The Tyranny of the Practice Overhead Debate

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Physicians working in a medical practice often use the term "overhead" to refer to the proportion of collected revenues they don't take home in the form of cash compensation or other direct benefits. Practice administrators always feel pressured to reduce overhead to improve the financial returns to the providers, whether they be owners or employees of a practice. Although effective management of practice expense is always prudent, "overhead," properly defined, makes up the smaller proportion of the accounted practice operating expense burden. If improved financial yield for the providers is a goal, the best path is rarely the reduction of overhead. Management's time and effort would be more effectively directed to the economic productivity, and related variations, of the providers' preferred clinical practice style, and all effects on operating revenue productivity, direct operating expense allocations, and productivity performance on fixed assets—facilities, for example. Medical practices are composed of individuals who together create a clinical model that translates to a business model. That business model creates an operating economic signature that drives the financial performance of the practice. Every medical practice, regardless of clinical specialty, is uniquely created by the providers' preferred practice style. The solution to an apparent compensation problem usually is found in the economic productivity performance of the providers' preferred clinical practice models.

KEY WORDS: Medical practice economics; physician compensation performance; managing practice productivity; overhead.

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Does the following scenario sound familiar to your medical practice administrators and physician leaders?

A physician returns from a medical conference where there was a conversation among peers comparing "practice overhead." Following the conference, the physician shares this discussion with the practice administrator, which usually starts something like this: "I was chatting with colleagues at the conference about practice management and one doctor said their practice overhead rate is $X. As I recall, ours is $X+. Why is ours so high?"

At this point in the conversation the practice administrator is on the defensive, with no defense. We refer to the conversation that is about to happen as the "tyranny of the practice overhead debate"— a lose/lose proposition unless the administrator and physician leader know how to have the right conversation.

The right conversation starts when both parties are speaking the same language. For many physicians, *practice overhead* is defined as the percentage of practice net revenues that physicians, especially owners, don't take home as total compensation. What is rarely shared in nearly every physician-to-physician conversation comparing practice overhead is the answer to the more important question: "What is your compensation earned for your professional efforts?" In other words, how much do physicians net (take home) from the business model they have chosen for their practice? This conversation is the right one to have with peers, but is somewhat less comfortable.

Let's go back and reframe the right conversation. The important question actually has little to do with practice overhead, and more to do with the practicing physicians' preferred clinical model, productivity patterns, and the effects on financial performance and take-home pay. *Practice*

overhead is best defined as ongoing business expense that is not directly related to the actual production of goods or services. It is the indirect operating expense structure of the practice, composed of categories that are relatively fixed, but are sensitive to provider productivity. These include operating expense categories such as billing and collections, accounting, occupancy cost, accounts payable, scheduling, human resources, insurances, information technologies, occupancy expense, marketing, and the like. The greater proportion of the operating expense structure of a medical practice is affected by the economic productivity of the preferred clinical practice model and productivity patterns of the clinicians. The economic productivity of the preferred practice model drives the greater proportion of financial productivity of the practice, and, thereby, owner compensation.

Clarity of concept is important here. Every clinician in a practice, whether a single- or multi-specialty, has a preferred way of doing what they do, including the pace at which they prefer to work, the type of patients they prefer to see, and the support staff complement they prefer to apply to their practice model. These preferences produce an economic productivity signature within the practice, which, in the aggregate of all providers, yields the net financial productivity performance of the practice.

A brief case study vignette is useful here. Two comprehensive ophthalmologists in a practice of 20 ophthalmologists and optometrists are qualified to treat the same patients, medically and surgically. Each has been in practice for at least 15 years with the same group. Each is an equal owner with all other owners. One averages 20,000 work relative value units (WRVUs) of medical and surgical productivity annually. The other averages 15,000 WRVUs. The former allocates 45% of WRVU productivity to surgeries; the latter 35%. Each uses the same number of clinic staff. Each is happy with their practice pattern and style. One takes home 30% less than the other, and neither complains about the total practice operating expense rate, which on a blended basis is 77%. Because the important question is not the "overhead rate," it is the level of net compensation produced for the owners of the practice. How can a 23% return on revenue rate be satisfactory? The answer lies in the question, "23% of what?" The practice business model includes ownership of clinics, employment of optometrists, retail optical shops, and ambulatory surgery centers. The business model creates an aggregate operating revenue base that extends beyond the direct professional services productivity of the physician owners. So, while on the surface it may appear that the practice runs on a high overhead rate, the actual compensation productivity of the of the practice, for the owners, puts them in the top decile for compensation in their clinical specialty, while creating a practice valuation in excess of less sophisticated business models. Simply stated, their chosen practice model works fine for them.

MANAGING FOR NET FINANCIAL PERFORMANCE VERSUS OVERHEAD RATIO RATES

Physician and administrative practice leaders need to embrace three lessons:

1. If there must be conversation about "practice overhead," make sure those conversing share the same definition of the term.
2. Preferred clinical practice style, and the inherent related variations, including types of patients attended, is a principal driver of practice economic productivity and financial performance overall.
3. There is an important difference between practice efficiency and economic productivity, and how each affects financial performance for practice owners.

The third item listed is of specific interest. Practice leaders often stress practice efficiency as a management priority. Operating efficiency has its place in practice management, but it is not the same as economic productivity. Both affect the financial performance of clinical models.

Another case study vignette is useful here. A pediatric ophthalmologist, who works primarily with special needs patients, works in a comprehensive eye care practice. This physician attends children and adolescents with complex medical and surgical needs. This physician performs 100 surgeries per year, on average. Each must be done in a hospital setting. The support staff ratios for this physician at recoded productivity rates indicate that this physician is operating at high levels of efficiency, as compared with other pediatric specialists. When net operating revenue productivity is compared with that of adult ophthalmologists in the practice, the net operating revenue productivity of this physician is at least 35% less than the average of the adult eye care practitioners. Is this physician operating efficiently? The answer is yes, for the specialty. Is the clinical model as economically and financially productive? The answer by comparison with the adult ophthalmology practice peers, is "no." So a factual conclusion is that the pediatric services provider is operating efficiently, by comparison with industry standards, but the economic productivity of that pediatric practice, within the group, is less than other adult services partners who do their surgeries in a setting owned by the practice, and are capable of seeing more patients daily than their pediatric specialty partner. Making this physician marginally more efficient will not appreciably improve the financial productivity of the practice. So why include pediatric ophthalmology in the practice model? The answer is that doing so fits an overall strategy of comprehensive eye care, as defined by the owners. Pediatric eye care is in short supply. Referrals to the practice are high. Children referred usually have or will have siblings, and parents and grandparents, who are good candidates to become patients in the practice.

Net financial productivity of every clinical model should be viewed as a manageable, multivariate equation. Active variables that interact to affect net financial yield include the following

1. Application of provider capacity (how providers elect to apply their professional services productivity potential to medical and surgical services);
2. Provider effort unit-productivity rate (patient encounters and WRVU production rate per clinical work day);
3. Patient payer mix;
4. Clinical staffing expense structure allocable per provider (number of staff, and type, required to support the provider at their preferred rate of daily work effort);
5. Availability of billable ancillary, and related, services opportunities captured within the business model of the practice, including diagnostics services, various procedural and surgical services , and rehabilitation, for example;
6. Availability and sales of retail products and service related to the clinical specialties;
7. Net revenue produced from the total facilities base of the practice, measured as a function of net revenue produced per square foot of useable space, per facility occupied;
8. Design and management of the capital structure of the practices, especially as it relates to the management of owner buy-ins and buy-outs;
9. Days worked per provider, per week and year, and the flexibility of related support staff when the provider is out of the practice;
10. Patient service slot fill-rate management, as well as policies and procedures that are applied to best match the right patients with all available provider service schedule slots;
11. Ability of the practice to accommodate new patients in a timely fashion, from all sources of referral; and
12. The owners' philosophy on reinvesting in the practice: Is it their philosophy to routinely sweep all available cash to owners, or reinvest a portion of net financial yield to fund practice growth without over-burdening the enterprise with debt?

LESSONS LEARNED

Although effective management of practice overhead is always prudent, real practice overhead ratios explain very little of the *net financial yield* performance, or potential of a medical practice. The more important conversation to be had between physician-owners of medical practices and practice administrators pertains to the how the operating economics of a preferred clinical model produces the net financial yield for the owners, together with shared understandings of where a practice is in its growth, development and execution of its strategic plan.

The practice buy-in/buy-out structural design also can weigh heavy on the financial productivity of a practice. Although this is a topic for another article, three observations of how equity management can affect practice model economic productivity and financial yield are worth mentioning:.

1. The new partner purchases equity directly from owners. The capital from the purchase price is not contributed as paid-in capital, available to fund future practice growth and development.
2. When it comes to the buy-out, owners often can execute a termination at any time, even with little or no prior notice, and trigger a buy-out, which, in turn, often is funded by current practice earnings, or debt that needs to be repaid by the practice.
3. The formula for the buy-out often bears no relevance to the actual balance sheet condition of the practice. It is easy to identify examples of million-dollar (or more) buyouts from practices where the owners managed to create a business with negative equity value based on their philosophy of managing practice finances.

The most common enemy of net financial yield of any medical practice is excessive variation of clinical practice productivity and staffing patterns across providers in the practice. Physician groups often sacrifice net financial yield in favor of excessive owner professional autonomy. Managing the aggregate net financial yield produced by many physicians, each operating their own independent practice under a unifying corporate umbrella, with attempts at increasing overall practice operating efficiency, usually produces diminishing returns on effort and resources invested.

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Lastly, and final lesson learned: the financial productivity performance of every professional services organization—accounting firms, law firms, consulting firms, and medical practices—is a product of the design interacting with the management of the design. Likewise, the unique properties of the design dictate the financial productivity potential of the design. In theory, every practice model design has a financial productivity cap. Owners need to decide how to use that potential.

Although discussions of practice overhead rates might make for interesting conversation at medical conferences, they are usually of little utility back home.