Physician Compensation: What's the right model?

Presented by:
Bill Clayton &
Ryan Peters
wclayton@cshco.com
rpeters@cshco.com

Certified Public Accountants & Business Consultants

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STRENGTH IN NUMBERS

Determining the “Value” of Your Business

- Our Credentials
  - Clark Schaefer Hackett *(Accounting & Consulting Firm)*
  - Ryan Peters, is a healthcare consultant with Clark Schaefer Hackett focusing on compensation models and building management accountability programs for medical groups.
  - Bill Clayton, MBA is a Principal with Clark Schaefer Hackett and has more than 20 years of experience in healthcare management with responsibilities ranging from Systems Implementation Engineer to Chief Operation Officer.

Our Credentials

- Manage Independent and Hospital Owned Medical Groups
- Conduct Valuations for Healthcare Entities
- Negotiate Physician Compensation Programs
- Implement and Manage Co-Management Programs
- Conduct Operational Turnaround for Healthcare Entities
- Coordinate Audits, Tax Management and Outsourced Accounting
- Placement of Key Staff (CEO, CFO and Practice Managers)
- Conduct Revenue Cycle Improvement Programs
- Conduct and Review 990s
- Implement Accountability (benchmarking) for Healthcare Entities
- Business Advisors / Strategic Partners for our Clients

Physician Compensation Modeling

- The purpose of this session is to explain the success factors in physician compensation models for hospital employed and independent medical groups. Additionally, we will discuss the lease and encounter model.

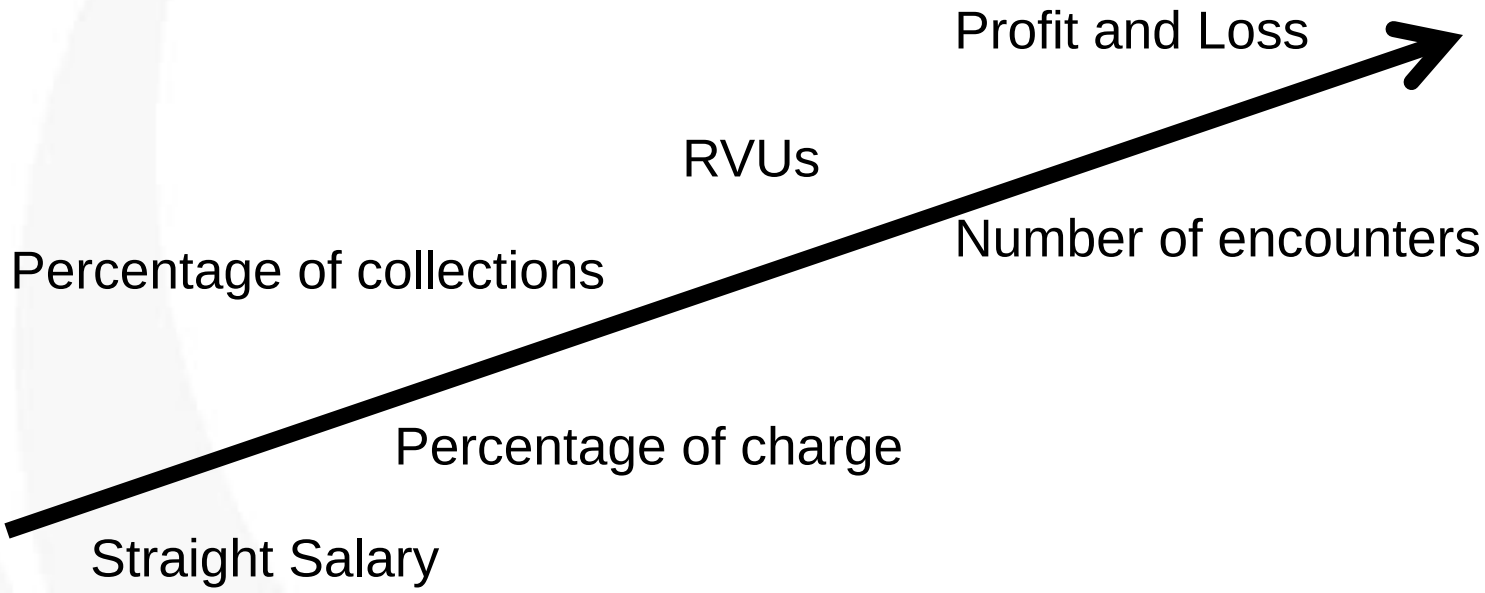
Questions – Hospital Employed Physicians

- What is the standard physician employment contract used in todays situation?
- What are the major issues with Work RVU contracts?
- Where did Work RVU physician contracts originate?

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.

Compensation Evolution



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 hospital 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

Questions – Hospital Employed Physicians

- What are the key elements when working with hospital employed physicians?
  - Physician engaged
  - Hospital is the bank
  - Measurement that is easily understood
  - Supply necessary reports

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**	

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

- How best to change the culture when recruiting additional physicians?
  - Create the correct expectation

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 Contract

- 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

- What is the 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?

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

Independent Physician Compensation Model

- What is the number one issue in building a successful independent physician compensation model?

Independent Physician Compensation Model

- How do you find the best way to help an independent physician build their practice?

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…

How do you find the best way to help an independent physician build their practice?

1. Set expectations day one
2. Number of patients needed to breakeven
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 physician lose money

Compensation Models in Independent Medical Groups

- What is the best method to allocate expenses in an independent medical group?
  - Evenly
  - Percentage of collections
  - Combination of fixed & variable expenses

  (Best model: depends on culture, specialty and volume variance between providers.)

Compensation Models in Independent Medical Groups

- What is the success factors regarding salaries for independent medical groups?
  - Meet monthly
  - Have matrix program
  - Build consensus
  - Budget base allowing for bonus (this is key)

Compensation Models in Independent Medical Groups

Is there successful methods of having the physicians compensated for quality?

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!
- Ryan Peters
- rpeters@cshco.com
  937-399-2000
- Bill Clayton, MBA
  wclayton@cshco.com
  614-286-0504

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Next Webinar

WHAT IS CLINICAL CO-MANAGEMENT?

Date: Thursday, June 18, 2015
Time: Noon – 1pm

Will hospitals soon lease various service lines to medical groups to manage? An example of this emerging concept is when hospital administration operates the facility, and physicians operate the clinical aspects of various service lines. Ted Clemans, Principal at CSH has experience in implementing this type of model and will discuss experiences with this approach, referred to as “Clinical Co-Management.”

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