

## **Dividing the Income**

Dividing a group practice income can be as simple as taking all professional income at the end of the day, paying the expenses and then dividing all remaining money among the physicians equally, or you can base the entire compensation on productivity (whether measured in charges, collected income or "points"). In any event, your plan should take into account both your practice plan and the behavior you want to encourage.

In the ultimate system, physicians work tangibly to achieve stated practice goals. Those who work *for* the group reap rewards. Those who work *against* the group goals, or in counterproductive activities, earn less than their productive counterparts.

There are no "best" ways to divide the income among anesthesiologists. And, anesthesiologists, like physicians in all other specialties, find themselves in groups of physicians who are very often at different stages of their lives - both financially and personally. This is one of the main reasons that "no one compensation plan fits all."

So, what are groups doing?

Some very large and some very small practices use productivity systems. Others, from large to small, divide the money equally. Both methods, in addition to having their own strengths and weaknesses, result at the end of the day in paying all available money out to physicians. Yet, in many cases this is unwise, since it leaves no money left to either invest in growth, or to reward (or punish - take away from) appropriate physicians.

Therefore, recognizing the differences among physicians, how do you fairly compensate your group members on a way that both rewards the appropriate members and motivates them to achieve your practice goals? Recognize that any program can be "gamed." Nonetheless, what do you need to consider when evaluating or changing your plans?

## **How Groups are Paying Physicians**

### **1. Equally**

One of the more common themes in income division is to divide everything equally among physicians and then only adjust vacations to compensate for "actual work" discrepancies (cardiac versus cataracts) among physicians. In some cases using this method to encourage group behavior is beneficial, particularly among changing groups. For example, if your group is growing and needs to send an existing physician to cover a new location, or to offer a new service, you may find that he or she requires an "equal share" of income because it is too hard to predict how much income will be earned or even achievable. Yet, to prevent competitors from encroaching on "your territory," you find the need to offer the service. Likewise, where your problem may be "over-zealous" partners "stealing cases," then decreasing the emphasis on production may help.

Sometimes however, equal division of income is simply a default position for many groups unable or unwilling to evaluate the actual work effort among physicians. And yet, most physicians really do not work at the same pace, do not have the same level of work enthusiasm, or bring the same talents to the table. In this case, dividing the net income equally, punishes your over-achievers, rewards those who may be doing the least, fails to reward practice management, and leaves no income in the group to invest in practice development.

## 2. Productivity Systems

Some groups use either a straight or a modified productivity system, most commonly using points as a surrogate for productivity. Under a straight point system, the group uses the billing system to collect base and time units (possibly, also including modifiers) for each physician. The practice then collects the total units for all physicians and divides that number into total collected income for the "universal" conversion unit. (Associates and CRNAs are usually not paid on the points system and therefore count as overhead.) That conversion unit, times each physician's total units equals his or her share of net income.

Under a modified points system, the practice may include only time units, leaving out the base units or modifiers, and may create and assign units for "procedures" (such as OB epidurals, pain management, cardioversion, MAC, and so on). If the practice is more sophisticated, it has likely started to grapple with the issues of administrative time, likely creating units for non-billable activities (such as Board and director meetings, hospital staff meetings, lectures which enhance group reputation, and so on).

On the one hand, this is fair; you are paid based on your work efforts. On the other hand, while it encourages work effort, it may also encourage individual goals which differ from the group goals - such as creating specific surgical requests for anesthesiologists.

And, even under a full productivity (points) method, someone must oversee both administrative time and workloads. Management of workload is important to prevent overachieving physicians from burnout and underachieving physicians from disrupting your schedules or coverage.

### **New Methods**

Whichever method you favor, or if you use a hybrid method (base units aggregated and divided equally, productivity measured in time units), you still need to retain some of the income to reward or punish members who either carry an extra workload or continue to produce the least and violate the call schedule.

Consider setting ground rules. For example, let's say you believe a hybrid method of compensation would work, but that your group is growing, and is becoming "multi-sited." While you all share some resources (billing, administration, etc.), you will benefit from the growth by offering more pain management services.

Further you agree that some income should be divided equally to encourage group behavior. If your total base points to total points are about thirty percent (30%), consider making that the "base pay."

Then, to encourage work activity, consider paying the next fifty percent (50%) based on points (here, time only) modified to your situation to account for the supervision of CRNAs, anesthesiologist of the day ("AOD," also known as clinical coordinator), for rapid procedures, administrative efforts and so on.

You then agree to hold back the remaining ten percent (10%) of your available income. Consider the amount paid to physicians (regardless of method) as "worker-owner" compensation (associates are an overhead expense at this point). If physicians show up late, do their work and go home, they receive fair compensation. Those who spend time on beneficial administrative activities, contracting, business planning, which is productive for the group, and so on, now have a mechanism from which to be rewarded -- the ten percent (10%) of income held back to be paid for those physicians who further specific group objectives. This also provides a mechanism to "correct for" physicians who may appear, just on the numbers, to be underachievers but who are really expanding a new line of activity, managing, or otherwise encouraging group success.

### **Summary**

Like in every other business, when everything is going well, and the money is fine, no one is going to focus much attention on the bottom line and who received how much of what, and if that was fair. But, when the money gets tight, or the payment parameters change, every organization needs to decide what it is paying for and if that is appropriate.

No one compensation plan will achieve all the goals of each group, or even encourage desirable activity. But, with advance consideration of practice needs, an objective and effective plan can be developed to encourage group participation and keep doctors motivated.

Many group practices stumble, when it comes to instituting or revising compensation plans. Every compensation plan creates winners and losers. However, if the plan is sound, and can be eased in over time, then the adjustment period can be accommodated and the "swings" in income predicted.

Compensation plans that cope with the reality of the current environment and take practical steps to remain successful as the system transitions will greatly increase their chances to prosper well into the next century.

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