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How to Break Even on an Acquired Primary Care Network

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Challenged by declining revenues, hospitals are taking steps to improve the financial performance of hospital-owned primary care group practices. Although some hospitals are divesting themselves of their group practices, others are attempting turnaround strategies to help them break even on their investment. Ensuring that expenses do not exceed revenues in a primary care network can be achieved by implementing initiatives on networkwide and practice site levels and may require draconian measures. By setting a financial target of break-even, primary care practices can experience dramatic improvements.

Many hospitals and the primary care physicians they employ are challenged by the financial losses being incurred in hospital-owned medical practices. Several factors, including the effects of the Balanced Budget Act of 1997, have reduced the ability of hospitals to sustain such losses.

Although some hospitals may find ways to exit the primary care business, for others, the costs of and financial, political, and legal barriers to exiting are too high. Still others fear losing market share and competitive advantage. For many, the only viable solution is to make the primary care network strategy work. Senior hospital administration and physician leaders need to develop and implement a turnaround strategy that will result in break-even operations.

Break-even operations can be achieved by the successful implementation of initiatives on two levels—networkwide and practice site. When necessary, an organization should implement draconian measures to meet the network's immediate financial needs and mandates.

Networkwide initiatives. Networkwide initiatives are conceived and implemented in a participative manner. The networkwide approach requires primary care network physician leaders and senior management to address challenges faced by the network and develop networkwide initiatives, whose implementation they jointly support.

Practice-site initiatives. Because each primary care practice must achieve break-even status in its own time, every group practice and physician also needs to engage in financial performance improvement at the practice-site level. These initiatives involve the use of a break-even action plan to set performance targets at the practice site.[a]

Draconian measures. Draconian measures are implemented rapidly, in a top-down manner. They typically include reducing the number of provider and nonprovider staff, closing practice sites, consolidating resources into fewer physical locations, and revising compensation and benefit plans. Such steps achieve the greatest financial improvement in the shortest time. Draconian measures are summarized in a rapid-improvement plan.

Networkwide Initiatives

Although networkwide initiatives include expense reduction and control, they focus more on optimizing revenues. The primary care business is labor-intensive as opposed to capital-intensive. Labor is a fixed cost over the short term, representing up to 75

a. The authors' definition of break-even is based upon revenues and expenses included at the net one level. Net one is defined as the revenues and expenses normally found in a private practice setting and excludes corporate allocations, goodwill amortization, and other expenses attributable to the network's association with a hospital or hospital system. See Marc D. Halley, MBA, and Anthony W. Little, MBA, CPA, "Net One, Net Two: The Primary Care Network Income Statement," Healthcare Financial Management, October 1999.

percent of total costs.[b] Because high-fixed-cost, low-profit-margin businesses such as primary care practices succeed on the revenue side of the income statement, there is a special focus on revenue at the network level.

Net patient revenue in primary care practices and networks is affected by eight critical factors: volume-capacity mix, payer mix management, fees for services, provider productivity, relationship management, coding and documentation, receivables management, and service mix.

Having a common fee structure and reviewing that fee structure frequently is essential.

Volume-capacity mix. Volume-capacity mix involves matching the primary care network capacity with the hospital's ability to attract patients to its primary care practices. Excess capacity needs to be filled within an acceptable timeframe or removed. In mature markets where the supply of primary care providers meets or exceeds the demand for services, the volume-capacity question becomes especially critical. Obviously, this revenue factor is heavily influenced by the effectiveness of the organization's payer-contracting leverage and capabilities. Many PHOs have fallen far short of their initial projections for capturing patients and directing them toward the hospital-owned primary care practices.

Payer mix. Managing a primary care network's payer mix has many financial, ethical, mission, and even legal facets. Patients/customers want to build a long-term relationship with their preferred provider. Because attrition rates of patients are relatively low, changing a poor payer mix in a primary care practice is a slow process. It is far better to manage the payer mix up front and insist on filling practice capacity with patients who participate in higher-margin health plans.

Fees for services. Having a common fee structure throughout the primary care network and reviewing that fee structure frequently to optimize payment is essential.

Provider productivity. The key to the success of any primary care network is the productivity of its providers. Productivity is largely a function of a compensation model that promotes high productivity and a culture among physician peers that requires it. Providers operating at median levels of benchmark productivity or below will have difficulty creating viable practices.

Relationship management. As markets mature and the supply of primary care providers exceeds demand, it becomes more difficult to maintain established practices, which naturally lose patients through attrition. It is even more difficult to build new practices, or strengthen those that are marginal performers. Primary care practices depend upon referrals from established patients as their primary source of new patient volume. Developing a culture of excellent customer service that attracts and retains a group of loyal patients who refer their friends is critical. Monitoring patient satisfaction through surveys and the new-patient ratio (new-patient visits as a percentage of total patient visits) and setting demanding customer-service targets is essential.

Coding and documentation. Primary care providers are trained to document for clinical purposes, not billing and compliance purposes. The Federal government's fraud-and-abuse investigations in recent years underscore the importance of accurate coding for billing by physicians. Providing ongoing education about how to code accurately and reviewing physicians' coding and documentation have a positive impact on revenues for many practices and networks.

Receivables management. Hospitals that own group practices tend to centralize the billing process and often mix practice and hospital billing. However, there are significant differences between hospital billing practices and the needs of the primary care business. For example, many of the steps in an effective practice billing process occur at the group practice site. A totally centralized process disengages the practice site from accountability for those steps and leads to higher days in accounts receivable, a lower collections percentage, and frustrated patients/customers and staff.

A central processing approach shares responsibility for receivables management. The practice sites focus on data verification, point-of-service collections, proper credit extension, and private-pay follow-up. The central processing office supports the practice sites by processing primary and secondary insurance claims, conducting insurance research, producing monthly patients' billing statements, and supporting the precollections process for private-pay patients. Site managers have accountability for receivables performance and become internal customers of the central processing office.

Service mix. The hours a practice site is open and the services it provides significantly affect the practice's bottom line and competitive position. In many hospital-owned networks, laboratory and radiology services are provided in the hospital, which enhances hospitals' bottom line but penalizes the high-fixed-cost, low-profit-margin primary care business. Enhancing the services provided by hospital-owned primary care practices is a very effective way for a hospital or health system to increase its patient volume. Forcing patients to travel to the hospital for services normally found in a primary care office has the opposite effect.

Effectively addressing each of these net-revenue issues and implementing networkwide expense controls begins with joint physician-hospital policy making across all sites. Improving payer contracting, changing the provider compensation model, reducing employee benefits, enhancing practice laboratory revenues, improving receivables management, and many other initiatives are best dealt with as networkwide initiatives.

b. Medical Group Management Association, *Cost Survey: 1999 Report Based on 1998 Data*, Englewood Colorado: MGMA, 1999, pp. 134-135.

EXHIBIT 1: EXAMPLE OF PERFORMANCE TRACKING FOR A GROUP PRACTICE

Deer Valley Family Practice

Revenue-Enhancement Strategies (actions from work plan)

Net Patient Revenue per Encounter	Jan.	Feb.	Mar.	Nov.	Dec.	Total
Base NPR/Encounter	$69.00	$69.00	$69.00	$69.00	$69.00	$69.00
Reduce bad debt via better collections	0.20	0.20	0.20	0.40	0.40	0.32
Review coding to improve accuracy		1.00	1.00	1.25	1.25	1.18
Fee increase–net				2.00	2.00	2.00
Total Net Patient Revenue/Encounter—Break-Even Action Plan	$69.20	$70.20	$70.20	$72.65	$72.65	$72.50

Encounter Projections

Provider Name	Jan.	Feb.	Mar.	Nov.	Dec.	Total
Physician baseline encounters	390	390	375	380	390	4,415
Open-access scheduling implementation				75	80	485
Extend hours		45	60	70	70	654
Reduce no-shows via reminder calls	17	17	17	17	17	177
Total Encounter—Break-Even Action Plan	407	452	452	542	557	5,731
Total PIP Projected Revenue	$28,164	$31,730	$31,730	$39,376	$40,466	$415,497

Expense Reduction Strategies

Description of Actions	Jan.	Feb.	Mar.	Nov.	Dec.	Total
Physician compensation and benefits changes						
Incentive pay for additional volume		$1,863	$2,484	$5,995	$6,202	$47,163
Staff compensation and benefits changes						
Additional staffing for extended hours		950	950	950	950	10,454
Building and occupancy changes						
Increased utilities for extended hours		80	80	80	80	880
Other expense changes						
Drop maintenance agreement on dictaphones		(58)	(58)	(58)	(58)	(638)
Eliminate Yellow Pages advertising				(75)	(75)	(675)
Subtotal of Fixed Expense Change	0	2,835	3,456	6,892	7,099	57,184
Supply expense changes						
Group purchasing discount negotiations		(95)	(95)	(118)	(121)	(1,147)
Purchased services—laboratory and radiology						
Group purchasing discount for X-ray supplies			(276)	(276)	(276)	(2,764)
Variable expense for visits changes above			811	1,763	1,818	13,378
Subtotal of Variable Expense Change	0	(95)	440	1,369	1,420	9,467
Total Expense Changes	0	2,740	3,896	8,261	8,519	66,651
Current Total Expense Level	31,808	31,808	31,808	31,808	31,808	388,696
Achievable Total Expense	31,808	34,548	35,704	40,069	40,327	455,347
Achievable Net Income (Loss)	$(3,644)	$(2,817)	$(3,973)	$(693)	$139	$(39,850)

Break-Even Action Planning

The break-even action-planning process is driven by a comparison of actual financial data with benchmark data, focusing on individual practice sites. Developing a break-even action plan begins with a clear understanding of any significant shortfalls against benchmark, with a special focus on provider productivity in terms of visits, relative value units (RVUs), and net patient revenue. Ideally, office or site managers can assist in the development of a break-even action plan using the following process:

- Identify the shortfalls, or gaps, in key revenue and expense areas that are barriers to achieving break-even financial operation, or a lesser target if needed initially;
- Engage physicians and practice staff in brainstorming ideas to achieve break-even, focusing on both revenue enhancement and cost control;
- Estimate the financial impact of each viable idea in terms of dollars per patient visit or a comparable measure;
- Commit to implementing enough ideas, each with an implementation deadline, to achieve the established financial-performance target within the specified timeframe;
- Ensure that every physician and nonphysician caregiver has a productivity target in terms of visits and work RVUs;
- Document the baseline revenue and expense ideas for performance tracking (see Exhibit 1, above);

EXHIBIT 2: OPERATIONS-IMPROVEMENT OPPORTUNITIES THROUGH BREAK-EVEN ACTION PLANNING

Improvement of Net Patient Revenue per Visit

Review coding practices to improve accuracy.

Review practice's lost charges and revenue capture process.

Manage the payer mix by not contracting with, or setting new patient limits on, low-paying plans.

Reduce bad debt by improving point-of-service collections and taking greater care when extending credit.

Increase the number and types of intensive procedures provided.

Ensure that fee schedule changes are realized in actual collections.

Improvement of Variable Expenses

Participate in group purchasing for office and clinical supplies.

Standardize frequently used clinical supplies and negotiate quantity discounts.

Establish minimum and maximum inventory levels for key supplies and have vendors monitor and restock shelves weekly or biweekly.

Keep supply inventories at reasonable minimums (avoiding out-of-stock situations) to increase inventory turnover and reduce storage costs.

Reduction of Fixed Expenses

Staffing Cost Reduction

Examine each vacated position to determine ways to streamline or eliminate activities.

Implement process-improvement techniques to improve work methods on a proactive basis.

Coordinate staffing with physician scheduled time.

Develop wage ranges to set maximums.

Eliminate overtime.

Building Occupancy

Stay within acceptable benchmarks when building or leasing space.

Lengthen the lease term to reduce the costs of amortizing tenant improvements.

Explore adding after-hours services to increase productive use of space.

Group purchase janitorial, maintenance, and snow-removal services to obtain discounts.

Obtain another tenant for unused space.

Plan new office suites to optimize utilization of space and reduce excess square footage.

Share physician offices and examination rooms by scheduling split shifts for physicians (eg, 8:00 AM to 2:00 PM and 2:30 PM to 8:30 PM).

Keep long-term storage offsite in less expensive storage space to increase the productivity of more expensive office space.

Increasing Volume and Productivity

Increasing Volume via Provider Productivity

Schedule visits effectively (eg, wave scheduling, open access).

Keep examination rooms occupied at all times so the physician is never waiting.

Focus the clinical assistant working with the physician to improve productivity.

Reduce nonessential telephone time of the clinical assistant (eg, move most telephone calls to the front desk).

Encourage new or less productive providers to shadow more productive physicians.

Use process-improvement techniques to improve the flow of patients through the office.

Increase the number of hours worked by the physician.

Improve patient on-time arrival.

Improve physician on-time arrival.

Track patient time in and time out of the office.

Set performance targets for physicians and clinical assistants and recognize target achievement.

Simplify and/or automate charting where possible.

Schedule physician and staff meetings to discuss barriers to productivity.

Increasing Volume via Office Efficiencies

Eliminate no-shows.

Schedule similar ancillary procedures, such as flexible sigmoidoscopy, on the same morning for several patients.

Move referral calls and preauthorizations out of the back office.

Train staff in telephone message management.

- Measure actual performance against the break-even action plan and report discrepancies monthly, adding new ideas to the action plan if some ideas are not meeting their financial target (see Exhibit 2, above); and
- Continue to implement break-even actions in the practice until the break-even target is achieved.

Rapid-Improvement Plan

The need for a rapid-improvement plan depends upon the time available for financial performance improvement and the level of tolerance for continued financial losses. If the hospital has adequate cash flow and supportive stakeholders, the networkwide initiatives and break-even action plan for practice sites will achieve adequate performance improvement over time, when effectively implemented. However, only the draconian measures that characterize a rapid-improvement plan will achieve the significant short-term results required by many boards or necessitated by the hospital's balance sheet.

The process for developing a rapid-improvement plan is relatively simple, but certain steps must be followed to ensure success (see Exhibit 3, next page). First, a financial target and timetable must be identified for the network as a whole. Identifying a target for the first 12 months is particularly critical. Obtaining hospital CEO support for this performance target is *the* essential component in the success of the planning process. The CEO becomes what Daryl R. Conner, author of *Managing at the Speed of Change*, calls the initiating sponsor of these critical change initiatives.[c]

Next, the planning process for the rapid-improvement plan requires accurate financial statements, by practice site, which can be compared with benchmarks for financially viable primary care practices. A review of net revenues, provider costs, nonprovider labor costs, building occupancy expense, and supply costs serves as the basis for comparison. Practices and providers with the largest negative gap from the benchmark are the initial

c. Conner, Daryl R., *Managing at the Speed of Change*, New York, New York: Villard Books, 1992, p. 116.

EXHIBIT 3: EXAMPLE OF A TIME LINE FOR IMPLEMENTING A RAPID-IMPROVEMENT PLAN FOR A PHYSICIAN NETWORK

Action	Due Date
1. Develop opportunities for improvement at each practice site.	August 30
2. Quantify annual savings for each opportunity.	September 3
3. Obtain "sponsorship" support for proposed actions and the implementation schedule.	September 7
4. Present the rapid-improvement plan to the physician leadership committee.	September 13
5. Work with sponsors to communicate the need for improvement and the potential opportunities to all physicians in a group meeting.	September 24
6. Implementation:	
• Present approved opportunities to each practice	October 15
• Develop implementation schedule	October 22
• Notify affected parties/individuals	October 29
• Begin implementation of actions	November 1
7. Evaluate and quantify actual financial impact against target.	Monthly
8. Report outcome of plan implementation to hospital and physician sponsors.	Monthly
10. Revise and update plan, as needed, to achieve financial target.	

targets for rapid improvement.

Once opportunities for improvement are identified, a cost-savings estimate is attached to each. These cost estimates help the hospital determine the number of rapid-improvement actions required to achieve the financial performance-improvement target. Then the opportunities are reviewed by senior management and physician leadership to determine which measures, if any, to implement for each site. If an initiative is rejected for strategic or mission purposes, another has to be substituted to achieve the overall financial target. The CEO attempts to obtain what Conner calls sustaining sponsorship from the senior physician and executive leaders involved in the process.[4]

Once rapid-improvement initiatives have been approved and implemented, significant change occurs in weeks or even days. The management team assigned to the task is accountable to the initiating and sustaining sponsors for effective implementation. If it appears that the initiatives are not achieving the financial target, additional measures have to be implemented to ensure target attainment.

4. Conner ...

A rapid-improvement plan needs to be considered carefully and implemented properly. The process requires considerable effective communication. Undertaking such a plan has significant strategic, mission, ethical, and behavioral implications and potential negative consequences, including damaged relationships with the medical staff and community.

Conclusion

Primary care network financial performance can be improved dramatically with the right tools. Hospital-owned practices can operate at break-even. Primary care physicians can be well compensated for the work they do. Staff can be fairly compensated and receive reasonable benefits. Most importantly, the integration envisioned by hospital and physician leaders can be attained. Most efforts to achieve improved financial performance require a combination of draconian measures, networkwide initiatives, and an action plan for every practice site. Organizations that commit to their turnaround efforts will have a sustainable competitive advantage over those that fail to achieve break-even. ■

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