Hospital-Physician Alignment: Is it Different this time?

By Michael Ehlen

Background:

The current move towards Hospital-Physician alignment feels like things we've done before – networks, joint ventures, and practice acquisitions. Provider integration has been a cyclical strategy for hospitals dating back to the early 1980's. Just like in the past, physicians are currently looking for deals, but will falling physician reimbursement mean that hospitals end up getting burned again?

Previous hospital-physician alignments were the result of hospitals buying primary care physician practices to protect market share and gain the upper hand with managed care contracting. Once employed by the hospital, physician productivity tended to nose dive and many hospitals experienced annual losses of $70,000 to $90,000 on their practice investment.[1] To add insult to injury, many hospitals ended up selling their practices back to the original employed physicians, at a discount, once the perceived threat from managed care went unfulfilled. What is different this time is that the strategic implication from not aligning with physicians is a larger financial threat to hospitals than just market share. The shift from inpatient procedures to outpatient procedures and the loss of those patient encounters is stressing many hospitals' financial performance.

Current Environment:

Complicating matters today is the fact that market data on outpatient and physician office services is lacking or limited. Without reliable data, many organizations seek advice from outside consultants, who may or may not possess the unique medical valuation skills to understand the risks and true value of a practice acquisition or joint venture. Not understanding values can be misconstrued as overpaying in exchange for patient referrals as some hospitals have learned the hard way.

Unlike the past, it is crucial for today's financial manger to take a more active role in the due diligence process of any current or future hospital-physician integration. As the pressure to migrate to a consumer driven model gains traction, many physicians do not have a clear understanding of the economics of their current practice and the business pressures to which they are exposed. This is where the financial manager can address potential problems during due diligence and improve the hospital-physician negotiation process.

This article takes a look at five key physician practice performance areas to gain a proper financial perspective before any alignment takes place:

1. **Market share:** New patient encounters in a physician practice need to exceed 10% of all encounters on a year over year basis to keep a practice viable. Any percentage below that is too low and "patient churn" needs to be addressed for any hospital-physician alignment to be successful.

2. **Denial Management:** The most common way practices lose money is through inadequate or inaccurate ICD-9 and CPT coding. Just looking at the evaluation and management (E/M) coding for office visit codes, there are over 1,600 combinations of unique decision points for the physician to choose during a typical patient visit.[2] Leaving coding to a support staff is almost guaranteed to cause significant losses. Any denials over 2% of claims submitted needs to be investigated and identified as part of due diligence.

3. **Electronic Medical Records (EMR):** The pros of EMR outweigh the cons; however there is one financial aspect that needs to be addressed. If a physician practice is using an EMR system, there is a tendency for the physician to simply check a series of boxes, or "clicks," to complete a patient chart as a substitute to charting from "medically necessity" and building the chart documentation from the diagnostic codes. Before the implementation of an EMR system, it was more common for a physician to under code their documentation below the actual level of resources consumed. This is due to the overwhelming task of backtracking the decision sequence for all the patients seen at the end of the day by dictation or chart notes. If the practice is seeing a significant increase in the number of medical necessity denials, (post EMR implementation), a whole new category of compliance violations may need to be addressed as the chart documentation is not being supported by the diagnostic coding.

4. **Medicare Resource Based Relative Value Scale (RBRVS):** There is a wealth of research on the use of RBRVS as a means to both physician productivity and/or physician compensation. All physicians establish fee schedules based on the costs incurred by their practice and the value furnished in delivering quality medical care. Policy adopted by the American Medical Association (AMA) vigorously recommends the use of RBRVS as a basis for setting physician fee schedules. [3] The issue with using a RBRVS to set fees is that both age and sex have a great deal to do with utilization and the intensity of services provided to the practice's patients. The Medicare population is older than the general population and consists of a higher percent of females. Unless the practice is 100% Medicare, the value of RBRVS is diminished to the degree that the payor mix is other than Medicare. In order for financial managers to make sense of any practice specific RBRVS data and perform a physician productivity analysis, an acuity

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factor, (AF) or intensity of service factor, must be applied to the practice's data. This is the only way to generate meaningful results applicable to every physician, regardless of payer mix. A by-product of calculating an AF and applying it to the physician's RBRVS frequency distribution, is the elimination of the "my patients are sicker than others," defense as the physician's true level of service can be quantified either by provider to peer group or provider to national average.

5. **Point of Service Collections:** With the sharp spike in patient co-pays and deductibles, a shift to collecting as much of the guarantor balance at the time of service has become a necessity for physician practices. In order to make the transition to point of service collections (POS), many practices will offer discounts of up to 20% to patients, who pay their portion of the bill at the time of service. If the practice offers discounts to all patients, without categorizing them by work effort, loss of income will occur as a large group of patients, who previously paid 100% of their balance from their first statement mailed, will now be paying less than they would have. This can be significant. For example, a family practice with a typical 62-percent overhead and 38-percent profit margin that loses or wastes an extra 5 percent of collections actually loses approximately 13 percent of net income, since the losses come directly from the "last-dollar" profits that remain after overhead has been paid. That 13 percent represents approximately $20,000 for a practice with a profit of approximately $145,000, the median for a family practice without obstetrics. [4]

Summary: The above five physician practice performance areas highlight a few of the opportunities where financial managers can make a difference. Physician practice valuation is an increasingly critical component of the various transactions among health care entities and referring providers. Although not touched on here, regulatory considerations also require that any findings used to determine value are not based on "tainted" market data. The result of a bad valuation method can be a liability under Anti-Kickback Statues, False Claims Act, Stark, or Administrative Sanctions such as exclusion from the Medicare Program.

Whether one is doing a current physician portfolio review, a potential joint venture or a physician practice acquisition, and regardless of whether one is relying on internal data or an external consultancy's report, today's healthcare financial manger must take an integral role in the process to ensure that all findings are consistently applied and the appropriate documentation is created to support any hospital-physician alignment going forward.

Michael Ehlen resides with his family outside of Savannah. If you have any questions regarding this article or physician practice performance, he can be reached by phone at 843/815-5425 or at mehlen@healthcarefinancialadvisor.com

Footnotes:

[1] Restructuring Employment Relationships between Healthcare Organizations and Primary Care Physicians, Journal of Healthcare Management, July/August 2000

[2] Critical Condition: A Coding Analysis for a Physician Practice Valuation CPA Expert, Fall 2006

[3] www.ama.assn.org/go/pmc

[4] Joint Statistics: Medical and Dental Income and Expense Averages, 2009 Report Based on 2008 Data. National Association of Healthcare Consultants, September, 2009

Carl A. Ridley

-In Memoriam-

Carl was a member of the chapter back when it was called The American Association of Hospital Accountants (AAHA). On a national level he was actually the two thousandth member to join. With so much growth with hospitals in the health care industry he decided to join the Georgia Chapter of AAHA. He went on to serve in several key chapter roles.

He started his career as a public school teacher, but in 1928 decided that he needed more education and money so he went back to college. He landed a new job and ended up being a clerk in charge of the accounts receivable and payroll of a company. Then he served as an office manager, auditor and finally an accounting consultant. That organization was the Georgia Department of Public Health. He even distributed Hill Burton Funds. It was during this time that he became a member of AAHA.

Eventually he received an accounting degree from Georgia State University. Shortly after receiving his degree, he started work for University Hospital as a comptroller and stayed for 9 years. Then he worked for South Fulton Hospital for 4 years as an assistant administrator and controller. Then he became the administrator at Griffin Spalding Hospital a 150 bed facility. He retired after 11 years with a 225-bed hospital. While in Griffin, with the help of others, they organized the Griffin Chamber of Commerce. He was also a nursing home administrator along the way.

He also served in many other significant roles (i.e., civic organizations, church, city council, national office management association, American College of Hospital Administrators, etc.). He even got tired of retirement and organized with others, a new company called Health Consultants, Inc.

He was healthy and still active up to the age of 96. He passed away on May 30, 2009. We'll all miss having him around. Carl was our second chapter president (1956-57).