Anesthesia Group Self-Assessment Key to Stipend Success

Maintaining financial stability in an environment marked by shrinking reimbursements, growing competition and rising costs

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Hospital subsidies or stipends are an important tool for helping anesthesia groups 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 are skeptical of financial complaints registered by physician groups, particularly if the claims are not backed up by solid evidence. That's why it is essential that anesthesia groups conduct a comprehensive operational evaluation before engaging in subsidy negotiations with the hospital.

Do Your Homework

By carefully examining and documenting their service requirements, staffing patterns and labor costs, practices can calculate the stipend level they need to meet cash flow objectives and sustain competitive compensation rates. Just as important, they'll be able to identify hospital scheduling inefficiencies that may be undermining the group's financial performance.

By reviewing not just labor costs but all major overhead components, anesthesia practices can preempt hospital arguments that excessive salaries and other costs may be the primary cause of the group's profitability shortfall. Similarly, documentation from the revenue side showing optimal billing performance can go a long way toward demonstrating to the hospital why a specific stipend amount is necessary.

Practices that take the time to conduct a detailed operational evaluation will have a far better understanding of their subsidy needs and a clearer picture of the financial implications associated with a variety of hospital counter-offers. They also will be able to show how the hospital's scheduling inefficiencies hurt both parties. Most significantly, they will increase the odds of securing a desired subsidy amount by supporting their arguments with empirical evidence. And they will bolster goodwill by demonstrating a willingness to work cooperatively with the hospital to resolve systemic inefficiencies.

Balancing Cost and Revenue

A subsidy evaluation begins with an assessment of 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, when and for how long. In addition, the hospital's on-call requirements should be documented, whether in-house or beeper.

The next step is to examine how the service requirements are 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 in conjunction with the volume of cases performed at each site and the corresponding revenues generated.

From this analysis, mismatches between staffing expense and revenues can be easily spotted. For example, an OB location that must be covered 24 hours a day, seven days a week may not produce enough revenue to cover the compensation expense of the three physicians needed to staff it. This kind of information is critical when calculating an appropriate subsidy level. At the same time, it also can provide groups with the opportunity to improve efficiencies without necessarily shifting the revenue shortfall to the hospital.

In this instance, the group might consider staffing the OB location with CRNAs to meet coverage obligations at a significantly lower cost. Of course, this is only one possibility to consider. Typically the group would present several options, including a fall-back position. Understanding the full range of potential staffing scenarios before negotiations begin is vital for success.

The labor-cost versus case-volume comparison can reveal other areas where groups may be able to reduce expense and still meet hospital service requirements. For instance, if the hospital wants to extend OR services by several hours per day, each physician in the group could be asked to work a longer shift one day a week to avoid the necessity of hiring an additional Full Time Equivalent (FTE).

Flagging OR Inefficiencies

By examining current staffing patterns and volume, anesthesia groups should be able to develop staffing models that meet hospital requirements more efficiently. Once these options are identified, groups should next focus on the hospital side of the equation to pinpoint areas where hospital scheduling may be creating undue financial hardship for the group. An OR efficiency study that examines OR utilization by hours-of-the-day frequently will reveal areas ripe for streamlining.

If the group can clearly show that inefficient OR scheduling is costing the practice a specific amount of money, then the hospital is put in the position of either reconfiguring OR throughput or acceding to the group's stipend request. To further induce the hospital to action, the anesthesia group should present an alternative optimized schedule that addresses existing imbalances in a way that incorporates concessions from both sides.

Of course, it is quite possible that the hospital may not be willing to close an operating room due to marketing issues or concerns about disrupting surgeons' schedules. Anesthesia groups therefore should exercise caution in this area. For example, if the hospital were to make scheduling changes that caused a surgeon to become unhappy and leave the hospital, then the savings gained for the anesthesia group from the room closing probably would not make up for the loss of revenue associated with the surgeon's departure. Anesthesia groups need to balance their preferences and needs regarding room closures against the importance of maintaining good relations with both the hospital and surgeons.

Compensation

Because physician and CRNA salaries and benefits are the largest component in a group's cost structure, it is important that practice leaders understand how the existing compensation packages rank in comparison to market rates. This 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.

Since the definition of market inherently speaks to a point in time that is ever-evolving, groups are advised to present market compensation as a range supported by several sources. Putting too much emphasis on a single source, especially the highest, can be risky. If the hospital is able to discredit the source or methodology utilized, the group's negotiating position could be severely damaged.

Regardless of the sources used for market salary information, the group should provide the information in published form to validate their compensation claims and then back it up by communicating recent local market events that similarly support the group's salary position.

If the group is relying on published salary reports to make its argument, it is important to fully understand the various components that make up the study's compensation packages, including hours worked, call and benefits. Clarification about this information typically is found in the report's definitions or methodology sections. When presenting the data to the hospital, groups should be sure the information is easily understood and compared in a parallel manner to existing and target group compensation levels.

The group should also evaluate retention risk by taking into consideration competitive forces in the market, both locally and nationally. For example, it is healthy to evaluate a series of "what if" scenarios. What if compensation drops 5 percent over the next two years? What if compensation would increase 5 percent over the next two years? By evaluating these scenarios, the group should be able to identify local and national competitive opportunities that may -- or may not -- attract group physicians. Honestly assessing the risk of losing key physicians will allow the group to further support its market claim to the hospital.

Establishing agreed upon market rates for providers is at the center of many stipend calculations and negotiations. If the group is, on average, above market, then it is unlikely the hospital will be willing to provide subsidies to help maintain these rates. Conversely, if compensation rates are below market, then the argument for stipend assistance is strengthened.

Ensuring Optimal Financial Performance

Staffing, volume and OR efficiency assessments represent the heart of a subsidy evaluation. But other steps are equally important in the development of a strong negotiating position. Chief among these is a review of practice overhead. Costs can include practice manager 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. Again, the objective is to be able to clearly demonstrate to the hospital that overhead is not excessive when compared to similar-sized practices in the region or around the nation. When possible, groups should use this review to reduce costs that are identified as above-market, as much to improve their own financial condition as to bolster their negotiating stance with the hospital.

A review of managed care contracts and billing processes also should be conducted to ensure that the practice is collecting the appropriate revenue per case based on its existing payor mix and managed care contracts. Key performance metrics should be evaluated and benchmarked against industry norms. Managed care terms also must be scrutinized and similarly compared to ensure parity with peer practices. To the extent that the group's finances are adversely affected by a disproportionate percentage of Medicare, Medicaid and self-pay business, that fact should be noted and brought to the attention of the hospital during negotiations.

In addition, physician groups should make sure they're meeting the hospital's implicit service expectations. That means 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 good rapport with the hospital and convey a willingness to do everything possible to ensure the highest level of care.

At the Negotiation Table

Financial support discussions with the hospital typically take place either as part of the overall anesthesia services agreement negotiation process or independently. In either case, engaging in a thorough self-evaluation process ahead of time will help groups make a cogent and powerful argument in support of a specific subsidy amount.

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

As in any financial negotiation, practice leaders need to anticipate counter-offers and be ready to respond accordingly. For example, if the group has calculated that it needs a $2 million stipend but the hospital is expecting to pay $1 million, then group negotiators should be in position to offer various alternative staffing models that require a lesser subsidy. This usually involves a discussion about which services the anesthesiologists may need to reduce or no longer provide. Of course, a thin line exists between making threats and negotiating forcefully. Groups must tread carefully. This is particularly true given the rise of national anesthesia staffing companies that provide hospitals with previously unavailable options for meeting service needs.

That is why it is imperative for practice leaders to establish a cooperative and conciliatory tone from the outset of the negotiations. By positioning the group not as an adversary but as a partner, the chances of successfully achieving the target stipend or a mutually beneficial compromise will be greatly improved. In fact, adopting a more collaborative stance with the hospital can pay dividends that extend beyond the stipend negotiations. The hospital may be less willing to explore competitive alternatives in the future and more willing to work closely with the group to further streamline the OR process. This is particularly true if the group can demonstrate areas where it has pro-actively improved efficiency within its own operations.

Finally, groups should remember the importance of timing and not approach the hospital regarding stipend negotiations late in the hospital's budget preparation cycle after many key spending decisions may already have been made.

Preparing to Succeed

Stipends are a critical element in the overall revenue mix of anesthesia groups. Yet they are not automatic. In fact, subsidies are becoming increasingly difficult to secure or increase as hospitals struggle with higher costs and lower reimbursements. National

anesthesia staffing companies are visible alternatives. It is therefore incumbent upon anesthesia groups to make the best possible case for financial support. By providing the highest level of service, identifying inefficiencies, suggesting alternatives, ensuring that their own financial house is in order and thinking more like partners than contractors, groups will be in a much better position to earn the relationship and financial stability they seek.

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About MMP

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