

Physician Strategy News

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Building Synergy: Hospital and Physician Strategies

Physician Strategy News

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Challenges With Anesthesia

Hospitals around the country are struggling with anesthesia services. Without an adequate supply of anesthesia providers, hospitals are limited in their surgical capacity—not an advantageous market position. But a tight supply of MDAs and CRNAs, and declining reimbursement, particularly from Medicare, are working together to create a problem.

Increasingly, private groups are not making enough money to attract the anesthesia talent desired by hospitals. They simply cannot pay competitive wages. The result is a request for subsidies from the hospital or employment of the anesthesiology group by the hospital. The subsidy approach is the more

prevalent of the two.

The compensation for anesthesia is a reality. Per MGMA data, the mean compensation rose about 1%-2% each year, from 2002 to 2004. The increase from 2004 to 2005 (the last year for which data is available), showed an increase of 6.5% (from a national mean of \$334,402 to \$356,178).

At a major tertiary hospital, which revealed that about one half of the hospitals in our sample were providing subsidies of some description. That percentage has grown to about 75% in 2007.

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Financial Impact of Physician Recruitment

As hospitals develop a physician recruitment plan, it is important to consider the financial impact of the plan. Our client hospitals' boards are consistently asking for this analyses. The increasing resources required to implement recruitment plans, due to the growing physician shortage, makes it difficult to determine the financial impact of a recruitment plan.

In your recruitment analysis, you'll want to answer the following questions:

How much net revenue will the practice produce for the hospital when mature? To do this, utilize

national estimates of revenue from groups such as Merritt Hawkins, or data from you own medical staff if you have an incumbent physician in the specialty.

"A practice proforma for new recruits is a must."

How long will it take for the practice to mature and how quickly will volume ramp up? If the recruit is walking into a busy practice, he/she may reach 80%, 90% or even 100% of their potential in year one. If it is a totally new practice, it will take longer.

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Challenges With Anesthesia

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We are seeing hospitals tackle this in all cases, hospitals are weighing two types of risk: 1) the risk that subsidies will grow beyond the hospital's means; and 2) the risk that the group will fail, anesthesia coverage will be lost and surgical volume will therefore decline.

Approach 1: Deciding to do nothing. In the current environment, with groups looking for anesthesiologists, this is potentially risky behavior. It may work if the anesthesia group is well established, well managed, and has stable leadership.

Approach 2: Employing the providers and guaranteeing competitive wages. This reduces the risk of losing providers, but will likely increase the size of the subsidy. It is attractive to those facilities that need control. One HSG client employed this strategy

as they were expanding OR capacity by about 25%. Given the costs of that facility and the investment they had made in recruiting surgeons, the employment option for anesthesia providers seemed prudent.

Approach 3: Guaranteeing collections for the group. The guarantee is tied to what the group must collect in order to pay competitive wages and retain staff. In this scenario, hospitals assume the risk for volume, managed care rates, and collections, but can virtually eliminate the chance of the group failing. Clients who have utilized this approach have generally been in markets where the groups are protected from aggressive payers and when the group needed to turn around the effectiveness of its collections.

Approach 4: Providing money for services provided by the group (i.e., coverage, medical

direction, indigent care, etc.) monthly amount. It helps the group, but does not insulate it from aggressive managed care companies or poor collections. It also might need to be adjusted over time as the market for anesthesia providers continues to evolve.

Approach 5: Test the market with a RFP and look for a new group. This approach is certainly prudent if the hospital believes it can get a better deal in the open market, and might be required by the board as part of your due diligence. But it, too, is not without risk, as transitioning a service such as anesthesia is no small undertaking.

For more information, call David Miller at (502) 814-1188.



Financial Impact of Physician Recruitment

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What will it cost the hospital to provide the care ordered by the physician? This can be expressed as some percentage of the revenue produced, and can vary greatly by facility. If the hospital wishes to express this as a percentage of revenue. If you use a variable costing formula, it may be much less.

What capital expenses must be incurred by the hospital to support the practice? The incremental depreciation cost can be expressed as a percentage of the physician represents a new specialty.

How much practice subsidy will be required? A practice proforma for new recruits is a must. In today's environment, a subsidy is almost always required, and that must be incorporated when evaluating the

PROJECTING FINANCIAL IMPACT

- + **Net Hospital Revenue Produced**
- **Cost of Providing Care to Hospital Patients**
- + (or) - **Direct Practice Operating Results**
- **Recruitment Expenses**
- = **Net Impact**

What are the recruitment costs? Recruiting might entail recruiter fees, travel, moving costs, student loan repayment, and other expenses.

With this information, a proforma for each recruit can be developed. The total proforma plan is the sum of the individual physician proformas.

HSG has developed tools to support this part of our **Physician Resource Planner**, the tools can be accessed over the web.

For more information about this product, call Leslie Robinson-Smith at (502) 814-1190.

Income Guarantees and Reconciliations

To ensure an adequate physician supply, most hospitals are actively involved in recruiting. And, in today's recruitment market, a net income guarantee is generally required to bring a needed independent physician to the community.

Once the need for a new physician is established, and before the recruitment process is initiated, the hospital should complete a **net income guarantee proforma**. The proforma is a document that details the new practice – both revenues and expenses.

Completing a proforma is a crucial step for a number of reasons:

- 1) It serves as the basis for the coming year's recruitment function budget.
- 2) Many net income guarantee agreements are designed around the results of the proforma. Total subsidy limits or maximums written into the contract are based on the use of incremental expense amounts calculated in the proforma as caps for certain categories of expenses.
- 3) The proforma serves as an exhibit to be shared with the recruited physician and/or the recruiting practice. A solid proforma is a document that details the physician and/or the practice to be recruited, as well as the workings of a net income guarantee.
- 4) The proforma serves as a benchmark for gauging the performance and progress of the recruited physician once he/she begins to practice.

Steps to Building a Net Income Guarantee Proforma

The subsidy period for income guarantees is typically 24 months; however, the

proforma may reveal that only 12 or 18 months will be required.

Is the recruited physician going to be a solo practitioner or is the physician joining an existing group practice? If joining an existing group practice, only expenses incremental to the new physician should be included in the proforma. Incremental expenses are those expenses that are directly attributable to the recruited physician.

Project volume. Project, by month, the volume of procedures, and hospital procedures, as well as other sources of revenue (i.e., payment for ER call coverage, medical director compensation, etc.). If the physician is entering a new solo practice, the volume projections at the beginning should be conservative. If the physician is joining an existing practice with pent up demand, volume projections can be more aggressive.

Determine average charges. Determine the average charge per unit. When recruiting into an existing group, the existing charge master can be utilized. When recruiting a solo physician, use local Medicare rates times 150% for office visits and times 200% for procedures and surgeries.

Estimate incremental expenses. Estimate all categories of incremental expenses by month. Again, MGMA Cost Survey data is an excellent source for estimating costs and benchmarking results.

Benchmark. Compare volume and charge results with benchmark and industry survey data. A reliable source is the Medical Group Management Association (MGMA) Physician Compensation and Production Survey. The volume and charge amounts should approach the MGMA 25th percentile for the selected physician specialty.

Second year totals can begin to approach the MGMA median. If need for the physician is extremely great and volume is expected to be high, meeting or even exceeding the median might be possible.

Calculate actual cash collections by month by estimating a collections percentage. Use historical collection percentages for existing practices. For a new practice, collection percentage data contained in MGMA Cost Surveys is a good starting point. Keep in mind the quality of the local payor mix when estimating the collection percentage.

Benchmark. Benchmark cash collections with survey data such as the MGMA Physician Compensation and Production Survey.

Collection Lag. You will also want to incorporate a collection lag in your monthly cash collections estimates. The reality that dollars will be collected in smaller percentage segments over a number of months. For example, if the collection percentage is 50%, then 5% might be collected in month 1, 10% in month 2, 20% in month 3, 10% in month 4, 3% in month 5, and 2% in month 6.

Estimate incremental expenses. Estimate all categories of incremental expenses by month. Again, MGMA Cost Survey data is an excellent source for estimating costs and benchmarking results.

Determine the recruited physician's guaranteed net income amount. The guarantee amount is determined by the market value, local physician salary requirements by specialty, available resources, the physician's experience, and the physician's ability to maintain and sustain the amount after the guarantee ends. Refer to the MGMA Physician Compensation

Income Guarantees and Reconciliations

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and Production Surveys and look for physician compensation data by specialty.

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Calculate the projected monthly subsidy by subtracting total incremental expenses by month from the month's projected cash collections. Next, contrast actual net physician income by month versus amount guaranteed to determine the amount due to the physician for the month. This is done by subtracting the monthly amount guaranteed (total annual guarantee amount divided by 12) from the net income or loss previously calculated. This amount is the amount due to the physician.

The Reconciliation

During the term of a net income guarantee, physicians with a running balance who exceed the guarantee amount in any month must repay the amount of the overage to the hospital, until their net income guarantee balance is zero. That will only be documented if you complete regular reconciliations.

This reconciliation evaluates what has happened and how cash must $\dot{U}ck`h`a`Yhih`Yhf`a`g`c`Zh`Yb`Yi`$ income guarantee contract. Before execution of that contract and before the physician begins practicing, the physician, the group practice, and the practice's administrative staff should all understand the details of the net income guarantee, its purpose, individual responsibilities, and expectations going forward.

The expectations and responsibilities of the practice or physician include:

- 1) Providing the hospital with detailed cash collections and incremental expense data in a timely manner, according to the agreement.
- 2) Answering questions regarding the information provided.

- 3) Remitting payment to the hospital in those months required, according to the terms of the agreement.

The expectations and responsibilities of the hospital will include:

- 1) Collecting the necessary cash collections and expense data on a monthly basis.
- 2) Reconciling the net income guarantee each month on a timely basis according to the requirements of the agreement.
- 3) When necessary, making payment to the physician or practice according to the agreement.

Hospitals should not take the reconciliation process lightly. Hospitals failing in this area have subjected themselves to legal $gMi`h`bnz`Ub`Uv`WU`cg`Yg`Xi`Yhc`$ subsidy overpayments, lost time and money in trying to complete reconciliations retrospectively, and damaged relationships with their physicians.

Steps in reconciling a Net Income Guarantee

Understand all pertinent terms and conditions of the contract.

Examples of provisions that may vary from agreement to agreement $lbW`XY`...`ja`l`hg`cf`Wdg`cb`gd`YM`UW`$ categories of expenses, annual or monthly subsidy limits, events that might trigger the start of the forgiveness period, and percentage reduction of incremental expense amounts allowed.

Communicate with the physician/practice manager. Make sure they know what information is expected each month and when it is expected.

Set up a standard reconciliation template.

Be critical of data. Evaluate the data to ensure expenses are appropriate and incremental.

Base payments on the

reconciliation. Do not pay any amounts without completing the reconciliation. If all attempts to collect the data have been fruitless and the practice is not forthcoming with the required data, do not send cash.

Be consistent and timely. Adhere to the agreement guidelines related to timely completion of the reconciliation and payment of any subsidy amounts.

Collect amounts due to the

hospital. In those instances when the physician/practice owes money back to the hospital, collect it or subtract amounts paid from any subsequent amounts owed.

Conclusion

$H`N`Yg`Y`Ub`Uv`WU`hc`g`UFY`Vch`j`jH`$ components of a successful physician recruitment function.

If you need help getting started, establishing processes, or actually completing proformas or reconciliations, contact Neal Barker at (502)814-1189.

HEALTHCARE STRATEGY GROUP First Quarter Clients

The Christ Hospital	Cincinnati, OH
Floyd Memorial Hospital	New Albany, IN
Great River Medical Center	Blytheville, AR
Halifax Medical Center	Daytona BchFL
Hugh Chatham Memorial	Elkin, NC
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Jennie Stuart Regional	HopkinsvilleKY
Lawrence Hospital Center	Bronxville, NY
Loris Healthcare System	Loris, SC
Medical Ctr of SE Oklahoma	Durant, OK
Mission Hospitals	Asheville, NC
Newport Hospital	Newport, RI
Norton Healthcare	Louisville, KY
Perry County Memorial	Tell City, IN
Perry Memorial Hospital	Princeton, IL
Sacred Heart Medical Ctr	Eugene, OR
Saint Joseph Healthcare	Lexington, KY
Saint Luke Hospitals	Ft. Thomas, KY
Wadsworth-Rittman Hospital	Wadsworth, OH
Woburn Nephrology Assocs.	Woburn, MA
Women First OB/GYN	Louisville, KY

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Developing a Practice Management Infrastructure

While hospital executives are very skilled at running hospitals, they often fall short when trying to manage their employed physician groups. We see three primary

contributors to this: 1) a lack of practice knowledge; 2) treating the practice like a hospital department; and 2) a failure to develop the necessary infrastructure required

for the physicians to be successful. In this article, we'll highlight and discuss the key infrastructure investments required.

KEY INVESTMENTS

There are nine key investments that the hospital must make when operating practices. These are:

- 1. Practice administrator.** If possible, select a manager experienced in working with the specialties you are employing. Each specialty has unique nuances, and prior knowledge is invaluable. No matter what, avoid placing a hospital employee in this role.
- 2. Billing supervisor.** Cash is the lifeblood of a practice. To minimize subsidies, it is crucial to have an effective leader in billing. Many practices outsource this capability, but they must still manage the patient registration and charge posting processes within the practice. A detail-oriented, almost compulsive, person is required for this role.
- 3. Practice management system.** The practice must have a system to drive its scheduling, charging, and the right system will help to produce more cash in the practice. Some of this capital expense can be saved if the service is outsourced.
- 4. Compensation model.** and models that cannot be sustained.
- 5. Practice environment/decor.** of these standards, additional investment might be required when buying existing practices.
- 6. Staff development.** Staff development for this new operation is critical, both for the operational staff who money on this aspect of the practice can be costly.
- 7. IT/EHR.** Investment in IT has many potential advantages, from better coordination of care with the with the growth of pay for performance systems for physicians, the focus must increase.
- 8. Support Services.** Allocation of hospital overhead to practices often creates controversy and concern among the physicians. Some support services, such as HR, maintenance, and accounting, may best be provided through the hospital. Decide early on if the practice will handle these tasks or purchase them from compensation.
- 9. Legal and Accounting Costs.** number. That will result in commingling of payments from insurers and will make production of practice

For more information on building your practice management infrastructure, call John Hill at (502) 814-1185.

