Compensation Packages for Physician Group Practices: Options and Combinations

BY JOHN D. FANBURG AND LEONARD LIPSKY

Physician groups have a variety of options available to them when determining how to compensate their members. From the outset, the most important factor in a group’s decision is whether or not to incentivize productivity.

Historically, first-generation group practices compensated their members on an equal basis. But while in the past group practices have not needed incentives to encourage their members to work hard, modern group practices have become so large and multi-faceted that, in order to deal with an evolving medical work ethic, they need to provide some form of incentive to elicit diligence. Most groups today should, therefore, incentivize productivity to reward hardworking members.

In order to understand the importance of incentivizing productivity, it is necessary to understand the strengths and weaknesses of the various compensation options.

Compensation Options

One option is the “equal split,” which allows each member of the practice to earn an equal share of the profits (and of course, divide the losses as well). This is the simplest compensation formula, taking into account only the members’ capital contributions. The benefit of this option is that, as equal members of the practice, physicians normally share equally in the responsibilities (all the members of the group are, more or less, equally productive). Smaller group practices have traditionally operated under equal compensation models because duties are typically shared equally, and in a small practice, each physician is aware of how each contributes to the practice. In addition, smaller practices have stronger personal ties among its members. As a result, physicians in such practices generally share equally in all responsibilities and possess a greater “sense of shared ownership” with respect to the practice’s success.

The pitfalls of this model, however, are two-fold. First, it is generally not suitable for current multispecialty practices because such practices have far too many members to effectively allocate and enforce equal duties among its members. Because under the “equal split” model each physician receives an equal share of the monies available for compensation, there is no economic incentive to work hard. While this natural human tendency is common among all practices, it is more difficult to curtail it within larger,
multispecialty practices because of the resources that are necessary to monitor such behavior. Second, because the "equal split" model does not incentivize productivity, it may ultimately stifle a practice’s ability to grow and generate revenues. Because the efforts of productive physicians go unrewarded under this model, such physicians may be discouraged from maintaining high levels of production. In turn, this may ultimately result in a race to the bottom, harming the overall health and productivity of the practice.

For smaller groups that choose the “equal split” option, each physician should also be allocated an equal share of the administrative duties and responsibilities of the practice. Because members are not normally compensated separately for such services, a physician saddled with the bulk of such duties may grow to resent the remaining members and eventually eschew these responsibilities altogether.

A Different Approach

A better approach to member compensation is a productivity-based model. Physicians are compensated based upon a formula that takes into account revenues generated by the work personally performed by each individual (and in some cases, revenues generated from certain ancillary services). Many mechanisms exist for calculating physician productivity. For example, such models are often based on quantitative factors such as the Relative Value Unit (RVU), which is the numeric reimbursement value associated with the services the practice provides, net professional charges, or net collections.

Unlike the equal split model, a productivity-based approach encourages diligence. Because human nature often leads an equally compensated individual to unilaterally shirk his or her responsibilities, it is necessary to incentivize compensation to cultivate a culture of hard work and growth. Experience has shown that productivity-based models tend to increase physician hours and patient volume. Not only do they have a direct, positive effect on the individual physician, they also foster a competitive environment that ultimately benefits the bottom line of the practice. Longer practice hours also directly benefit patients, who may otherwise be unable to schedule appointments at times convenient to them. A practice with longer hours of operations is generally viewed as more accommodating, in turn garnering a better reputation within the community and attracting more patients.

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The downside of this approach is that it is competitive and may not be suitable for smaller, single-specialty type practices or certain kinds of physician groups. When determining their compensation model, aside from productivity, smaller groups tend to value other qualitative factors as well (e.g., lifestyle considerations and personal relationships among the group’s members), something that is more difficult to account for through a productivity-based approach. Similarly, physicians that join such practices must be ready to work long hours because members who underperform within large multispecialty practices are often ostracized and eventually expelled altogether from the practice. Finally, a productivity-based compensation option may also have the effect of disincentivizing performance of certain administrative functions of the practice that are necessary for its success. For example, completion of charts and follow-up communications with insurance carriers are critical to obtaining reimbursement for services. If a physician does not pay attention to such tasks and instead focuses on only new patients or procedures, he or she is harming the practice’s ability to collect revenues.

As a group practice grows in size and range of specialty, more and more time must be dedicated to administrative functions. Often, this responsibility falls on the shoulders of the group’s management team, particularly the president. The time commitment involved with such duties hinders the ability of a physician on the management team to see as many patients or perform as many procedures as other physicians within the group. Because such functions are not directly linked to qualitative measures, such as RVUs, compensation in such cases must be based on alternative factors. In the event most of the administration is concentrated among a few members of the practice, these physicians can be compensated for their non-clinical work on an hourly basis or with an annual stipend. The group’s organizational documents should provide for such alternative compensation arrangements.

If ancillary services such as physical therapy, clinical laboratory services, or imaging services are involved (and would invoke Stark law) their revenues can be set off in another category to be split based on ownership interest in the group or some other predetermined formula that does not take into account referrals or volume of business generated.

Combinations

Because few physicians are true standalone when it comes to productivity, there is often resistance to a productivity-based compensation approach. Many physicians enter group practice for security and resources, not necessarily to maximize their profits. In cases of this kind, a blended compensation model, which shares characteristics of the equal split and productivity-based models, may be the answer. Depending upon the specialty, we have seen success in a 70/30 split (equal split to productivity-based ratio), as well in a 40/60 split. The type of formula most suitable for a group depends upon the specialty area and size of the practice.
The problem with this approach, however, is that it is neither here nor there. Physicians who are willing to work long hours to generate revenues for the practice are generally not comfortable with any form of equal compensation split. Equal compensation also makes it difficult to recruit hardworking, talented physicians because they would not be able to take full advantage of their own efforts. On the other hand, physicians interested in equal compensation usually prefer an arrangement that is not tied to any productivity compensation. These are normally older physicians who are no longer interested in a work-centric lifestyle. Such physicians already have a longstanding patient base and reputation in the community and are not necessarily interested in growing the practice.

Once again, ancillary services subject to the Stark law should be set off into another category to be split based on a predetermined formula that does not take into account referrals or volume of business generated.

**Packages Vary with Group Practice Type**

The compensation model a group practice selects is influenced by the character and type of practice. For example, because duties are typically shared equally within smaller, single-specialty and each physician is aware of how each contributes to the practice, “riding the coat tails” of other members can be quite stigmatizing.

Single-specialty practices have also had greater success than multispecialty groups in vetting a prospective member’s work ethic, as well as encouraging diligence on the job, without ever tying compensation to productivity. Specialists within a geographic region are normally familiar with each other’s reputations in the community, so groups have a better sense of the type of person they are inviting to join their practice.

Larger multispecialty groups, on the other hand, find the task of encouraging productivity without incentives harder to accomplish. As group practices grow and diversify, it becomes more challenging to assess each member’s work ethic, both during the vetting process and after admission. Similarly, within multigenerational practices, the work ethic is not always consistent from generation to generation.

It is important for physicians to have frank, upfront discussions regarding available compensation options. Members in large, multispecialty groups that are, or expect to be, more productive should take the lead in these discussions and clearly and succinctly call for some form of productivity-based compensation. Not only is such a compensation model most beneficial for the productive members, but it may encourage less-productive members to reevaluate their work ethic and increase their productivity.

John D. Fanburg chairs the health law practice and Leonard Lipsky is an associate in the health law practice of Brach Eichler L.L.C., a Roseland, New Jersey-based law firm.