HOW TO CUT HOSPITAL EMPLOYED PHYSICIAN LOSSES IN HALF

Presented by:

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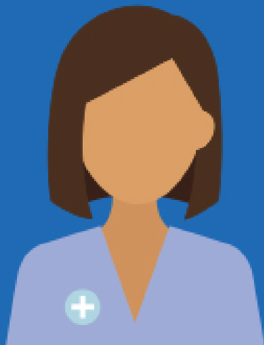
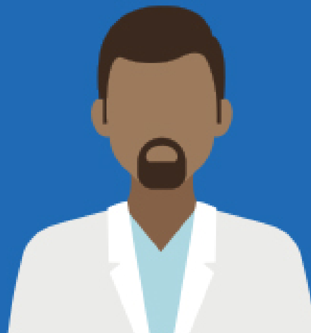
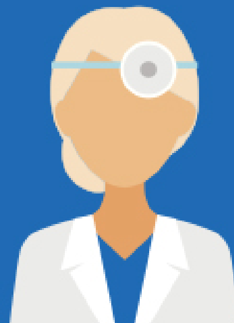
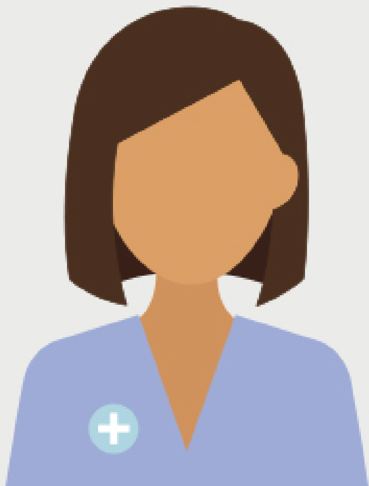




CLARK SCHAEFER HACKETT
CPAs & BUSINESS CONSULTANTS

OUR CREDENTIALS

- **Clark Schaefer Hackett** *(Accounting & Consulting Firm)*
- Bill Clayton has been designing, implementing and coordinating physician employment models since the mid-90s.
- Bill has worked with large multi-chain health systems and small community hospitals concerning physician compensation modeling.
- Bill has developed a program and an approach that cuts the losses in half.



OUR CREDENTIALS

- Manage independent & hospital-owned medical groups
- Conduct valuations for healthcare entities
- Negotiate physician compensation programs
- Implement & manage Co-Management programs
- Conduct operational turnaround for healthcare entities
- Coordinate audits, tax management & outsourced accounting
- Placement of key staff (CEO, CFO & Practice Managers)
- Conduct Revenue Cycle improvement programs
- Conduct & review 990s
- Implement accountability (benchmarking) for healthcare entities
- Business advisors / strategic partners for our clients

PHYSICIAN COMPENSATION MODELING

1. Learn the pros & cons of different compensation programs for hospital-employed physicians.

2. Learn the different compensation models

3. Learn different methods for direct employment vs. a lease model

4. Learn what culture is needed when employing physicians.

LEARNING OBJECTIVES

1. Recognize the link between organizational culture & physician loss
2. Discover the pros & cons of key compensation programs
3. Learn the difference between the direct employment model vs. the lease model

LEGAL ISSUES (OIG)

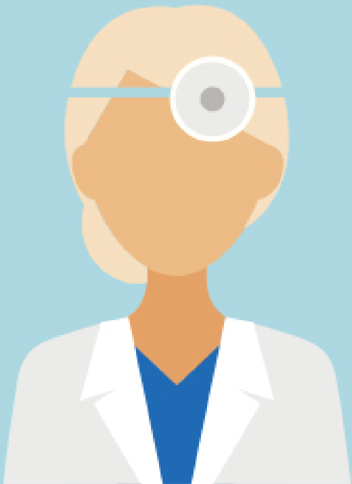
- Drakeford vs. Tourney Healthcare Systems, Inc.
- U.S. vs. Campbell
- Baklid-Kunz vs. Halifax Hospital Medical Center
- Perikh vs. Citizens Medical Center
- Schubert vs. All Children's Hospital System

CUTTING LOSSES IN HALF:
URBAN MYTHS

URBAN MYTHS IN PHYSICIAN COMPENSATION

Common Theme

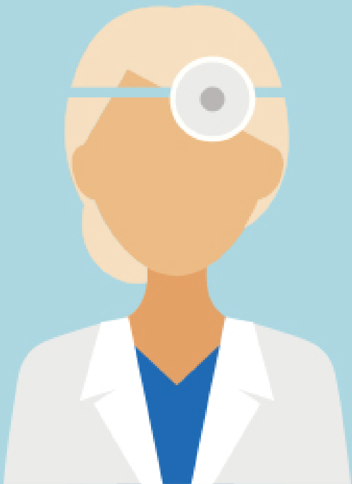
1. RVU
2. Compensation Risk
3. Quality



URBAN MYTHS IN PHYSICIAN COMPENSATION

“We have been developing a new physician employment contract and it will take care of all our problems. It has every clause and issue you could think of. This will fix our issues.”

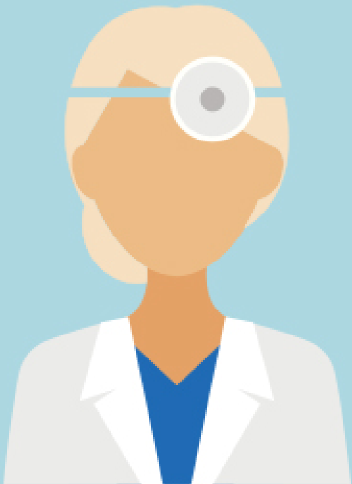
- Classic “employee handbook” theme – the rule book will manage the business for us.



URBAN MYTHS IN PHYSICIAN COMPENSATION

“We have the answer: we have just implemented the ultimate compensation model – Work RVUs Compensation Modeling”

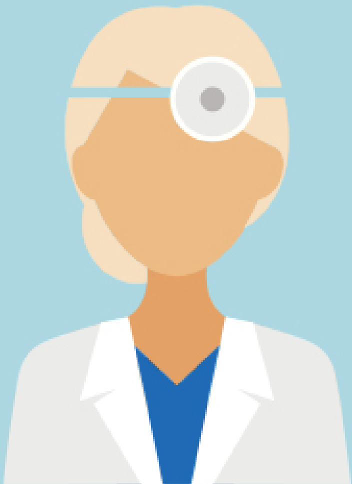
- Work RVU history
- Need a triangular approach
- Try to explain Work RVUs to your board members when you have an average of $150,000 loss per provider while at the same time explaining you have the “ultimate compensation model – RVUs.”
- Evolution of compensation programs



URBAN MYTHS IN PHYSICIAN COMPENSATION

"We need our part-time physicians to receive full-time national MGMA 75 percentile compensation to meet our physician recruiting goals."

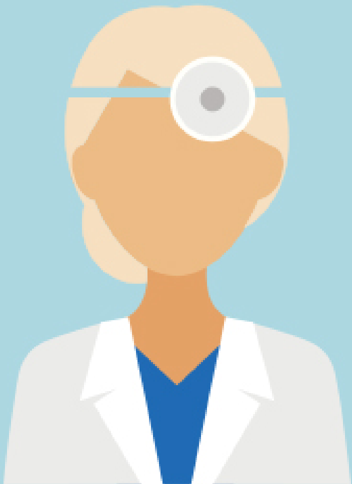
- Physician recruiting firms
  - Examples, change out of CEOs
  - New recruiting firms
  - Recruiting firms using the wrong MGMA norm
  - Average recruiter – "highest paid telemarketer in the U.S."
  - Do your "own" homework…



URBAN MYTHS IN PHYSICIAN COMPENSATION

You cannot recruit physicians into an independent physician group.

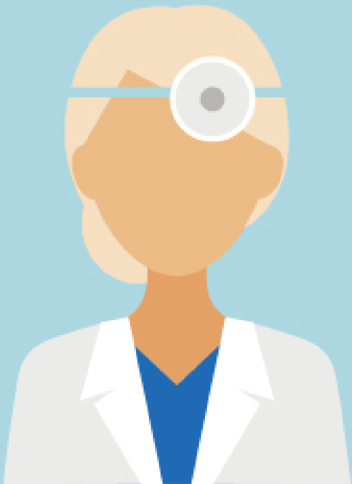
- Percentage of employed physicians
- Program directors – “university thinking”
- Not all the locations (states) are employing physicians for the same reason.
- Sweet spot – greater than 60K population and less than 150K population
- Cities have too many physicians and the rural communities do not have enough providers – same issues since the early 70s.
- Whole leadership generation forgot how an income guarantee works.



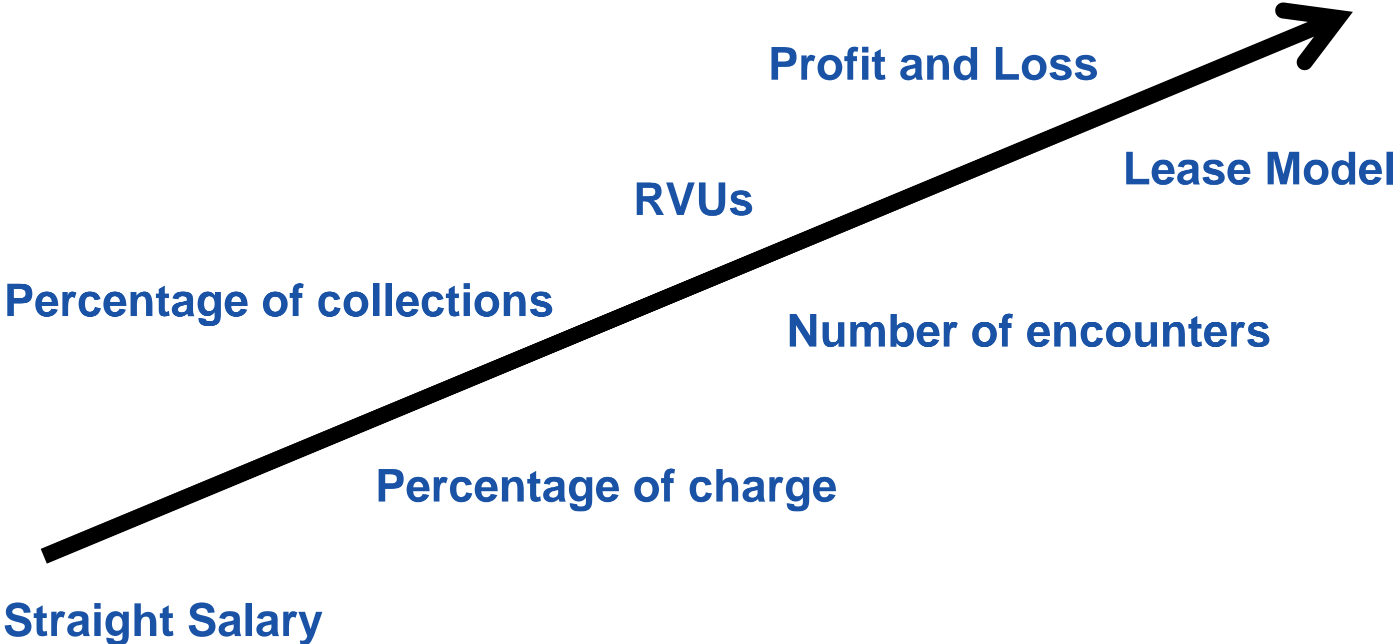
URBAN MYTHS IN PHYSICIAN COMPENSATION

"Killer solution: Adjust the physician compensation downward by putting the physicians at risk for 40% of their normal compensation. This will fix all our issues."

- We don't know what we don't know…



Compensation Evolution

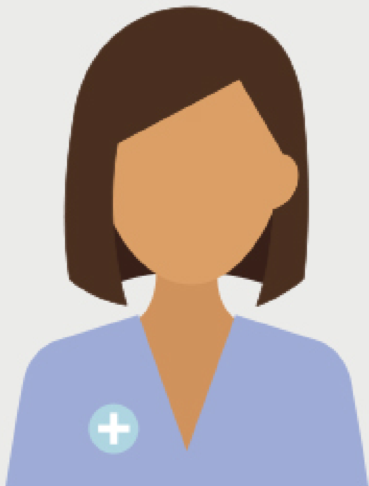


MANAGEMENT PROCESSES
THAT WORK

KEY SUCCESS FACTOR: STAFFING

Trade Staff for Productivity

- Staff levels
- Greater productivity
- Agreements / Negotiate
- How much more can the staff process



KEY SUCCESS FACTOR: WORK FLOW

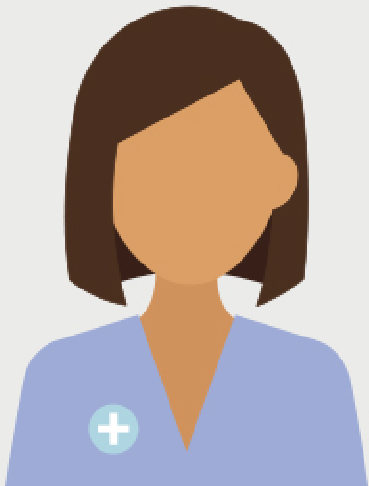
EMR

- Dictation
- Paper
- Home vs. work
- Scribe
- Template
- Staff model

KEY SUCCESS FACTOR: EXPECTATIONS

Low Expectations vs. High Expectations

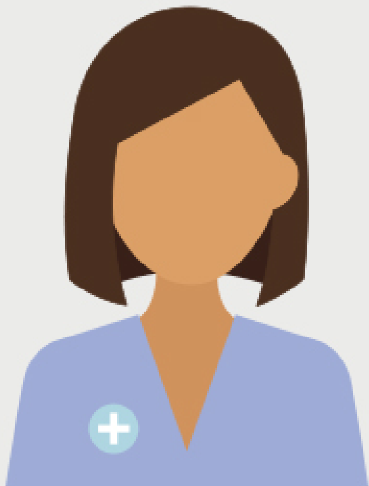
- Number of patients per week
- Number of patients per day
- Number of patients per hour



KEY SUCCESS FACTOR: PATIENT CONTACT HOURS

Part-time vs. Full-time

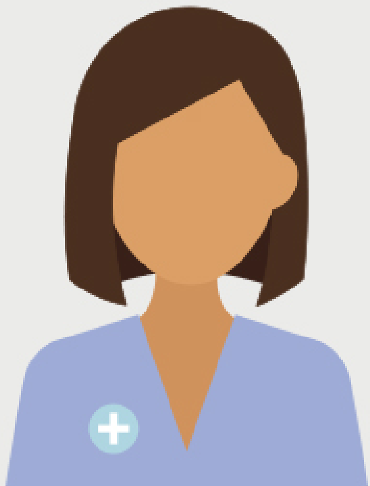
Find the majority of physicians working below stated hours in contract or they have no stated expectations.



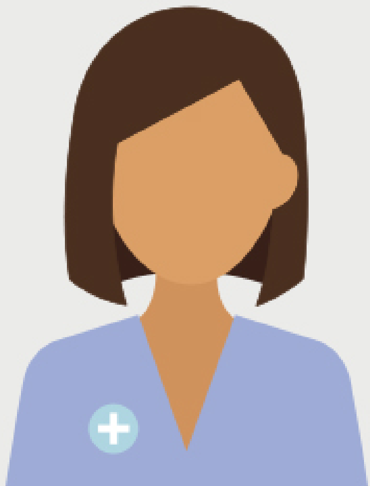
KEY SUCCESS FACTOR: FORCE RANKING OF PROVIDERS

Program Design

- Bell curve
- Wrong training
- Need more exposure
- Balanced life issues
- OCD / ADD / Fear / Authority / Other Issues



KEY SUCCESS FACTOR: SUPPORT STAFF



- McDonalds
- Turnover
- Dexterity
- Competitive pay
- Physician respectful culture
- Certification
- Part-time ratio
- Time to fill a job
- Force ranking

KEY SUCCESS FACTOR: CONFIDENCE

- Positive management system
- Balance between present & future
- Support staff

Need to hear positive…

POSITIVE CULTURE

What Does Work?

Correct Balanced Culture Elements

1. Monthly meetings (Business & Quality)
2. One-on-one meetings (Business & Quality)
3. Benchmarking
4. Profit & Loss Statements
5. Force Ranking

HOSPITAL LEADERSHIP ROLE

When the hospital / health system employs physicians, what is the role of the hospital leadership?

- Quality
- Patient access
- Financial responsibility

CREATING A WINNING CULTURE

CREATING A WINNING CULTURE

- Physician is “building a practice”
- Blending with the community
- Provide management tools
- Compensation tied to production
- Create high expectations
- Hospital looking for right fit to achieve vision (quality, access & financial responsibility)

EFFECTS OF ACHIEVABLE INCENTIVE-BASED EMPLOYMENT

- Physicians remain engaged in the operations of the practice
- Employed mindset does not set in
- Physicians take ownership of the practice
- Able to attract quality candidates

PHYSICIAN LEASE MODEL

Under a Practice “lease” arrangement, the physicians remain within their corporate structure and enter into a professional services agreement with the hospital / health system. The physicians reassign their right to payment to the hospital, which bills all payors for their services.

FIXED SALARY

Pros

- Easy to administer
- Easy to measure
- Does not encourage “cherry picking” payor types
- Good for newer physicians

Cons

- No direct influence on physician performance
- Not tied to revenue
- May pay out too much versus production
- No incentive to monitor expenses

BASE SALARY PLUS INCENTIVE PLAN

Pros

- If a certain amount of risk, can be used to encourage production
- Can tie quality into the program or good citizenship

Cons

- Can result in dysfunctional performance
- Can become complicated
- May not help with expense management

WORK RVU MODELS

Pros

- Can encourage performance if set up correctly
- Seemingly simple for some organizations who cannot produce a P&L statement

Cons

- Can be hard to explain in certain situations
- Cause the physicians to not be interested in expense management
- Some models are complicated
- Some models do not allow for adjustments for increases

PHYSICIAN COMPENSATION MODELING

Is there one physician compensation model that is better than other models?

No one compensation model fits all organizations.

ENCOUNTER MODEL

	Doc 1	Doc 2	Doc 3	Doc 4	Totals
Actual Encounters	4600	3200	4200	3400	15400
Target Encounters	4000	4000	4000	4000	16000
Minimum Encounters	3700	3700	3700	3700	14800
Encounter Surplus/Shortfall	600	(800)	200	(600)	(600)
% of Goal	115%	80%	105%	85%	96%
% of Minimum	124%	86%	114%	92%	
Rev per Encounter	$120	$120	$120	$120	
Estimated Revenue	$552,000	$384,000	$504,000	$408,000	$1,848,000
Current Overhead					$1,200,000
Overhead %	65%	65%	65%	65%	65%
Bonus Rate	$42	$42	$42	$42	
Bonus	$25,247	$0	$8,416	$0	
Total Compensation	**$225,247**	**$200,000**	**$208,416**	**$200,000**	

CASH LESS EXPENSE: P&L MODEL

Pros

- Only one model to run
- Everyone understands cash less expenses
- If normalization is used can be successful

Cons

- Can be an issue if gross losses
- In selected specialties, hard to explain
- Some organizations cannot seemingly produce a P&L on a timely basis

PHYSICIAN LEASE MODEL

Why put in place a physician lease model?

- Test run
- Retain infrastructure – move back to independent group
- Preserve successful culture
- Integration of care
- Payor contract leverage
- Decentralized model versus centralized model
- Preserve culture / referral patterns (multiple hospitals)
- Other reasons – cultural & political

PHYSICIAN LEASE MODEL

Basic Transaction in a Lease Model

Physician Enterprise

Practice / Clinic

Hospital

LEASE MODEL

Key Issues:

- Maintain the name
- Escape clause
- Who owns the AR
- Co-management
- Pool of money
- Billing / Accounting / HR
- Right of first refusal
- Compliance accountability

WHAT IS THE BEST WAY TO HELP PHYSICIANS BUILD THEIR PRACTICE?

1. Set expectations day one
2. Number of patients needed to break even
3. Number of patient contract hours for the office and surgery
4. Show successful model in practice
5. Assign a physician mentor
6. Monthly meetings one-on-one (physician mentor & practice administrator)
7. Work to make them feel part of the group (in the meeting or out)
8. Teach them to leave work at work
9. Overcome the program directors telling them all physicians lose money

REALITY FACTORS

- All ***compensation programs are checked against "cash flow"*** (cash less expenses).
- If you ***cannot confront, you cannot lead*** your physicians into a new compensation model and think you will achieve anything different.
- Compensation programs are ***consistently evolving***.
- ***Physicians need to be part of the solution***.
- High level of leadership is needed to ***implement solutions before issues evolve into a crisis***.

SUCCESS FACTORS – REGARDLESS OF COMPENSATION MODEL

- Able to build a practice ***(key: "build a practice")***
- Clinically sound
- Confidence with medicine (bell curve)
- Able to communicate (physicians, staff & patients)
- Winning expectations
- Wants to beat the norm

SUCCESS FACTORS – REGARDLESS OF COMPENSATION MODEL

Involved in practice

- Scheduling
- Staff
- Marketing
- Governance
- Quality
- Revenue enhancement
- Excited / intense
- Focused on growth
- Likes to measure *(goal oriented)*

COMMON SUCCESS FACTORS

- Physicians feel they are in control – “they are building a practice”
- Physicians provided a set of monthly benchmarks and financials
- Physicians held accountable as if they are independent
- Triangular measurement
- Complete “Practice Management Program”

QUESTIONS?

THANK YOU FOR YOUR TIME!

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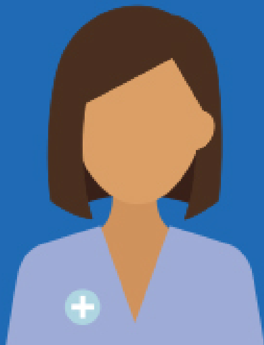
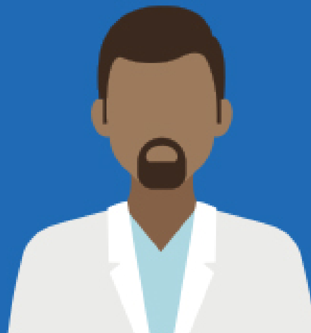
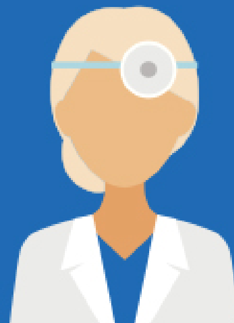

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