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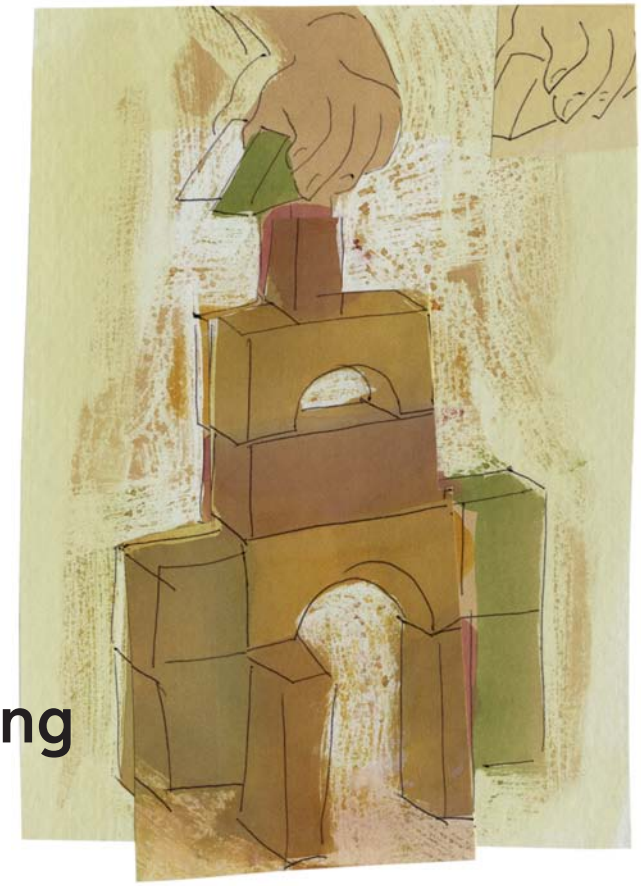

Craig D. Pederson

cost-based pricing and the underperforming physician group

Perhaps healthcare organizations should spend as much time and effort improving the revenue performance of their employed physician groups as they do on operational and overhead improvements.

During the 1990s, many hospitals and healthcare systems built primary care physician groups of significant size. Unfortunately, a large percentage of these same organizations have driven headfirst into the economic reality of owning medical groups that are viewed as underperforming and in need of significant performance improvement. Although overhead and operating factors can contribute to an employed physician group's poor performance, low payment is almost always a primary culprit; key payers often pay the groups at rates below what is needed to sustain a robust primary care base. From a revenue perspective, hospitals and healthcare systems should consider pursuing pricing strategies that take into account the true costs of operating a primary care-based physician group. Over time, cost-based pricing strategies will allow organizations with underperforming physician groups to reach breakeven positions on their group practice investments.

Undercompensation and Its Possible Causes

The following factors have contributed to undercompensation of many employed medical groups.

Unanticipated dependence on fee-for-service reimbursement. A significant number of today's hospital-employed groups were developed in anticipation of a heavily capitated environment. In fact, many hospitals and healthcare systems viewed employed physicians as a strategy for "locking into" a dedicated population of patients and the premium revenue associated with hospitalizations, primary care, and specialty care services.

However, instead of capitation and a dedicated stream of revenue, employed physician groups remain dependent on patients in fee-for-service products with a considerable choice of providers. Unfortunately, the group practice infrastructures developed by many organizations entering the physician-employment business were constructed toward a goal of securing and managing capitated contracts rather than negotiating and managing fee-for-service arrangements.

Lack of attention/focus/expertise. A healthcare organization's contracting focus can be demonstrated by what is known about its contracts. Are contracts on file? Can hospital and medical group contracts be quickly accessed? On a per total relative value unit basis, what is the group currently being paid by its top commercial or managed care payers? For contracts that include annual inflation adjustments, have the group's charges kept pace?

Many hospitals and healthcare systems have a poor understanding of the actual payment levels of their physician groups, suggesting lack of focus on this area. This situation was tolerated when hospital bottom lines were robust enough to support their owned physician groups. However, that isn't the case today.

Revenue-budget disparity. Within a hospital or healthcare system, the professional revenues associated with the physician group are typically dwarfed by hospital and/or health plan revenue. This disparity can be even more apparent when a physician group is not credited with ancillary or technical component revenue that would typically be developed in a larger independent group practice.

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As a result of this revenue-budget disparity, it is not surprising that some healthcare organizations are less willing to aggressively negotiate physician group demands with payers for fear of affecting negotiations at the system level.

Walls without a group. Many employed medical groups were built by gradually adding small primary care practices that were already established in the community. In addition to its base of "purchased" practices, the healthcare organization would recruit new physicians straight out of residency. This practice-building process resulted in groups with a significant number of providers. Unfortunately, what was lost amid the race to build critical mass was the importance of developing a group practice culture of interdependence and accountability for meeting goals. As a result, many hospital-employed groups are nothing more than a collection of individual physician practices with minimal cohesion and no incentive to improve overall performance.

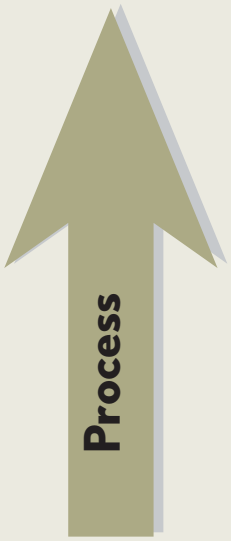
The enemy within. In the case of physician groups employed by a healthcare organization that includes an owned managed care plan, the healthy tension that typically exists between an independent physician group and a payer is lost. Instead, that tension is replaced with health plan and/or healthcare system strategies that can vary significantly among organizations. In many cases, it may be appropriate for the owned plan to receive a discount from the "in-family" physician

AT A GLANCE

Cost-based pricing may help healthcare organizations improve the revenue performance of their employed physician groups. Organizations considering a change to cost-based pricing strategies should be prepared to supply their major payers with the following supporting information:

- **Physician compensation rates**
- **Compensation methodology**
- **New practice development**
- **Operating benchmarks**
- **Overhead benchmarks**

CALCULATION OF BREAKEVEN COMMERCIAL REIMBURSEMENT



Payer Source	Payer Mix	Annual Total RVUs	Payment per Total RVU	Annual Professional Revenue
Commercial	52%	4,150	$56.52	$234,550 (calculation)
Medicare	31%	2,500	$37.00	$92,500 (given)
Medicaid	6%	450	$25.00	$11,250 (given)
Self-pay/other	11%	900	$33.00	$29,700 (given)
Totals	**100%**	**8,000**	**$46.00**	**$368,000**

Practice Profit and Loss Statement

Revenues	
Professional fees	$368,000 (calculation)
Ancillary revenues	$85,000 (given)
Drugs/injections/immunizations	$35,000 (given)
Other revenue	$12,000 (given)
Total revenues	**$500,000 (given)**
Total overhead	**$500,000 (given)**
Net income/loss	**$0 (given)**

group in exchange for a certain volume of patients. However, employed medical groups can run into long-term problems if primary care payment rates are held artificially low across a market, allowing competitive health plans to shadow price. In these cases, primary care providers can essentially end up subsidizing the fees of other providers, such as independent specialists, or paying for the health plan to build market share.

Cost-Based Pricing: An Example

Diagnosing the payment problem within an employed medical group is not overly complex. Poor economic performance combined with commercial managed care contracts that are below what is needed to support primary care in the marketplace can support an argument for a significant change to the group's contracting approach. The exhibit demonstrates (for a single physician FTE) how a "bottom to top" cost-based pricing methodology can be used to calculate a group's targeted reimbursement rate. It outlines how a typical primary care physician's production might break out by payer and payment rate within his or her particular market. The factors the group cannot change are the following.

Medicare/Medicaid/self-pay reimbursement rates. For the most part, reimbursement rates from government payers (Medicare and Medicaid) cannot be influenced by the group. In addition, although self-pay patients who pay full charges may be some of the group's most profitable patients, they are offset by those who do not or cannot pay their bills, resulting in a relatively low net reimbursement rate.

Payer mix. Unless the overall volume of commercial patients can be increased, an employed physician group's mix of self-pay and government-pay patients is fixed. If the group stays consistent with its mission and does not limit access to specific patient populations, its payer mix will not change.

Additional modeling factors included in the example include the following.

Target performance. If the employed physician group is credited with the ancillary revenues and overhead generated from lab and X-ray testing that would typically be performed in an independent group practice setting, the group performance target should be to reach a breakeven level (at a minimum) at year-end.

MORE ABOUT PRICING

Learn more about setting prices from the HFMA educational supplement "Strategic Price Setting: Ensuring Your Financial Viability Through Price Modeling." For links to that and other HFMA resources on pricing, go to www.hfma.org/resource.

Non-RVU revenue. Revenue associated with non-RVU production (for example, vaccines and injections) is assumed to be $35,000 annually in this example.

In the exhibit, a busy primary care physician produces 8,000 total RVUs (about 4,160 work relative value units) annually. If practice overhead is $500,000 (including physician compensation and benefits) and the group targets breakeven performance, then it would need to collect approximately $368,000 in professional fees (on a per-FTE physician basis) for the 8,000 total RVUs generated by the physician. Given the group's costs, payer mix, and reimbursement rates that cannot be negotiated, the sample group will need to realize at least $56.52 per total RVU from its commercial payers to reach its annual performance target. Practices with a lower percentage of Medicare/Medicaid patients would have a lower commercial target and vice versa.

Making the Case for Cost-Based Pricing

As the example demonstrates, providers adopting this methodology will most likely be looking for significant payment increases over time from their top payers (unless the providers believe their reimbursement rates are already more than adequate). In addition, it potentially suggests the need to set minimum contract levels (for lower-volume payers) at rates above current levels.

Although negotiating strategies will differ based on an organization's internal characteristics as well as unique market factors, the cost-based pricing approach is most effective if used as the first step—preparation—in the contract negotiation process. In the second step—education—the approach is one of leveraging the information learned and educating payers regarding the true cost of providing high-quality physician services to a payer's patient population. If the provider can successfully complete the first two steps, then the final step—negotiation—can be much more productive. This differs significantly from a "take it or leave it" approach in which both sides in the contract negotiation focus only on minimizing the cost or maximizing the revenue to their respective organizations.

Even with the benefit of a productive dialogue based on solid information and analysis, payers may continue to resist efforts to bring reimbursement rates up to breakeven levels. At that point, providers may need to decide between multiple directions:

- *Status quo.* The provider can continue to subsidize the physician group as it has in the past. However, as a result of working through the bottom-to-top methodology, the provider now understands the portion of the physician group's underperformance that is market-driven and probably not correctable.
- *Departicipation.* If departicipation is pursued, the work related to preparing for contract negotiations will be helpful in implementing the strategy—that is, developing patient communication material related to the decision.
- *Strategy adjustment.* In an environment in which providers are continually asked to subsidize the true costs of providing high-quality physician services, the hospital needs to ask whether it should be providing physician services in the future. Would independent physician groups or payers fill the void and fund the costs of specialization if the hospital or healthcare system focused on other areas?

Although providers will differ in their ultimate negotiation and decision-making approach, the move to a bottom-to-top methodology requires providers to anticipate in advance the kinds of supporting information and minimum performance standards that their largest payers will request.

At a minimum, providers should be prepared to demonstrate the following before embarking on a significant change to their contracting approach:

- *Physician compensation rates.* Compensation rates for established physicians (at least two-plus years of practice) should be reasonable on a per-FTE basis or on a per work RVU basis—for example, a group's highest-paid physician (based on total dollars) may also be its most effective if he or she is also a high producer.
- *Compensation methodology.* A compensation methodology provides physicians with

incentives to work full time and incrementally rewards physicians for work produced over and above target levels or thresholds. This methodology recognizes that practices are more profitable after the fixed costs of the practice have been covered.

- *New practice development.* Providers also need to be able to support new physicians and/or practices and meet minimum production expectations within a targeted amount of time—for example, 4,000 work RVUs per physician FTE after two years. An inability to do so may reflect a group that does not adequately support new physicians or that has overrecruited primary care providers in an effort to capture market share from a local competitor.
- *Operating benchmarks.* The group should meet or exceed key operating benchmarks—for example, operating staff or square feet per provider FTE.
- *Overhead benchmarks.* The group should meet or exceed key overhead benchmarks, such as operating overhead per FTE provider. Payers will want to confirm that costs allocated to the group are appropriate and that they reflect the costs typically found in an independent physician group setting. Conversely, employed groups will want to ensure that costs are not underallocated as a result of the methodology used by the hospital or healthcare system. Therefore, it may be necessary to "restate" an organization's physician group profit and loss statement to more accurately reflect the expenses that would be incurred by the group in an independent setting.

Education and Understanding—and, Hopefully, Cash

Payers most likely will initially resist a move toward cost-based pricing. However, an employed physician group that has prepared the necessary documentation and information should be able to support its case that it has efficient operations and appropriate overhead levels. This will potentially result in fees (over time) that more accurately reflect the true costs of providing high-quality primary care services. In return, payers receive a strong-performing, high-quality primary care base for their patients and customers.

Even if a group is unsuccessful in attaining targeted payment levels with payers, the bottom-to-top cost-based pricing methodology forces a level of intra-organizational education and understanding that, too frequently, does not occur within larger organizations. If, for strategic reasons, it does not make sense for the organization to pursue a cost-based pricing strategy with payers, the bottom-to-top methodology nevertheless allows the healthcare organization to quantify and attach a "cost" to the decision—for example, the gap between actual and targeted commercial revenue. Quantifying the cost of pricing decisions then allows these decisions to be put in context relative to broader organizational strategies and can assist in setting realistic performance expectations for groups in the future. ●

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