which calls for special negotiation if productivity consistently falls below a certain point. Under this system, a group member at a specified age and/or years of service is permitted to propose a written plan for partial retirement. Approval of these contracts is normally for only one year: the senior doctor must reapply each year to repeat his or her arrangement or to modify it. The benefit of this process is that it

Bonus Pools

Some groups are creating "bonus pools" that are distributed annually by a subjective evaluation of each member's contribution to the group's overall success. This is either done by electing two of the most respected members to decide on the pool's distribution, or by surveying each member. Some groups even perform patient satisfaction surveys to learn how well-received the doctor really is, and use that information as part of the basis for distribution. That information, along with other factors such as leadership, cooperation and assumption of responsibilities, helps a compensation decide on his relative bonus. Proponents of this method recommend 10% of net income as a minimum to make this an effective program.

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Changing Income Distribution Methods

Any group that attempts to change its income distribution faces considerable risks. Unless practice revenues are growing rapidly, it is likely that some physicians will "win" while others will "lose." Naturally, such a situation may create a highly-charged atmosphere and the person facilitating the change can end up being the "lightening rod" for physician frustration.

Because of this, we have found that groups who are successful in this endeavor:

- Find a way to depersonalize the process (possibly through use of outside facilitation).
- Establish the goals of the income distribution system first - what incentives are you trying to create?
- Develop suggested methods used to meet these goals.
- Test the results of these methods against both historical and projected data.

If the group attempts to discuss methods before it establishes its goals, it is likely that the change process will fail.

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Income Distribution Considerations

The following is a checklist to consider when evaluating a physician compensation system.

Income
- Equal share
- Productivity
  - Gross charges
  - Adjustments
    - Discounts (Patient, no-charge, billing errors)
  - Collections
  - Other basis (index)
- Allocation of ancillary services revenues

Expenses
- Equal share
- Productivity
- Cost accounting
- Ancillary services expenses

Special Payments
- Desirable Non-Income Producing Activities
- Seniority

Allocations
- Capital reserve fund
- Working Capital Requirements

Net Distributable Income

Other Considerations:

Calculation period	Other work "rules"
Salary draw	Buy-in/goodwill
Managed care discounts	Non-compete clauses
Benefits	Income from outside activities
Call	Stock purchase
Fail-safe Point	Deferred payments

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Physician Status

Employee	Partial retirement
New	Disabled
Fully Productive	Terminated
Reduced Productivity	Death

As you might expect, our knowledge in this area is based on the fact that Latham Consulting Group has provided **Physician Compensation Services** to many medical groups. If we can provide assistance or answer any questions you might have, please contact us at 704/365-8889.