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THE RFP PROCESS:
STEPS FOR GETTING THE MOST ACCURATE BIDS

Hospital based physician (HBP) services including Anesthesia, Emergency Department, Hospitalists, Pediatric Services and Radiology, are vitally important to the quality of patient care, efficiency and profitability of hospitals. Distributing a request for proposal (RFP) for a HBP service line can often be a painful process and one which should not be taken lightly.

Nonetheless, with the reality of shrinking margins, hospitals find themselves in a place where they must evaluate all major expenditures. In addition, requirements for provable quality of service supported by trackable metrics now frequently necessitates the search for better options available in the marketplace. Since hospital based provider subsidies are often a major expense item and since there are often perceived opportunities for quality improvement, it is a reasonable practice for hospital leadership to carefully evaluate all of their current hospital based services and associated financial support before each contract renegotiation. If warranted, issuance of an RFP is a useful tool to consider.

In the past, hospitals generally viewed RFPs as a way to reduce expenditure and increase service from their current vendor – they would rarely switch groups. Times have changed. The proliferation of large regional and national providers, with their ability to derive benefits from economies of scale, have made RFPs much more of a competitive processes. No longer does the incumbent group have a clear path to a new contract.

However, transitioning to a new hospital based group has the potential to be a costly and disruptive endeavor. It is certainly untenable when a hospital completes a service line transition and finds that its expenditure with the new group is higher than anticipated. A common cause of this situation is inaccurate hospital data contained in the RFP. The intent of an RFP is to communicate the exact needs of the hospital in order to generate accurate bids from groups who have the capability to deliver the required service.

THE INTENT OF AN RFP is to communicate the exact needs of the hospital and to receive bids from groups that are true representations of the service they will deliver as well as the compensation required to meet those needs.

Unfortunately, many hospitals distribute RFPs that do not paint an accurate picture of their needs. Many administrators will find an RFP put out by a similarly-sized hospital, often in another service line, and "plug and play," removing the other facility's numbers and inserting an incorrect estimate of their own data. Inaccurate or misleading information in RFPs often results in bids that are interpreted differently by vendors. This variation produces bids which are substantively different and challenging to compare.

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In addition, a poorly produced RFP can ultimately lead to dissatisfaction for one or both parties after the contract is signed.

To prepare an effective RFP and avoid the need for additional time and expense, the following are key items hospital administrators must accurately present in the document.

1. ACCURATE PATIENT ENCOUNTER FIGURES

Hospital administrators often rely on poor or conflicting data relating to how many cases require the services of various HBP groups in their facility each year. As a result, many RFP's over estimate or underestimate their volumes, translating into inaccurate revenue estimates by potential vendors.

Perhaps surprisingly, it can be challenging for many hospitals to get accurate patient care volumes. This is frequently due to misclassification, exclusion or even double counting of cases in information systems. In recent years, in certain specialties it has become more even difficult. For example in anesthesia we have seen a proliferation of "Out of the OR cases" like endoscopy, MRI and cardiac cath lab. These cases often require anesthesia, but the count of those cases may not be captured under surgical services. When the time comes to fill out an RFP, an administrator will ask the director of surgical services to simply fill in the numbers, often missing the "Out of OR" cases.

When preparing an Anesthesia RFP, hospital administrators should ask, "How many endoscopies were performed at this facility last year that require anesthesia?" They may know that their hospital performed, 2,000 endoscopies in total, but it could be that 1,500 of that total did not require anesthesia. If a hospital administrator puts in the RFP that the hospital performed 2,000 endoscopies, it would cause RFP respondents to overestimate expected collected revenue, leading to an underestimation of the subsidy required. Similar concepts apply to other HBP specialties.

Adding to this confusion is the fact that many hospital departments use different scheduling and computer systems that do not communicate with each other or which potentially double or triple count a case in their statistics. The end result is undercounting, over counting or double counting of patient encounters. This results in an RFP that fails to accomplish its goal of accurately communicating the needs of the hospital.

2. HOW MUCH CAPACITY NEEDS TO BE STAFFED, AND BY WHOM

Hospital administrators often state how many hours they want to have staffed by an HBP provider, or how many physical locations they have in their facility. For example, a hospitalist RFP may request 2 providers in the hospital at all times, but in reality, the utilization of such coverage in all hours outside of prime time may be abysmally low. If a more realistic option is one hospitalist available for all non-prime time hours, the department will require approximately 3 FTE fewer providers and a corresponding reduction in group expenses. Generally, for any HBP service, the facility must determine how many locations they need to have staffed by the specific department. Required staffing is a key driver of expenses for any service line and therefore will have a direct impact on expected subsidy.

In an RFP, it is important to have the exact number of staffed hours required both during prime time and after hours. It also matters what specialties are expected to be covered during various hours. For example, when looking at a radiology RFP, can call be covered teleradiologically, or is a local radiologist expected to be available? Is an interventional radiologist required during afterhours and weekend hours? The details of required coverage will again have a large impact on required FTE's and expenses. This will allow vendors to identify opportunities to use physician extenders where appropriate.

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A well written RFP will clarify exactly the coverage required, identify certain subspecialty types and the hours each will need to be staffed. Vendors will always staff based on the maximum amount of coverage needed, so failure to be clear in the required coverage hours may result in inaccurate bids.

3. THE PAYOR MIX OF YOUR PATIENT ENCOUNTERS

Payor mix has a huge impact on the revenue collected by HBP groups. Although the magnitude of the impact will vary between specialties, private insurers often reimburse providers at much higher levels than the government (Medicare/ Medicaid) does. Therefore, groups must know the facility's correct payor mix to develop accurate revenue projections, which will directly impact any potential subsidy paid by the hospital. To ensure the most accurate bid, the RFP should include the payor mix of all cases which the specific HBP specialty area would have had the opportunity to bill for over the most recent 12 months. It is important to note that the payor mix of a given HBP specialty area may be different than the overall payor mix of the hospital.

4. YOUR SPECIALTY AND SUB-SPECIALTY NEEDS

RFP's must clearly define and delineate sub-specialty services, which will often require specialized providers and may have an impact on the expense required to provide the coverage. Where applicable, areas where the hospital feels it is reasonable to use physician extenders (CRNA's, AA's, ARNP's) should be identified.

These are a few of the necessary items for constructing an effective RFP. Finding this information alone will require significant staff hours—even if the institutional knowledge exists.

ABOUT EHC

Enhance healthcare Consulting (EHC) is a specialized consulting firm that independently evaluates both outsourced and employed hospital based providers by specialty and across service lines to measure performance, improve service and reduce costs. Our services cover the entire provider and vendor management process, including managing existing providers to ensure optimal performance, remediating relationships that have deteriorated or grown outdated over time, and forging new value-add vendor partnerships supported by a strong and quantifiable business case.

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HOW TO PREPARE AN RFP & EVALUATE RESPONSES

The most efficient and cost-conscious manner for hospitals to write an RFP is to hire an unbiased, outside consulting group. An experienced consulting group regularly creates RFPs for hospitals; is aware of the numerous vendor options available; and understands exactly how to gather, analyze and communicate the information required. Hiring a consulting group mitigates the risks of creating an inadequate RFP, entering into a flawed agreement, and incurring high costs due to a second transition.

Extensive subject matter expertise will also prove valuable during the RFP response review process. An understanding of what constitutes reasonable staffing levels as well as fair market value compensation can determine which proposals are fair and accurate, and which groups will be a good cultural fit for your facility. While the group with the least expensive proposal may seem appealing, keep in mind that it still has to hire staff in your area and provide strong local leadership. A group with ties to the local medical community may prove to be more aware of the talent pool, and better able to meet the specific needs of your facility.

As the process moves from vendor choice to contract negotiations, an advisor with knowledge of contracting norms as well as potential pitfalls will protect your interests as a deal is negotiated and structured. Additionally, service line specific quality and performance measures, with a percentage of subsidized dollars at risk, may be added to align the interests of the parties. A consultant who has participated in many of those decisions at multiple hospitals will know the right questions to ask and know how to identify a group that will be the best match for the unique needs of your facility.

If your hospital is planning to assemble an RFP for any Hospital Based Physician service line, and would like to speak with an Enhance Perioperative and Anesthesia Consulting (EHC) expert, please call **954-242-1296** or email **info@enhancehc.com**. To learn more about EHC, please visit **www.enhancehc.com**.

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CASE STUDY:
ANESTHESIA RFP HOSPITAL SAVES $1.2 MILLION

SITUATION A 300 bed full for-profit hospital in the Southeastern United States needed to evaluate its anesthesia department.

This facility is a Level II trauma center, has a cardiac cath lab and cardiac surgery program, and does over 3,000 OB deliveries annually. In addition, the hospital serves as a teaching program for Family Practice residents and CRNAs from three nursing schools.

The original anesthesia department was composed of ten partner physicians and 22 CRNAs. This department staffed 20 daily sites and provided 18,000 anesthetics annually. The yearly anesthesia subsidy fluctuated between $1.5 million and $2.3 million with a current run rate of $1.8 million.

The hospital's CEO and MEC engaged EHC to evaluate the anesthesia department's level of service, staffing model and financial performance in an effort to validate its anesthesia group's subsidy request.

After a thorough evaluation, EHC determined that quality and patient care were not an issue. However, the anesthesia group was unable or unwilling to meet reasonable expectations such as in-patient pre-op evaluations, first case on-time starts, and provide adequate supervision of CRNAs. The group had been asked on numerous occasions to correct these deficiencies, but did not have the governance structure or physician leadership to respond appropriately. Based on the EHC's findings, the CEO and MEC decided to put out a Request for Proposal for Anesthesia Services.

EHC was enlisted to manage the entire RFP process. Working collaboratively with the hospital executive staff and OR nursing department, surgical case volume and case mix were clearly defined. The requested sites of service (Daily, On-Call) were reviewed and carefully outlined in the RFP, which EHC wrote for the hospital.

In addition to vetting local and national respondents for their ability to provide the service requested, EHC answered prospective vendors' questions and provided updated information to the RFP respondents. EHC also helped the hospital narrow the list of potential vendors, was on-site for meetings and finalists' presentations, and was also instrumental in helping the hospital executive leadership team make the final vendor selection.

Due to this streamlined Anesthesia RFP process supported by subject matter experts, and knowledge of respondents' business models, the hospital was able to bring in a new anesthesia provider which achieved a smooth transition, additional providers and was able to offer $1.2 million in subsidies subsidy savings the first year.

The group will also bring in new physician and CRNA leadership, initiate robust IP/OP pre-op process, and collect and report 7-10 quality and data points on a quarterly basis. Additionally, the new group expects to retain almost all incumbent MD and CRNA providers due to an attractive compensation and staffing package.

Thanks to EHC's unique ability to work closely with hospital administration, medical and nursing staff to understand specific OR and anesthesia issues, the hospital was able to navigate the RFP process in an expeditious and cost effective manner.

THE RESULTS

Substantially reduced subsidies, increased anesthesia coverage and enhanced service.

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