Determine best overhead model for your circumstance

PMP Staff

A number of options are available to determine a model for sharing practice expenses.

Staff at the Alberta Medical Association's Practice Management Program (PMP) often get asked which is the best model, which one should our clinic use, etc.

Although there is no single best answer, the following three broad principles seem to correlate with physicians' satisfaction regarding their choice of overhead model:

1. Knowledge of available options/issues
2. Transparency of information
3. Participation at the desired level of each physician

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1. Knowledge

To make an informed decision, it's beneficial to know the various options available. Samples of different models follow. There is no perfect model and each physician group needs to determine the best choice for their circumstances.

Proportionate expense sharing

Physicians determine expenses every time period (usually every month) and charge each physician a fixed share. In its simplest form, if five full-time physicians practised in a clinic, with $50,000 of expenses for the month, each physician would be charged $10,000 for that month.

This is a simple, straightforward model. However, it does present some challenges, including:

- Equitable proportion. A challenge for many clinics is to effectively define an equitable proportion for each physician.
  - » Should all clinic expenses be shared equally between all of its practising physicians?
  - » What if some physicians work part time verses full time?
  - » What if some physicians work full time, but only part time in the clinic (e.g., spend a significant portion of time in the hospital or in long-term care facilities)?
  - » If a physician bills twice as much as his colleagues, should he or she pay more or less overhead?
  - » For staff costs, should each physician be responsible for his or her own assistant or is this a shared cost to the entire clinic? If a shared cost, how does the clinic allocate the costs of assistants when the physician is not in the clinic?
- Timeliness. If the revenue is paid directly to each physician, there is a risk that a physician disagreement could impact the timely collection of clinic expenses.
- Extraordinary expenses. Payment toward a type of reserve fund is usually not part of the expense calculation. This can make it difficult to agree on/pay for large expenditures (e.g., office renovations, burst water pipe, etc.) because it must come out of each physician's current pool of funds.
- Loans. Taken by participating physicians, loans can present challenges without forethought and written agreements. If loans (e.g., for an office renovation) have been taken out by the physician group, and one physician leaves the group, does the loan obligation stay with the departing physician, attach to a new physician (if one can be found) or get shared between the remaining physicians? If a loan is taken out and is to be part of the shared expenses, how does the group determine a fair amortization period for the loan?

Percentage of billings

Under this model, the physician is charged a fixed percentage (e.g., 40%) of his or her billings, usually on a monthly basis.

This model is also relatively simple and straightforward, however, it ▸

▸ can have several variations. Thus, a number of questions need to be answered including:

- Full or partial billings. Does the percentage payment (e.g., 40%) apply to all or only some of the physician's billings (e.g., fee-for-service, WCB, third-party medicals, hospital work, other non-office work including long-term care facilities, committee work, etc.)?
- Level of billings. Does the percentage payment vary based upon physician billings? (E.g., same rate charged for part-time versus full-time physicians, physicians with lower- versus higher-average billings, etc.?)
- Location of practice. Two common contrary questions include: Why should a physician pay for overhead on revenue generated outside of the clinic? Given overhead costs must be covered regardless of how much or where each physician chooses to work, why should these costs be borne by someone else?

Mixed model

This is a bit of a catch-all category and often includes elements of the above two models, with some variants in the calculation of overhead including:

- Ceiling – providing a fixed-dollar amount for overhead. Participating physicians are charged a fixed amount or percentage, usually on a monthly basis, up to a maximum dollar threshold, e.g., $150,000. Thereafter, they retain 100% of their billings.
- Multiple rates – differing overhead rates based upon location. If a clinic operates out of more than one location, these locations may have differing overhead rates.
- Fixed verses variable – involves detailed separation between fixed and variable costs of the clinic. An attempt is made to determine the true fixed-cost elements that should be shared equally versus the variable costs that fluctuate depending on physician activity and, thus, can be assigned directly to an individual physician.

  This can get quite complicated and can invite intense discussion as staff time and other variable costs cannot always be so clearly allocated to a particular physician.

2. Transparency

When implementing an overhead formula for participating physicians, it is important to recognize, in the absence of information, there is a risk some people will fill in the blanks with false assumptions. It is ideal if both parties feel they are in a win-win situation.

So how do we get there? A key principle to help guide such a solution is transparency of information. It is critical both sides feel they are able to make an informed decision by being provided the relevant information in a timely fashion, including:

- Detailed costs. Share all the costs associated with running the clinic, from salary costs and rental rates to minor incidentals, as it helps both sides make informed decisions about where they should focus their spending.
- Risk premium. Understand the risk premium being charged by the owner(s) of the clinic. When participating physicians are not signatories to the lease/mortgage and/or are not responsible for other general office liability issues, there is often an additional cost within the overhead calculation to account for this added risk.
- Rationale. Understand the rationale/motivation behind each party's position. A physician may simply want to be free of all of the administrative and management duties associated with running a clinic and may be prepared to pay higher overhead costs to be alleviated of such stresses. Or the physician may be looking to share ownership, and may wish to be included in many of the clinic's decisions, etc.

3. Participation

It is important all parties understand and feel they have a choice in their level of participation in clinic operations and practice management.

Good communication, upfront and ongoing, helps to ensure a sense of fairness on both sides.

Some key elements for each party to consider include:

- Leasehold improvements. How are leasehold-improvement decisions and other relevant site-location decisions made? (E.g., who determines the quality and associated costs of waiting-room furnishings?)
- Assignment of costs. With a major leasehold renovation, are those costs payable by the participating physicians through personal loans or a clinic loan, an immediate cash call? If it is through a clinic loan, what is the amortization term of that loan and who carries the risk if a physician departs before that cost is fully recovered by the clinic?
- Rental rates. If the real estate is owned by some of the practising physicians, how are rental rates determined? What elements are included in the rental costs, etc.?
- Review period. Once an agreement is reached, how often is it reviewed?
- Legal review. Is a legal review of the overhead agreement required or are physicians comfortable and accept the risk of a less formal approach? ▸

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The ideal overhead formula is rarely about the numbers or securing the best financial deal. Rather it is more often a function of many elements including:

- providing a satisfactory work-life balance
- allowing a desired level of participation in clinic and practice management
- having an understanding and perception of financial fairness by each party
- working in an environment that meets one's professional and personal goals
- working with colleagues one can trust and respect

In the end, there is no single best overhead model. However, physicians who are collectively knowledgeable of the different overhead formulas, who seek transparency of information and are able to participate in their practices to a desired degree, will be positioned for win-win relationships and overhead models that works for them.

The Alberta Medical Association Practice Management Program (PMP) provides high-quality business consulting services to Alberta physicians as they develop and implement primary care networks. With offices in Calgary and Edmonton, the program serves physicians throughout the province. For more information about PMP services, please contact program staff at pmp@albertadoctors.org, 403.205.2089 or toll-free 1.866.830.1274. ■