managing the margin

...strategies for generating new revenue and controlling costs

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FEATURED FOCUS

Cutting Losses in Noncore Businesses: Hospital-Owned Physician Practices and HMOs

By R. Brent Hardaway and Bryan Smith

Having spent the past four years reducing expenses and pushing back against managed care rates, hospitals are finally seeing improved financial performance. Attention is turning to growing market share and expanding services, and some hospitals are again thinking about entering into noncore businesses. Of course, a number of hospitals never eliminated some of their noncore businesses for fear of the impact on the inpatient business or loss of important strategic positioning.

For these hospitals, two noncore businesses that they may own, and continue to struggle with, are physician practices and managed care organizations. Although there continues to be numerous reasons why financially distressed hospitals should not own noncore businesses, the following will be helpful to those organizations that have decided to make a strategic investment in these programs.

Physician Practices

There are a number of reasons why hospitals believe they should own physician practices, including:

- There is an undersupply of key physician specialties;
- Competing hospitals are purchasing practices;
- The uninsured are not being adequately medically managed;

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Operating Margins Increase, Yet Spending on IT Remains Stable

With growing pressures to meet HIPAA deadlines, improve patient safety, and address consumer demands for on-line healthcare services, hospitals are placing increased emphasis on the value and return on investment of their IT decisions. In this type of environment,

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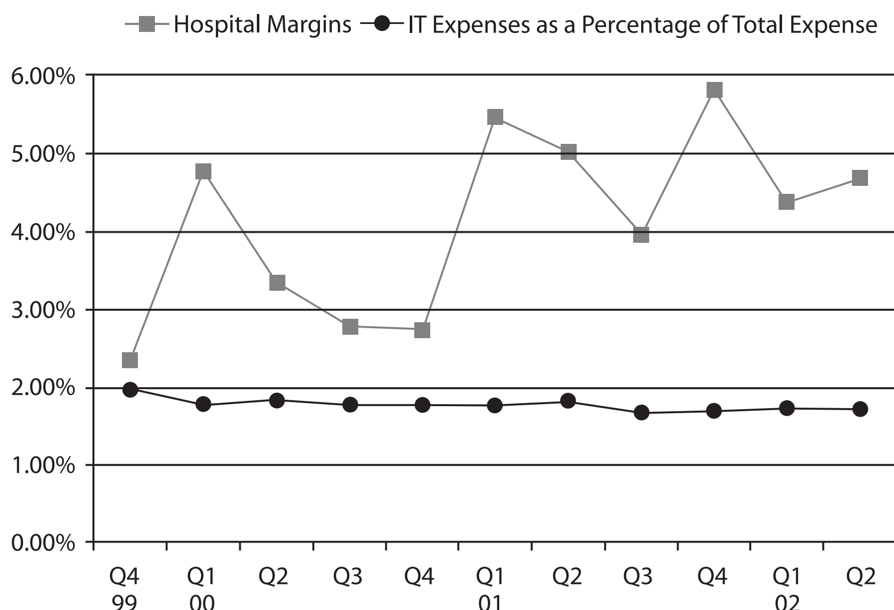
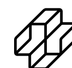
EXHIBIT 1: **IT EXPENDITURES, MARGIN GROWTH**





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- Private practice physicians will not provide call coverage for important service lines; and
- Ownership can provide leverage when negotiating with managed care companies.

The first step in minimizing your losses is to understand how much you are actually losing.

Evaluate the direct and indirect cost of ownership. There is no set methodology for evaluating the benefit of owning physician practices. The most important thing is setting up an objective methodology that everyone can agree to and that directly addresses the reasons for owning the physician practices.

For example, if the practices are owned for use as a leveraging point with managed care organizations, then compare your rates with the market rates. If you believe your inpatient rates for a specific payer are $200 per day higher because you own the physician practices, and you have 3,000 admissions per year from this payer, that is a benefit of $600,000. Then compare this figure with your operating losses for the practices. Which is greater? If you own more than seven practices, the odds are the loss associated with practice ownership is greater than the $600,000 in benefit.

If your goal is to reduce average length of stay (LOS) with a hospitalist program, then measure the change in average LOS directly. Calculate the hospital's average cost per day for an uninsured patient and compare the average LOS for the hospitalist's patients and the uninsured seen by other physicians. Is the reduced average LOS multiplied by the cost per day better or worse than the cost of the program? An adjustment also can be made for improving your medical staff satisfaction, since they do not need to handle these patients.

Minimize losses. The average owned practice loses $89,480 per physician before indirect benefits, yet practices not owned by a hospital have an average net income of $1,202.[a] Why such a difference?

In nonowned practices, the physicians are at risk for the profits and tend to act in their own best interest. Therefore, the first step toward minimizing losses is to make the physician responsible for the financial performance of the practice. Physician practices that are not owned by hospitals made 39 percent more medical revenue, $156,754, than owned practices, according to a 2001 Medical Group Management Association survey. Simply tying physician productivity or profitability of the clinic directly to physician compensation can have a huge impact on performance.

One compensation model that has proven successful is the "net income" model, in which physicians are paid 100 percent of earnings after direct practice costs, direct professional costs, and allocated billing costs. Implementing this model can significantly improve the bottom line. Many providers discover a portion of the savings results from particularly low-producing physicians who realize that their income will soon decrease and decide to work elsewhere.

> ***Provider-owned HMOs can easily lose $5 million annually.***

Hospitals also can minimize expenses by:

- Moving the scheduling center away from the physicians' offices to minimize their attempts at "blocking" time slots or complaining about the workload;
- Outsourcing billing and collections to agencies that have a core competency in it;
- Working with the human resources department to make sure the compensation offered is in line with the market (physicians traditionally pay nurses less and offer few, if any, benefits compared with hospitals); and
- Trying to keep offices of owned physicians that aren't hospital-based away from the hospital's campus to leave room for other non-owned physicians.

Hospital-Owned HMOs

Today, few hospitals show any interest in starting an HMO. However, a number of hospitals insist on maintaining those already opened. In fact, by 2001 there were still over 700 hospital-owned HMOs.[b] The most common reasons hospitals have retained ownership of HMOs are primarily defensive in nature. Providers tend to argue that ownership is necessary because:

- It prevents another payer from gaining too much control in the marketplace;
- A local competitor has an HMO that appears to be gaining volume;
- It helps organize and manage the Medicaid population; and
- The city, state, or other large employer would likely be upset if its insurance program were eliminated.

Although there may be tangible reasons for maintaining an HMO, providers must always bear in mind the large risk associated with ownership. Based on experience, provider-owned HMOs can easily lose $5 million annually and as much as $50 million with an average loss of $155 per member per year. Experience shows that in well over 50 percent of operational reviews of HMOs, the hospital would be

a. www.mgma.com/press/idssurvey.cfm.

b. "Hospital Statistics 2003" Health Forum, LLC (affiliate of the AHA).

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well-served to shut them down or sell off a large portion of the company to a partner who has more experience in the business.

Still, for those hospitals that wish to maintain their HMO, a few actions can help increase return and minimize risk.

Maximize revenues whenever possible. If your premiums are lower than the market, you are putting the HMO at risk and defeating a strategic purpose for having the HMO. If your HMO cannot pay the hospital rates that are equal to or higher than the rates of the largest HMO in the area, you are actually harming yourself. Also, make sure the coordination of benefits subrogation is at least 1.5 percent of premiums.

Minimize risk, even if it means losing business. A health plan can act as a steerage tool while limiting the downside of exposure. Unless you are committed to growing your business to the point that it can truly manage risk and take all of the losses associated with the learning curve, it's best to play it safe:

- Increase premiums significantly on high-risk groups and consider dropping them entirely. Slight deviations from the actuarial projections can quickly make these groups large money losers;
- Shift from high-risk products to those with lower risk, such as minimum premium plans and defined contribution models;
- To whatever extent possible, share costs with enrollees. Increased deductibles and copayments give members incentive to reduce utilization on their own.

Focus on expeditiously managing expenses, not just cutting them. Your largest expense—medical loss—deserves your greatest attention. Closely monitor your utilization rates and make sure they are in line with the market as a whole.

Some ways to reduce utilization include:

- Enforcing prior authorization rules on elective procedures;
- Profiling and working with physicians with high admitting rates;
- Establishing physician committees to monitor average LOS and utilization.

Unfortunately, these tactics may anger your physicians, who also happen to be your hospital's most important customers.

Make sure that communication with physicians is as clear and open as possible. And, when possible, resist the temptation to cut costs by lowering payment rates to physicians below market rates.

Although doing so can have a positive impact on the HMO, the long-term impact of retribution on the hospital could be disastrous.

Consider outsourcing as much of the operations as possible. The best HMO executives and resources are not going to be within your organization, so seek them out and contract with them. The most common exception to this premise is the sales staff and some underwriting/pricing capabilities.

Conclusion

Owning and operating noncore businesses can be risky. However, many hospitals see potential for strategic advantage in doing so. If your hospital decides to acquire or develop a noncore business, make sure that you provide regular evaluation of the benefits being received from the program and work to minimize the operating losses. ■

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Learn more!

To request a copy of Phase 2 Consulting's white paper, *The Ten Components of a Successful Hospital/Health Care Delivery System*, contact R. Brent Hardaway at rbhardaway@phase2consulting.com.

REVENUE TRENDS

Use Care When Weighing a Bariatric Service Line

The use of gastric surgery to control morbid obesity is growing. And as procedures become less invasive, demand among patients is increasingly high. Accordingly, many hospital administrators are—or soon will be—receiving pressure from surgical staff members and questions from board members to expand these services and provide necessary support.

Although profitability can be excellent when bariatric services are managed effectively, it's important to proceed carefully before committing your organization to any type of program—supplementary and hidden costs can run high. A top-quality bariatric program requires extensive and complex services beyond the surgery itself. These services include counseling before and after the surgery, nutritional education, and follow-up services for the patient and his or her family. Also, the bariatric patient population frequently has other health and psycho-social issues that require difficult and costly treatment. If you're considering investing in a bariatric program, be sure to account for the costs and payment associated with all the services involved, or you could end up with a "lighter" bottom line!

Source: ECG Management Consultants, Inc., Seattle, Wash. and Wakefield, Mass., www.ecgmc.com