Retooling the Rural Hospital Employed Physician Network for the Future

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Objectives

• Understand the micro dynamic of the employed ambulatory enterprise and the macro current state
• Understand the nuances of the employed model, from an “in the trenches” perspective
• Be able to discuss the complex physician interactions and value of physicians in your employed model
• Address the “worth” of the employed enterprise and its role in the future delivery of “value based” care delivery
• Embrace ways to effectively engage physicians within the “new paradigm” of care delivery

Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum
System Finances – Where are You?

Positive margins → Break Even? → Negative margins
Ambulatory Structure – A Sound Foundation

- Strategy
- System Administration
- Senior Administration
- Management
- Operations
The Ambulatory Lifecycle – A System Approach
Strategy

- (Good) strategy should drive the ambulatory Enterprise (vs. bad swags)
- Ambulatory side impacts entire system, in/out patient
- The hospital “System” strategy should align with the ambulatory side so the two attain symbiosis
- Cannot be “closed system”
  - Providers (physicians & extenders)
    - Employed/Community
  - Operations
  - Revenue
  - Review, amend, repeat process
    - Must infuse data, information, politics, climate considerations
Strategy (cont’d)

• Starts with Vision of where the “System” should go
• Boils down Vision into workable pieces that comport
  – System-wide Strategy to empower and align ambulatory side and inpatient side
• Should contemplate how to work with physician partners, whether employed or tightly aligned (professional services agreements, community, etc.)
• Critical strategic steps for healthcare systems include:
  – Assessing current state and anticipated needs
  – If one does not exist, develop a proactive and strategic physician-hospital alignment plan
    o If needed, prioritize implementation to address “high need” physicians/practices first
  – Ensure the economic implications of any alignment plan are considered upfront
Strategy (cont’d)

• Is there a defined strategy for the Enterprise?
  – Does it comport with the System’s “greater” strategy?
• Has the Strategy been elucidated down through the physicians to the “operators?”
• Is the Strategy revisited with a defined interval/frequency?
• Who “owns” implementation of the Strategy?
• Do we hire more physicians, align, or change what we do?
  – E.g. are we “subsidizing” far too much!?
• Are we empowering our physician partners?
• Is the Strategy malleable enough to change as the (macro/micro) climate(s) alter?
Service Line Stabilization Strategies

As part of the greater Strategy, service line considerations are essential:

• Incentivize physicians (particularly for specialty service lines)
  – Alignment with local private practices, independent providers and physician-based networks via non-employment contractual agreements
  – Create a Management Services Agreement that compensates for administrative work and performance engage physicians and promote quality

• Consider partnering with regional players to achieve “strength in numbers”
  – Develop relationships with tertiary care providers to sustain, grow or develop particular services

• Increase awareness of the “value” era within the medical community
  – The integrated delivery system functions on an interdependent network of providers
## Physician Alignment Strategy

<table>
<thead>
<tr>
<th>Limited Integration</th>
<th>Moderate Integration</th>
<th>Full Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Managed Care Networks</strong>: Loose alliances for contracting purposes</td>
<td><strong>Service Line Management</strong>: Management of all specialty services within the hospital</td>
<td><strong>Employment</strong>: Strongest alignment; minimizes economic risk for physicians</td>
</tr>
<tr>
<td><strong>Call Coverage Stipends</strong>: Pay for unassigned ED call</td>
<td><strong>MSO/ISO</strong>: Ties hospitals to physician’s business</td>
<td>**Includes the Physician Enterprise Model (PEM) and the Group Practice Subsidiary (GPS) model</td>
</tr>
<tr>
<td><strong>Medical Directorships</strong>: Specific clinical oversight duties</td>
<td><strong>Equity Group Assimilation</strong>: Ties entities via legal agreement; joint practice ownership</td>
<td><strong>Employment “Lite”</strong>: Professional services agreements (PSAs) and other similar models (such as the practice management arrangement) – self-employed independent contractor</td>
</tr>
<tr>
<td><strong>Recruitment/Incubation</strong>: Economic assistance for new physicians</td>
<td><strong>Joint Ventures</strong>: Unites parties under common enterprise; difficult to structure; legal hurdles</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Co-management</strong>: Strong economic and strategic alignment; relatively minor return</td>
<td></td>
</tr>
</tbody>
</table>
Physician Engagement – Valuing Your Partners
Physician Engagement Relationships

(1) Strategy

(3) Service line stabilization

(2) Physician alignment, compensation, and practice operations
Physician Engagement – Valuing Your Partners (cont’d)

• How much is “losing too much”?  
  – How much “downstream” revenue flows to the hospital from the employed physicians?

• To “right the ship,” perform an operations assessment  
  – Staffing and management span of control (right person, right job)  
  – Physician productivity relative to “best in class”  
  – Physician compensation relative to benchmarks  
  – Revenue cycle relative to “best in class”  
  – Maximizing patient demand and flow  
  – Coding audit/education

• IT/EHR Implementation
Trends: Survey of Healthcare Leaders – How Does this Align with your System?

Top 3 motivations behind alignment strategy for employed physicians:

- Create coordinated physician buy-in to quality and safety initiatives: 62%
- Ensure coverage for strategic service lines: 49%
- Physician Retention: 42%

Base=279 Multi-Response

*Source: HealthLeaders Media – 2012 Intelligence Survey: Physician Alignment: Integration over Independence*
Trends: Survey of Healthcare Leaders – How Does this Align with your System? (cont’d)

**Key Industry Trend**

Stronger collaboration between health systems and physicians/practices

*It is a fact that alignment is occurring in a variety of ways and that this not only impacts the care delivery model, but also internal operational factors, such as physician compensation*

*Source: Merritt Hawkins Annual 2012 Report*
Physician Engagement – Valuing Your Partners (cont’d)

• Where are you on the “engagement continuum?”
  – Are your Providers “widget makers” or valued contributors?

• Is your “subsidy” acceptable?
  – Why?
  – How do you “value” the subsidy?

• Did you employ physicians only to “lose” money on them?
  – How have they reacted to that message?
  – Pro rata share of expenses
  – Ancillaries pulled from practice
  – Accrual vs. cash?

• Regardless of system size, have you engaged with your physicians, both in/out of the hospital?
  – Physician involvement?
  – Dyad of leadership?
  – Roping in “community physicians” to “think ahead”
Physician Engagement – Valuing Your Partners (cont’d)

An absurd example to demonstrate the subsidy

<table>
<thead>
<tr>
<th>Physician Private Practice</th>
<th>Employed Model - Ancillaries Removed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>Revenue $80.00</td>
</tr>
<tr>
<td>Expenses $(50.00)</td>
<td>Expenses $(60.00)</td>
</tr>
<tr>
<td>Partner pay $50.00</td>
<td>Employed physician $(50.00)</td>
</tr>
<tr>
<td></td>
<td>Hospital's bottom line $(30.00)</td>
</tr>
</tbody>
</table>

• Considerations:
  – The system pulled out the physicians’ ancillaries,
  – The system guaranteed to physicians the same compensation they were making, and
  – The system baked in pro-rata costs of legal, HR, IT, administration that the practice heretofore had included “above the line”

• Is the “subsidy” acceptable?
Physician Engagement - Structure
Physician Engagement – Valuing Your Partners (cont’d)

• Dyad model
  – Physician/Administration Partnership

• Committees structure
  – Engage physicians to provide input
  – Quality (which goes toward compensation)
  – Physician-to-physician performance issues
  – Input on provider hiring process; pro forma discussion with Administration
Rural Health Physician Compensation

• Typical Approaches to Compensation:
  – Distributable Net Income
  – wRVU-Based
  – Salary (especially prevalent in rural healthcare) – sometimes higher to draw talent?

• Foundation is rooted in production (today)

• **How do you include performance bonuses?**
  – Non-productivity incentives
    o Financial incentives for achieving targets in patient satisfaction, quality, cost savings, etc.
    o May be a percentage of the physicians’ base salaries (at-risk model)
  – Challenges for rural hospitals:
    ✓ Establishing appropriate tracking methods/metrics
    ✓ Including performance-based incentives into compensation frameworks
Physician Engagement – Valuing Your Partners (cont’d)

1990s - Guarantees

2000s - wRVUs

2012+ - Outcomes
A Brief Compensation History

<table>
<thead>
<tr>
<th>Period</th>
<th>Highlights</th>
</tr>
</thead>
</table>
| 1990s  | - High guarantees  
         - No productivity expectations  
         - Significant benefit packages |
| 2000s  | - Strong focus on productivity (mainly wRVUs)  
         - Guarantee treatment largely depends on locale  
         - Limited performance incentives (outside of productivity)  
         - Reasonable benefit package (no more pensions) |
| 2010s  | - Continued, though changing, focus on productivity  
         - Significant focus on inclusion of performance incentives (outside of productivity)  
         - Decreasing guarantees  
         - Reasonable benefit package (no more pensions)  
         - Questions of what the future looks like |
The Salary Model

• Standard Formula:

Salary + Possible Production Incentive Payment = Compensation

Non-productivity incentives have not always been included

• Note: This is NOT the most common model outside of the rural health setting
The wRVU Model

• Standard Formula:

\[ \text{wRVUs} \times \text{Conversion Factor} = \text{Compensation} \]

Historically, “non-production” measures/incentives have not been included
“New” Salary Model?

• There is NO “standard formula”:

\[ \text{wRVUs} \times \text{Conversion Factor (sometimes “stepped”) } + \text{Non-Production Incentives (Quality, Svc Line Efficiency)} \rightarrow \text{Compensation} \]
### New Compensation Components

<table>
<thead>
<tr>
<th>Quality Measures</th>
<th>Chart Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction</td>
<td>Administrative Adherence</td>
</tr>
<tr>
<td>Expense Control (Practice)</td>
<td>Good Citizenship</td>
</tr>
<tr>
<td>Targeted Cost Savings (Hospital)</td>
<td>Adoption of EHR</td>
</tr>
<tr>
<td>Coding and Compliance</td>
<td>Referral Patterns</td>
</tr>
<tr>
<td>Call Coverage</td>
<td>Medical Home</td>
</tr>
</tbody>
</table>
What Does This All Mean for Rural Healthcare?

- Compensation is often a great driver for engaging and motivating providers and strengthening service lines
- Rural healthcare organizations must design a plan that incentivizes volume and value
- **Key Tenets for Establishing a Sustainable Compensation Structure in a Rural Health Setting:**
  - Regularly assess current structure for scalability and adaptability
  - Bring physicians into the discussions and educate them on options
  - Establish metrics for success and methods for tracking them
  - Non-productivity incentives:
    - Choose no more than three key areas
    - Let system dictate some, physicians choose some
    - Pay no more often than semi-annually
    - Establish scoring mechanism as objectively as possible
Operations – The Foundation

- Strategy
  - Importance
  - Why
  - Plan
  - Partners

- Physicians
  - Alignment
  - Advise
  - Compensation
  - Empowerment

- Revenue Cycle
  - Process
  - Data Measurement
  - Data Management

- Operations
  - Management
  - Scheduling
  - Patient Flow
  - Reporting
Operations – The Foundation (cont’d)

- All clinics require good, fundamentally sound management
- Often health systems and private practices “under invest” in this difficult and challenging layer of the organization; however, a “sound” investment would deliver a good ROI
- Rubber meets the road in “new” delivery of care alphabet soup of acronyms/new paradigms
- Lower cost/higher quality on the way; get ambulatory side in line!
- Administrators should have, minimally, a facile understanding of their specialty and/or the administration of care
- Administrator should be given tools, defined authority, a management “dashboard,” and be mentored by a seasoned leader with ambulatory, outpatient experience
  - Should manage with a “dashboard” of data designed to deliver updated practice-specific data to the Administrator
## Administrator Dashboard

### Ambulatory Clinic, Anywhere USA

<table>
<thead>
<tr>
<th>Month:</th>
<th>2014</th>
<th>2013</th>
<th>Monthly % change</th>
<th>Monthly $$ change</th>
<th>YTD % change</th>
<th>YTD $$ change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. 1</td>
<td>$100,000.00</td>
<td>$600,000.00</td>
<td>$95,000.00</td>
<td>$600,000.00</td>
<td>5.3%</td>
<td>$5,000.00</td>
</tr>
<tr>
<td>Dr. 2</td>
<td>$120,000.00</td>
<td>$650,000.00</td>
<td>$120,000.00</td>
<td>$600,000.00</td>
<td>0.0%</td>
<td>$-</td>
</tr>
<tr>
<td>Dr. 3</td>
<td>$175,000.00</td>
<td>$725,000.00</td>
<td>$225,000.00</td>
<td>$625,000.00</td>
<td>-22.2%</td>
<td>$(50,000.00)</td>
</tr>
<tr>
<td>Total:</td>
<td>$395,000.00</td>
<td>$1,975,000.00</td>
<td>$440,000.00</td>
<td>$1,825,000.00</td>
<td>-10.2%</td>
<td>$(45,000.00)</td>
</tr>
<tr>
<td>Expenses</td>
<td>$200,000.00</td>
<td>$950,000.00</td>
<td>$210,000.00</td>
<td>$1,000,000.00</td>
<td>-4.8%</td>
<td>$(10,000.00)</td>
</tr>
<tr>
<td>Overhead</td>
<td>50.63%</td>
<td>48.10%</td>
<td>47.73%</td>
<td>54.79%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| New Patients |      |      |                  |                  |              |               |
| Dr. 1  | 20  | 120 | 18  | 120 | 11.1% | 2 | 0.0% | 0 |
| Dr. 2  | 25  | 130 | 25  | 130 | 0.0% | 0 | 0.0% | 0 |
| Dr. 3  | 30  | 145 | 40  | 130 | -25.0% | (10) | 11.5% | 15 |
| Total: | 75  | 395 | 83  | 380 | -9.6% | (8) | 3.9% | 15 |

| Surgeries |      |      |                  |                  |              |               |
| Dr. 3  | 30.00 | 145.00 | 40.00 | 130.00 | -25.00% | -10 | 11.54% | 15 |
| Practice RVUw | 1750.00 | 15250.00 | 1800.00 | 14200.00 | -2.78% | -50 | 7.39% | 1050 |
| Days in AR | 35.00 | 45.00 |                  |                  | -22.2% | -10 |            |   |
Operations – The Foundation (cont’d)

• Budgets should be built on actual dollars projected to spend and actual revenues
• “Actual” budget dollars should be appropriately allocated
• Senior management structure (e.g. senior management FTEs/staff member) should be reviewed and aligned (span of control)
• Site management should handle:
  — Patient throughput
  — Revenue cycle (unless Central Billing Office [CBO] in play)
  — Day-to-day staffing
  — Operational fire-fighting
  — MBA not a must but aptitude is!
Operations – The Foundation Scheduling/Patient Flow

• Ensure balance of provider schedules
• Does the EMR really keep me from seeing 10 patients a day?
• Physician schedules must be managed and expectations must be defined:
  — 7 hours of patient time in clinic; 20 patients per day (or some defined expectation);
  — 4.5 days worked per week (~36 hours per week)
• Charges must be captured and an audit system put in place to ensure that each encounter is billed, revenues received, and AR processes delivered
• Providers can “massage” their schedules within reason and parameters established
Revenue Cycle

- Strategy
  - Importance
    - Why
  - Plan
  - Partners

- Physicians
  - Alignment
    - Advise
  - Compensation
  - Empowerment

- Revenue Cycle
  - Process
  - Data Measurement
  - Data Management

- Operations
  - Management
  - Scheduling
  - Patient Flow
  - Reporting
Revenue Cycle - Process

Define measurements for these components (via Strategy from Senior Administration to Administrator to Revenue Cycle team)

• Insurance verification
• Front end collections
• Back end collections (if any)
• Charge capture
• Charge batch/submission
• Process in place to aggressively follow up on accounts
• Look at “buckets” and compare aging, days in AR, etc.
• In an operational assessment, all of these components should be reviewed
Revenue Cycle – Data Management

Deploy quantified/defined/”best in class” measurements such as:

- Net charges (not “gross charges”)
- Net collections
- Collection % (e.g. % of *collectible* money actually collected)
- Point of service collections (verify these against charge slips)
- Days in each “bucket”
- Days outstanding
- Cost to collect
- Backend collections (if any)
- Charge capture
- Charge batch/submission
- Process in place to aggressively follow up on accounts
  - How assigned to staff, how worked, when to punt to collections, reporting
- Statistics for aging, days in AR, cost to collect, etc.
Revenue Cycle – Data Measurement

Deploy defined measurements such as:

- Net charges - Benchmark against similarly situated "groups" (e.g. employed physician models, similar size, etc.)
- Net collections - 95 – 99% expectation
- Point of service collections (verify these against charge slips) – 100% collections (unless mitigating circumstance that should be cleared via site administrator)
- Days in each “bucket” – preferably bulk in 0 – 30 days; 80 – 90% in 0 – 60 days?
- Days outstanding – 25 – 30 days?
- Cost to collect - what are our human capital costs to collect? If >5%, should we outsource?
- Back end collections (if any)
- Charge capture (coding/auditing) ensure physicians have documented and captured all work performed
- Charge batch/submission – clean batch submission nightly via 3rd party clearing house; if not, why are they rejected? Correct, resubmit, document, educate
- Process in place to aggressively follow up on accounts
  - Assigned staff?
  - Rules for pursuing? E.g. $$ thresholds; # of letters submitted
  - Rules for turning over to collections? (e.g. 120 days out)
Revenue Cycle Dashboard

- As with any data, do NOT review in a vacuum

<table>
<thead>
<tr>
<th>Revenue Cycle Monthly Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Days outstanding</td>
</tr>
<tr>
<td>27</td>
</tr>
<tr>
<td>$$ outstaindg</td>
</tr>
<tr>
<td>Charges</td>
</tr>
<tr>
<td>Aging Buckets</td>
</tr>
<tr>
<td>0-30 days</td>
</tr>
<tr>
<td>31-60 days</td>
</tr>
<tr>
<td>61-90 days</td>
</tr>
<tr>
<td>91-120</td>
</tr>
<tr>
<td>&gt;120</td>
</tr>
<tr>
<td>Total:</td>
</tr>
<tr>
<td>Net collections</td>
</tr>
<tr>
<td>Cost to collect</td>
</tr>
<tr>
<td>Balance Chk in</td>
</tr>
</tbody>
</table>

= worse vs. PYTD or benchmark
Why Review Ambulatory Operations?

- Value over volume, less “heads in beds,” however you digest the alphabet soup (ACA, PCMH, CIN, P4P, etc.)
- Are you ready for this? Have you maximized your employed model and squeezed out costs/redundancies and built in systemic efficiencies??
Traditional Care Delivery Model

- Providers working in silos
- Staff performing duties separately
- Quality focus largely for hospitals
- Payer contracting done separately
- No uniformity in performance measures
- Proven to be a costly and unsustainable model
Accountable Care Era: Rural Health Opportunities

• Strategies for combatting CAH crisis:
  – Increase utilization of telemedicine
  – Collaborate with medical schools in recruitment efforts
  – Streamline operational processes to increase efficiencies and pare down costs
  – Engage patients in care coordination efforts to reduce gaps in care
  – Take advantage of government programs and incentives that target care quality and primary care development
## Contemporary “Value Based” Models

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>BASIC CONCEPT</th>
<th>COMPENSATION FRAMEWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-Centered Medical Homes</td>
<td>• Team of providers and medical individuals collaborating to provide patient-centric care in a focused ambulatory care environment; can be part of ACO/CIN model</td>
<td>• Varying incentives based on contractual relationships with payers</td>
</tr>
<tr>
<td>Quality Collaboratives</td>
<td>• Consortium of providers focused on furthering the quality outcomes for a defined population</td>
<td>• Internal or external funding sources determine scope and structure of available funds</td>
</tr>
<tr>
<td>Clinically Integrated Networks</td>
<td>• Interdependent healthcare facilities form a network with providers that collaboratively develop and sustain clinical initiatives</td>
<td>• Incentive (i.e. at-risk) compensation based on achievement of pre-determined measures</td>
</tr>
<tr>
<td>Accountable Care Organizations</td>
<td>• Participating hospitals, providers, and other healthcare professionals collaborating to deliver quality and cost effective care to Medicare (and other) patient populations</td>
<td>• Incentive (and punitive) financial impacts based on cost savings and quality</td>
</tr>
</tbody>
</table>
Benefits of Clinical Integration

Patients
- Access to high-quality, coordinated and comprehensive care

Providers
- Access to greater financial incentives
- Opportunity to drive healthcare quality and value
- Opportunity to engage in hospital-physician alignment

Hospitals
- Opportunity to cut costs and deliver improved patient-centric care
- Opportunity to engage in hospital-physician alignment

Employers
- Opportunity to work with major employers in the community
- Opportunity to connect with the top 2-3 companies via the CIN
Key Takeaways

Value Based Medicine (regardless of acronym) is ushering in a wave of changes, all of which pose unique challenges for the dynamic between healthcare systems and physician partners.

While risks/challenges exist, doing nothing will detrimentally impact independent physicians and employed models – traditional care delivery will prove to be more costly and unsustainable.

Many systems under invest in operational infrastructure; this will haunt them as they move forward.

Federal and commercial payers have begun supporting new delivery paradigms via programs/incentives/penalties.

All systems with an employed physician model MUST develop a STRATEGIC PLAN, ensure it aligns between the system and ambulatory enterprise, engage their physician partners, and drive care and operational efficiencies into their clinics.
Now What?

• To move forward in the brave new world of increased quality and reduced cost, all health systems will require a new “view” of the ambulatory care model

• Systems should assess key components such as:
  — Physician compensation and productivity
  — Operational structure and costs
  — Staffing costs and alignment
  — Revenue cycle operations

• The time is now; the future is almost here!
Q & A