

PARTNERSHIPS AMONG HOSPITALS AND PRACTICES GIVE STIPENDS A FAIR ASSESSMENT

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PHYSICIAN BILLING — PRACTICE MANAGEMENT

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Subsidies or stipends must be beneficial for anesthesia practices and hospitals in order for both to maintain financial stability in an environment marked by shrinking reimbursements, growing competition and rising costs.

Securing a subsidy is far from guaranteed in today's market. Hospitals face their own economic difficulties and often need claims to be backed up by solid evidence when working with anesthesia practices. This is why it is essential that anesthesia practices conduct a comprehensive operational evaluation before engaging in subsidy negotiations with a hospital. This paper will examine ways anesthesia practices and hospital CFOs can give themselves an honest assessment of the financial support landscape.

THE ECONOMICS OF THE SERVICE REQUIREMENT

A subsidy evaluation for a practice begins with an assessment of the service requirement. The service requirement is simply defining the locations and total hours of service required by the hospital. A matrix is created to show how many operating rooms (ORs), obstetrical sites (OBs), outpatient surgery centers and other service locations must be covered, for when and how long. In addition, the hospital's on-call requirements should be documented, whether in-house or by beeper.

The next step is to examine how the service requirement is currently being staffed. The number of anesthesiologists and certified registered nurse anesthetists (CRNAs) used at each location for each period of the working day is presented. By researching the volume of cases performed for each site and corresponding time period, revenue estimates are generated and corresponding costs assigned. From this analysis, mismatches between staffing revenue and expenses can be easily recognized.

SCHEDULE CONSIDERATIONS

By examining current staffing patterns, volume, revenue and expenses, anesthesia practices should be able to develop staffing models that meet hospital requirements more efficiently. Once these options are identified, practices may then focus on the hospital side of the equation to pinpoint areas where changes in hospital scheduling could benefit the subsidy arrangement.

If the practice identifies unprofitable staffing scenarios, it can and should present an alternative optimized schedule that addresses existing imbalances in a way that incorporates concessions from both sides.

FINANCIAL SUPPORT BASED ON COMPENSATION

One family of approaches to calculating financial support is based on compensation. Guaranteed compensation by physician is one method. Another method is to approve the staffing or anesthesia budget and provide financial support if practice revenue is not adequate to cover the costs. In both type of arrangements compensation assumptions are the main component of the support calculation.

Establishing agreed upon market compensation rates for providers is at the center of these stipend calculations and negotiations. If the practice is on average, above market, then the hospital may not provide subsidies to help maintain the rates depending on its market calculations. Conversely, if compensation rates are below market, then the argument for stipend assistance may be strengthened due to obvious benefits on both sides. Because physician and CRNA salaries and benefits are the largest component in a practice's cost structure, it is important that all parties understand how the existing compensation packages rank in comparison to market rates.

Market compensation information can be obtained through a variety of sources, including published surveys or reports, medical societies, trade associations, locum staffing companies and even advertisements for open positions.

MODELING "COST SHARE" ARRANGEMENTS THAT EXCLUDE PHYSICIAN COMPENSATION

The American Association of Clinical Directors (AACD) says best practice ORs should average about 900 inpatient OR cases per year, per OR room and 1,400 outpatient cases per OR room, per year. Too frequently it is the number of rooms the facility has and elects to open that drives staffing requirements and thus costs. Facility administrators are frequently under tremendous pressure from surgeons to open all operating rooms at the first of each day. This typically creates block times that are inefficiently utilized and set the stage for decreasing efficiency throughout the rest of the day.

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Ideally, the number of anesthesia providers is determined by the number of cases to be done. Of course, it is quite possible the hospital may not be able to close an OR due to marketing issues or concerns about disrupting surgeons' schedules. Anesthesia practices therefore should exercise caution in this area and balance their preferences and needs regarding room closures against the importance of maintaining good relations with both the hospital and surgeons. This suggests a "cost share" arrangement whereby each party, the facility and the anesthesiologist bear some responsibility for inefficient scheduling.

It might be preferred by both parties that stipend models exclude physician compensation. The term "stipend" is perceived to be synonymous with anesthesiologists' pay by many administrators. In a surprising number of occasions, the actual reason for a stipend may have little or nothing to do with anesthesiologists' compensation. For that reason, the term "cost share" more accurately reflects a cooperative effort to cover the costs of anesthesia care. In the cost share model, the anesthesiologists provide needed physician coverage as well as the cost of CRNAs that are actually utilized in a billable manner by the anesthesiologists. The facility cost share should reflect the costs of inefficient utilization of CRNA time that is unbillable by the anesthesiologist.

Model One: stipend is the cost of OR inefficiency as determined by benchmarks and targets

By using a standard efficiency target from a well accepted source such as the AACD, the target efficiency goal might, for example, be set at 75 to 80 percent with a 15 minute turnover time (T/O). If a rollover room is used, meaning that cases are immediately started in an unutilized, already set-up room, then no real T/O time occurs and those cases would be excluded in T/O computations.

The actual efficiency relating to CRNAs would be illustrated in the following equations:

- Gross available CRNA minutes = full time employee (FTE) CRNAs x 2,083 (hrs/FTE) x 60 min/hr
- T/O minutes = number of cases x 15 T/O minutes
- Net available CRNA minutes = gross available CRNA minutes - T/O minutes
- Efficiency, expressed as a percentage = actual utilized CRNA minutes from billing date /net available CRNA minutes

For T/O minutes, the first case of every day and the last case of every day have no CRNA T/O time. This can be calculated by subtracting two cases for each operating room day (typically Monday through Friday) in the study period before multiplying. It should be noted that AACD uses T/O time as the time between one patient leaving the OR and the next patient entering the OR. In anesthesia, T/O time is the time between one patient ending anesthesia time and the next patient beginning anesthesia time.

The percentage by which the actual efficiency misses the target efficiency is the percentage of total costs attributable to an inefficient use of CRNA resources. For example, if the actual efficiency is 45 percent with a target of 75 percent, then the facility stipend equals 30 percent of CRNA costs. The stipend would typically be paid in monthly installments to the employing group. One presentation of this concept might illustrate a "disappearing stipend" that zeros out at the target of 75 percent efficiency. Below is an illustration of this concept that assumes 10 FTE CRNAs at \$165,000 total cost each:

- Total CRNA costs: 10 FTE CRNAs @\$165,000 each = \$1,650,000
- 30% inefficiency = $\$1,650,000 \times 30\% = \$495,000/12 = \$41,250$ per month
 - 25% inefficiency = $\$1,650,000 \times 25\% = \$412,500/12 = \$34,375$ per month
 - 20% inefficiency = $\$1,650,000 \times 20\% = \$330,000/12 = \$27,500$ per month
 - 15% inefficiency = $\$1,650,000 \times 15\% = \$247,500/12 = \$20,625$ per month
 - 10% inefficiency = $\$1,650,000 \times 10\% = \$165,000/12 = \$13,750$ per month
 - 5% inefficiency = $\$1,650,000 \times 5\% = \$82,500/12 = \$6,875$ per month
 - 0% inefficiency = \$0.00

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Model Two: stipend is the facility caused cost of unproductive CRNA time

Similar to model one, first determine gross available CRNA minutes, T/O minutes and net available CRNA minutes. The actual utilized CRNA minutes can be determined from existing billing data. By subtracting the used minutes from the available minutes, you get the unbillable, wasted minutes or units of CRNA costs that are due to the hospital's inefficient use of CRNA resources. Below is an illustration of this model that assumes 10 CRNAs @ \$165,000 total cost each and 749,880 minutes (49,992 units) used and billable.

Calculation using minutes:

- › Total CRNA costs: 10 FTE CRNAs @\$165,000 each = \$1,650,000
- › Available CRNA min = 10 x 2,083 hrs x 60 min/hr = 1,249,800 minutes (83,320 units)
- › Cost per minute = \$1,650,000/1,249,800 = \$1.32/min (\$19.80/unit)
- › Available min = 1,249,800 min - 749,880 used = 499,920
- › Unused min x \$1.32/min = \$659,894 yr/12 = **\$54,991** per monthly stipend

Calculation using units:

- › Total CRNA costs: 10 FTE CRNAs @\$165,000 each = \$1,650,000
- › Available CRNA min = 10 x 2,083 hrs x 60 min/hr = 1,249,800 minutes (83,320 units)
- › Cost Per unit = \$1,650,000/1,249,800 = \$1.32/min (\$19.80/unit)
- › Available 83,320 units - 49,992 used
- › Used units = 33,328
- › Unused units x \$19.80/unit cost = \$659,894 yr/12 = **\$54,991** per monthly stipend

ENSURING OPTIMAL PERFORMANCE

In addition to agreeing on the revenue and costs to meet service requirements, both parties must be comfortable that a practice's overhead is not excessive when compared to similar-sized practices in the region or around the nation. Costs can include practice management and non-clinical salary expense, malpractice insurance, lease expense and the cost of billing services. All should be carefully scrutinized and, to the extent possible, justified via market benchmarks.

Being customer-focused is also instrumental to the success of an anesthesia practice in a hospital environment. Physicians should make sure they are meeting the hospital's implicit service expectations by starting anesthesia cases on time, maintaining good relations with surgeons and being responsive to special requests physicians may have. It also means actively participating in hospital committees, task forces and other provider forums as requested by the hospital. The overall objective is to maintain a strong partnership between the two parties and convey a willingness to do everything possible to ensure the highest level of patient care.

CRITICAL DISCUSSIONS

Financial support discussions typically take place either as part of the overall anesthesia services agreement negotiation process or independently. In either case, a thorough practice self-evaluation process that is conducted ahead of time is beneficial to both parties.

Practices should be able to determine whether support is needed because of staffing requirements, inefficiency, payor mix, overhead or all of the above. Knowing the quantifiable reasons why financial support is necessary will set the agenda and tone of negotiations.

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As in any financial negotiation, practice and hospital leaders need to anticipate legitimate disagreements and be ready to respond accordingly in a non-emotional manner. That is why it is imperative for both parties to establish a cooperative and conciliatory tone from the outset of the negotiations. If both parties are positioned as an equal partner, the chances of successfully achieving an equitable stipend or a mutually beneficial compromise will be greatly improved.

PREPARING TO SUCCEED

Stipends are a critical element in the overall economical development for both anesthesia practices and hospitals that are struggling with higher costs and lower reimbursements. By thinking more like partners, both parties will benefit from a fair stipend agreement that offers increased financial stability for both parties.

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About MMP

Medical Management Professionals, Inc. (MMP) was founded in 1993 and is a leading provider of billing and practice management services to anesthesiologists. It currently serves more than 60 anesthesiology practices with more than 1,100 anesthesia providers combined. MMP's flexible solutions range from billing-only services to full-practice management services.

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