Lessons for Financial Success

CHAPTER 4

Profitability and Cost Management

WHAT YOU WILL LEARN

✓ Basic terms and concepts in managing costs
✓ Techniques for operations planning and budgeting
✓ Strategies to improve payer contracting
✓ Ideas to market a medical practice
INTRODUCTION

Costs – in today’s economy everyone wants to manage them the best they can. But to do that, you need to understand the types of costs and how they affect medical practices’ day-to-day functions. Managing costs takes planning and innovation. This chapter points out the importance of both strategic and operational planning, as well as the financial side of planning, otherwise known as budgeting.

Politics brings the issue of revamping healthcare to the minds of many more Americans. The truth is that insurance payers – both private and governmental – have been around for years and continue to add complexity and confusion to the process. You must understand how to best work with insurance payers so that your practice gets paid for the services it delivers.

Patients remain the major focus of any medical practice, but you have to know how to attract patients to your practice and keep them coming back. You will gain a few tips on how to do this and see how other practices have succeeded in creating a sustainable patient base.

WHAT’S COVERED

This chapter covers planning, budgeting and marketing, while weaving in a focus on maximizing profitability and managing costs. You will also see strategies in managing both governmental and private payers that will encourage you to ask the right questions and get paid appropriately for the medical services provided. In best practices and examples, you will also find suggestions to improve your practice’s daily operations, along with excerpts from success stories in the MGMA Performance and Practices of Successful Medical Groups Report that describe real-life medical-practice examples.

IN THIS CHAPTER

✓ Overview
✓ Profitability and cost management essentials
✓ Success stories
✓ Best practices
✓ Examples
✓ Summary
✓ Discussion topics
✓ Glossary
✓ Benchmarking data from MGMA survey reports
✓ Appendix
OVERVIEW

Every function, item and service has an associated cost. Understanding the differences among the types of costs and how to manage them will give you better insight to your practice’s overall financial success.

Further, planning is critical to any business. Strategic planning establishes high-level goals and objectives for the practice, while operational planning supports these goals with specific task-oriented objectives that employees can follow.

Creating a positive relationship with each of your insurance payers, understanding your contracts and negotiating payment terms can help improve practice revenue.

Finally, a practice needs patients to survive. How do you attract new patients and keep the ones you have? You will learn a few tips and perhaps a new approach to marketing your practice’s services to your community.

PROFITABILITY AND COST MANAGEMENT ESSENTIALS

Cost concepts

Costs can be associated with many things, such as providing a service or product, running a department or marketing a practice. Two cost classifications are important to know:

- Direct costs – Costs that can be traced to or caused by a particular service, product or practice activity. For example, the direct costs of treating patients include the physician’s salary, medical personnel salaries and supplies.
- Indirect costs – Costs that cannot be traced to a particular service, product or practice activity and cannot be directly measured. Examples include business office salaries, rent, building and machine maintenance, utilities and insurance.

Managing costs may seem simple – don’t spend money the practice does not have. However, this process can be complicated because many factors affect a medical practice’s costs. To understand the basics, you must consider how costs respond to changes in the level of activity associated with them. Some call this cost behavior; two specific elements in this area are:

- Fixed costs – Costs that remain constant regardless of activity. Examples include rent, property taxes, insurance and administrative salaries. These costs may increase over time, but they are not related to changes in the level of activity within a period of time. One important fact about fixed costs is that although the total amount remains the same at different activity levels, the fixed cost per unit changes with the activity levels. (See Exhibit 4.1.)
Variable costs – Costs that vary as the volume or level of activity changes. Examples include hourly laborers whose total hours worked vary, and supplies costs that vary based on number of patients and types of procedures performed. In a medical practice, variable costs are tied to patients. Exhibit 4.2 shows an example in which a medical practice uses an outside laboratory. The costs vary with different volumes of tests performed.

Exhibit 4.2 Variable-cost example

<table>
<thead>
<tr>
<th>Number of tests</th>
<th>Cost per test</th>
<th>Total variable cost of testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>100</td>
<td>$20</td>
<td>$2,000</td>
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<tr>
<td>1,000</td>
<td>$20</td>
<td>$20,000</td>
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</tbody>
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Understanding why specific costs change when operating conditions change will aid you in managing the costs of your practice and allow you to better estimate future costs. For example, if your practice wants to add an ancillary service, you need to know the costs associated with equipment, supplies, personnel and space allocation. Does this change impact current processes? Who needs to be trained or hired to perform the service? You need to determine these costs before adding the service.

Cost management

You can think of cost management as a continuous process of planning, monitoring and controlling operational costs to meet the strategic goals of the medical group. It’s an approach that focuses on profit improvement.

What areas should you first address when trying to manage costs? The first, and most likely the area with the greatest impact, is personnel costs, which
account for about 30 percent of the average practice’s annual revenue. You need to evaluate the number of staff that support each physician and, if necessary, determine if tasks can be changed to reduce the number of support staff. The MGMA Cost Survey Report contains staffing benchmarks that might be helpful in beginning this evaluation. Be cautious in cutting staff to a level too low to meet a benchmark. Each practice operates differently and you know what works best to support your physicians and processes.

Next, evaluate staff functions such as scheduling, front office and transcription to see if these areas can be centralized. Look at employees’ tasks to see if they match the skills required for their job. In some cases, overqualified (and expensive) staff are hired to do jobs that could be done by less expensive employees. Take a look at these steps to help reduce staff costs:

- Limit the number of registered nurses, using them only for tasks requiring their training and skills;
- Cross train the staff to fill in for temporary vacancies such as vacations or illnesses;
- Avoid overtime by keeping office hours on time and staggering staff work schedules;
- Move payroll to an outside payroll service, thereby reducing manager and accounting time; and
- Consider outsourcing functions such as billing.

Supplies also contribute to the costs of any business, including medical practices. If possible, one member of the practice staff should be in charge of ordering and monitoring supplies so that you have sufficient inventory and can take advantage of volume discounts.

Some other areas to consider when trying to reduce costs include:

- Telephones – Monitor bills, especially long-distance calls;
- Laboratory fees – Find volume discounts with outside laboratories;
- Legal and accounting functions – Negotiate reduced fees with an outside accountant and lawyer;
- Competitive bidding – Seek competitive bids for expenses such as medical supplies, office supplies, stationery, printing and insurance; and
- Group-purchasing organizations – These organizations may offer discounts on many expenses, including, but not limited to, medical supplies and office supplies.

In this uncertain economy, you can also consider adding new lines of service that will generate revenue and allow staff to function in a new capacity. Once the overhead (for example, new equipment and staff training) is in place, a new service will go a long way in increasing profitability. Instead of approaching cost management as merely reducing overhead, using your
existing capacity to drive new business will allow you to keep staff and possibly gain new patients.

**Planning and budgeting**

Medical practices that want to run efficiently plan. Treating a medical practice as a business requires that management look ahead and identify action steps that will meet the practice’s strategic goals. Planning includes deciding on services and procedures, the number of physicians and staff needed to provide the services, physical space and the effective design of that space to meet patients’ needs.

The planning process should involve developing goals and objectives. Goals are broad statements that indicate what the practice wants to achieve. Sometimes these goals become the practice’s mission statement. For example, providing efficient, timely healthcare for patients could be a goal for any medical practice.

Objectives help the practice achieve its goals. Objectives are specific, cover a short time period and include aspects of the practice such as hours of operations, physician compensation and collections.

How do you start the process of determining your practice’s goals and objectives? First answer these basic questions:

- What patient groups will be served?
- What types of services will be provided?
- What will the practice’s role and leadership position be in the medical community?
- What impact will changes in technology have on patient care?
- How large of a professional staff does the practice want in five or 10 years?
- What will be the impact of changes in the local healthcare market on the practice’s market share?
- Is the practice’s community growing or shrinking? Is the population getting older or younger?
- What does the future pool of physicians look like for your practice or specialty?


After answering these questions, you can start developing your strategic plan, a long-term, visionary and high-level plan, will set the course for the practice. This type of plan usually sets the stage for the practice’s next five to 10 years of operation. Some practices go offsite for a day or weekend with key personnel to focus on the plan.
To achieve the long-term goals set forth in the strategic plan, you should then create an operational plan that includes short-term goals that can be achieved within a week, month or longer as needed. All goals and objectives should be communicated to all staff so that everyone understands the direction of the practice and contributes to its success.

Exhibit 4.3 shows an example – providing superior quality medical care – and objectives for just some of the areas in the practice to achieve that goal.

**Exhibit 4.3  Example of objectives supporting a goal**

**Goal:** Provide superior quality medical care

**Professional services**

Objective 1 – Add three general practitioners within six months.

Objective 2 – Add all major specialties within five years.

**Financial resources**

Objective 1 – Negotiate a line of credit with a local bank for working capital within three months.

Objective 2 – Set up a two-year capital budget within one month.

**Innovation**

Objective 1 – Establish a marketing plan for the practice within one year.

**Productivity**

Objective 1 – Initiate a system that tracks individual production on a monthly basis within six months.

Objective 2 – Increase professional production by 5 percent within one year.

You can see that goals and objectives provide the framework for developing yearly operating plans. Objectives bridge the strategic-plan goals with the short-term operating plans. What’s missing is how you will pay for meeting these objectives and what revenue will be gained through their implementation. To accomplish this, you need a budget.

Budgeting can be thought of as the money plan. It’s the tool that shows expected income and the expenses necessary to pay for the objectives. Budgets also help with:

- Unifying planning and control functions;
- Aiding in the creation and coordination of short-term plans and communicating these plans to all managers;
- Motivating managers to achieve the goals of their departments by providing target measures;
• Providing authorization for staff to use and acquire resources during the budget period and expand existing or implement new activities;
• Enabling managers to anticipate favorable conditions so that money can be used to implement desired objectives, or, if unfavorable conditions exist, taking steps to minimize the impact; and
• Establishing benchmarks to control ongoing activities and set criteria for evaluating management performance.

Without a budget, a practice would have little control on spending and would not be able to predict revenue and profit.

Some budgets are simple, while others are more complex. A medical practice should prepare different budgets depending on the mission, approach to management and organizational culture and structure. Typical budgets that a medical practice may prepare include:

• **Provider compensation forecast** – The remainder of revenue after the operating costs and salaries of nonphysician providers and salaried physicians are paid that is available for distribution to the physician owners and shareholders.

• **Statistics budget** – Also referred to as a service volume forecast, which predicts the volume of services a practice can expect to perform. It is the foundation for all other budgets and crucial to the budgeting process. More often than not, a practice will assign relative value units (RVUs) to particular services. RVUs help a manager predict a total number of patient visits and can be thought of as a common denominator that relates all services on the same scale. If your practice does not use RVUs, the services might need to be budgeted individually.

• **Operating budget** – Includes the revenue and expense budget that predicts the practice’s financial performance. In most practices, the operating budget predicts the practice’s profit or loss. For planning purposes, apply the formula:

\[
\text{total revenue} - \text{total operating expenses} - \text{provider compensation forecast} = \text{profit}.
\]

If the amount calculated is positive, the profit can be pooled into provider compensation. If it is negative, adjustments should be made because physician owners and shareholders will not be paid as expected.

– **Revenue budget** – Based on the statistics budget, a practice manager should prepare a revenue budget on a monthly basis, which will help predict monthly revenue. The revenue budget includes the practice’s ability to collect accounts receivable depending on the mix of services and the mix of payers.

– **Expense budget** – Also based on the statistics budget, the expense budget focuses on each expense category and includes a labor budget (fixed and variable labor expenses), a supplies budget (non-labor expenses such as variable costs associated with services) and what
the business world refers to as the administrative and general (A and G) budget (fixed costs such as interest, depreciation, utilities, rent, cleaning and housekeeping). The expense budget goes through extensive revisions as projects and staffing levels are approved. Staffing decisions have the greatest impact on the expense budget and should be monitored.

After preparing these budgets, a manager may now calculate expected profit or loss on both an annual and a monthly basis and decide whether or not the budget satisfies the practice's goals. Once the operating budget is approved, the manager can prepare other key budgets such as:

- **Capital budget** – A capital budget is necessary if a practice's goals require additional capital expenses. The capital budget summarizes the practice's expectations acquiring capital assets that have lives greater than one year, such as land, equipment and other fixed assets. It can be considered a detailed list and acquisition schedule based on medical necessity or economic benefit to the practice. The return on investment must also be calculated to justify acquisitions.

- **Cash budget** – A period-to-period estimate of the practice's cash levels. Days in accounts receivable becomes a critical measurement in a managerial cash budget, and this type of aging analysis should be applied to each payer so that you know when you will receive payments that can be used to run the practice. An organization does not want to have too much cash on hand because that would limit opportunities for short-term investment. Too little cash on hand is a problem as well, because the practice may need to borrow, which inevitably involves paying interest. Preparing an adequate cash budget involves looking at the expense budget, the revenue budget, the practice's balance sheet from the previous year and an aging analysis.

These budgets form the comprehensive budget that you can present to the practice's governing board. The *Examples* section contains a sample budget. You also can find a thorough budget worksheet in the *Chapter 4 – online tools page*.

**Payer contracting**

Both private and governmental (Medicare and Medicaid) insurance payers play a large role in medical practice reimbursement for services. With Medicare and Medicaid, you cannot negotiate your fees, but you can stay current on changes by getting more politically active with both local and state initiatives affecting healthcare in your community. Know your state's regulations such as whether it regulates payer fee disclosure. Some states regulate payer fee disclosure and others do not.

Today, the political healthcare climate is ripe with potential change. Medical practices need their voices heard so that change works for all. With that said, the current private payer situation can be daunting at best. Effectively
navigating the system takes work and patience. Most importantly, you should know the allowable fee schedules for each of your payers. Too often, practices engage in a payer contract without knowing the reimbursement amount for specific services.

Negotiating and renegotiating with payers will force you to evaluate your contracts so that you get paid appropriately for the services you provide to patients. Also knowing how dependent the practice is on each payer can help form your contract discussions.

The Best Practices section contains a payer-contracting checklist and guidelines from an MGMA better-performing practice that can make this process a little easier.

Marketing strategies

Most successful medical practices invest time and money in marketing their practices. One practice may benefit more than another from specific marketing approaches. Marketing may seem to be just one more thing to add to an already full to-do list. But competition can be fierce in today’s healthcare market, and you should take the lead in promoting your practice.

The size, specialty and location of your practice can help determine the best approach to promoting it. Large practices may have more money to spend on marketing campaigns, and specialty practices can target specific audiences such as parents or seniors.

Relying on positive word-of-mouth from current patients will bring new patients to your practice and can be the most rewarding and effective approach to practice marketing. You can also participate in community outreach activities such as health fairs, senior centers and charity functions to help get the practice’s name out to many individuals. You may also take a traditional approach with ads in phone books, or on radio or television. Today, many practices have Web sites that contain basic information about the practice, contact information, services provided and physician profiles. A Web site can provide a positive image to potential patients.

If your practice is a single-specialty practice, you may want to focus your efforts on marketing to referring physicians. Building a relationship with these physicians can go a long way in driving business to your practice. Some practices host golf outings, lunches and open houses for referring physicians.

It’s important to know that marketing is not just creative advertising. This aspect of the business includes research to plan investment strategies and the services and equipment that are needed to stay competitive.

Regardless of the approach you decide to take, start with a plan that will aid you in developing the best course for your practice. The Examples section contains a nine-part model with a suggested marketing action plan that will help you start marketing your practice or enhance your current marketing plan.
SUCCESS STORIES

**Corpus Christi Women’s Clinic**

Since 1981, the Corpus Christi Women’s Clinic has served Nueces County, performing 25 percent of the town’s deliveries (more than 40,000 to date). Its wide spectrum of women’s health services ranges from infertility to urogynecology to laser hair and vein removal. Currently the practice has 10 physicians, two nurse practitioners and 59 staff serving in one location. MGMA has designated Corpus Christi Women’s Clinic a better-performing practice because of the practice's outstanding record in profitability and cost management.

**Efficiencies**

Practice administrator S. Craig Winkle believes in a practical approach to financial health and cost consciousness. He cites support staff numbers as an example. “I tell physicians, if you want $400 of income an hour, you don’t do $12 per hour paperwork. That’s why we have plenty of support staff. Result: high volume, high collection ratio.” Another source of savings is requiring the business office to handle surgery scheduling, so nurses can devote their time to patient care. This also affords the business office greater ease in tracking and billing for surgeries.

Winkle reports, “About four years ago when two physicians retired without replacements in place, I took my research on payer mix and per-patient cost to the physicians. I told them that if they wanted to maximize profitability with limited physician capacity, we must carefully manage the number of lower-pay patients. Medicaid pays far less than private insurance. So we encourage physicians not to book up with Medicaid patients, but rather to always leave some space for higher-pay patients. The clinic will utilize capacity with all payers but will not increase capacity for lower-pay patients.”

He emphasizes that with costs rising, quality care is dependent on gaining and retaining patients. The goal: To have a completely filled schedule with a balanced payer mix. Winkle works with the payers, communicating with them about rates and codes for new products. He says, “Physicians often want to do new treatments with heavy costs, maybe a $1,000 supply cost. I research such requests but deny them until the payers will pay appropriately. My motto: Never get ahead of the payment stream.”

**Challenges**

Winkle emphasizes cost-management issues such as employee costs. Using MGMA survey data and regional figures, he keeps wages in line. The clinic offers the full array of benefits, including a strong profit-sharing plan. There are bonuses for some job categories with measurable elements.

He says, “We work hard on retaining employees. It is difficult to find new people motivated to help others in a team environment — with sensitivity to
patients.” He notes that generally an OB/GYN practice is “happy medicine. But for some patients, a visit could be the worse day of their lives and staff can’t be seen as uncaring or indifferent.”

Winkle also focuses on medical malpractice costs. He and other staff went to the state legislature three to four times every session. Because of a recent constitutional amendment limiting awards in Texas, the malpractice situation has improved, but is always under attack by attorneys.

**Physician and management leaders**

The clinic has a physician management committee elected by the staff. Winkle says, “Four physicians meet with me on a monthly basis and I keep them involved with financial measures. I counsel those having difficulty with production-pay realities; if revenue drops, so does pay. We send all physicians to coding meetings where they learn that if coding is not done right, we can’t maximize collections.” Winkle also has five department managers to keep the practice running smoothly and efficiently.

**Financial goals**

Winkle keeps close watch on the economy. “If insurance reimbursement trails off or patients forgo treatment, we don’t want excess capacity when we have fewer patients. We also watch what the government is doing to Medicare, because all the other payers will follow suit.”

The administrator notes that three new physicians are working to create a 2009 budget that is superior to the 2008 budget. “We plan a 3 percent COLA increase across the board. We recognize that something always can affect the budget; for example, a physician’s pregnancy or an injury.”

**Cost-management specifics**

“As a CPA, I count everything all the time. I look for bottlenecks in processes. I use job costing to look at inputs and outcomes and where we can change things. In particular, I look at each line item with an eye on what can be improved, even if it is a necessary cost,” says Winkle.

Here are some of Winkle’s cost-saving suggestions:

- Rent a phone system with phone lines from one source. “We are spending slightly more than we did on just monthly phone lines, but have no repair costs and did not buy a new system to replace the 1991 system when we moved in 2006. We can decrease or increase the number of phones and/or lines any time”;  
- Use only networked copy machines that can print/fax/scan, replacing many other machines and supplies. The costs for copies purchased in high volume (toner and maintenance) are much lower than having separate machines;
- Monitor laboratory costs. “We do not do any type of test in our own laboratory on a regular basis unless it is profitable and has a volume that will sustain the capital cost of new equipment. Even after this step, we send labs out to reference labs if some payers do not pay well on a certain test. This avoids the overhead (staff, supplies, and billing) to do any break-even testing. We mostly use rental laboratory equipment so that the cost of use follows the revenue of the tests. It is much less costly if we change our mind about certain testing or a better method comes along”;

- Use a postal service. “They charge us regular postal rates but they, in turn, presort the mail to pay less, keeping the difference as a fee. This also means we have no employee costs in mailing, no monthly lease for a mailing machine, no mistakes in the postage spent”;

- Major equipment. “I usually look for demo machines or overstocks by manufacturers. I lease if the item will become obsolete within a few years and purchase the rest. I also like deals where, if you buy a supply in volume, you get the equipment for free. I find it much easier to charge the physician who uses the supply unit than to get the group to buy a surgery device because many times, only four to six physicians want to do certain procedures and the others do not want to pay for a machine they do not use”; and

- Use electronic time clocks. Keep overtime to a minimum with real-time data.

Oregon Orthopedic & Sports Medicine
This practice, just outside Portland, Ore., started in the early 1970s as the first orthopedic surgery center in the county and surrounding area.

Efficiencies
The focus of this practice, says Fred Flaherty, administrator, “is productivity first and cost second. We look at the surgeons and see how they work and want to work regarding staff, space, equipment and supplies. I believe you should not let cost drive you; instead focus on productivity and profit.”

Innovation
Noting that computers have adopted a key role in healthcare in the past decade, Flaherty says, “We try to make innovative changes in processes as we move away from non-electronic, paper systems. We are always aware of the kind of technology coming on the scene, research it thoroughly and plan its integration carefully. Over the past two years, we have migrated to a document-imaging system. The system allows our surgeons and staff to be efficient and effective.”

Physician leaders
Flaherty reports that all of the practice’s physicians have a strong work ethic and are very conscious of how resources are used — a great cost advantage.
He meets with all the physicians every month to report on operations and finance. He provides dashboard indicators and can drill down to the details as needed. Comparisons are then made to MGMA data.

Financial goals
Flaherty reports that this group likes to do things in a dynamic way. For example, while they keep strategic-planning factors in mind, they do not have a formal retreat to develop a strategic plan. Rather, they focus on specific projects anticipated in the next two years or less. One example is adding a new surgeon or more physician assistants and how that will impact revenue and costs. Only projects with positive projections are approved. Financial goals and budgeting are therefore straightforward, taking into consideration projects, the economy, population growth and expected returns.

Financial performance areas
The administrator concentrates on aggregate indicators such as net revenue after operating costs. Another focus is on billing and collections. If there is any issue, he discusses it with the individual physician. He notes that “the key to productivity/profitability in a practice is how the physicians impact their own revenue. Their behavior is highly correlative to financial health and cost management.” The practice has some shared revenue, but primarily it uses an individual physician income model.

The information gained from such analysis is put in front of the entire group. Because the physicians are highly profit oriented, they encourage each other to adhere to a strong work ethic. As Flaherty works with the group, he specifically focuses on:

- **Economies of scale.** Determine how to leverage space, how to fill space, how to handle purchasing and inventory;
- **Economies of scope.** Look carefully at the product/service mix. In this case, the practice has chosen not to offer spine and neck surgery but to focus instead on its defined, broad spectrum of services and core ancillary services, such as diagnostic imaging and durable medical equipment.
- **Economies of experience.** Capitalize on the ability to produce more by learning through doing. Accrual of knowledge is a key advantage in a competitive business. Capture that knowledge and maximize it — don’t let it just sit in the back of your head.

Digestive Health Specialists
Success factors

Gastroenterology continues to be an important field of medicine and keeps this practice very busy. Donaldson attributes much of the success to the longevity of the physicians and management staff. The founding physicians are still with the practice and overall the practice experiences low turnover.

“The physicians practice medicine and allow the business leaders to do their jobs,” Donaldson says. “The physicians allow me to do what I do best, and I work to help them do what they do best.”

Physicians can be efficient in what they do because of established scheduling procedures, scheduling review and automated appointment reminders to patients. Efficient processes also contribute to the success. Donaldson is a big believer in information technology and supported the conversion to an electronic medical record (EMR) system years ago. They also have a new practice management system, which has allowed much of the staff to operate more efficiently. The practice does not store paper reports, but rather uses Adobe® PDF format to store reports electronically, and have multiple scanners throughout the practice to scan all paperwork.

“You should never reinvent the wheel, but look for areas to be better and more efficient,” Donaldson says.

This particular practice has also incorporated physician assistants (PAs) who help accommodate more patients and allow the practice to open more ancillary services. It was one of the earlier practices to begin using PAs.

Donaldson also attributes success to managing the payroll. They take the approach of fixing issues instead of just throwing more people at it and not seeing results.

“Payroll is one of our biggest expenses and you have to get your best value out of it,” Donaldson says. “We pay our people well and seem to be in the low range of support-staff-to-physician ratio benchmarks, which works for this practice and specialty.”

Self-pay patients and health savings accounts (HSAs)

Self-pay patients do visit the practice and receive a substantial discount for prompt payment at time of service. Although the practice has a relatively high fee schedule, Donaldson doesn’t put much emphasis in the amount of charges billed. Collections play a more significant role in the profitability status of the practice.

“Because of the increase of self-pay patients and a few high-deductible health plans, we had to hire a full-time collections manager to keep up, and this affected our bottom line somewhat,” Donaldson says. “We experienced an increased cost of collecting that dollar. It isn’t as simple as it was before when all we had to collect was a $20 copayment.”
**Practice operations**

The practice takes a team approach to billing because they are not large enough to break out the work by payer. Instead they break the work out by function — hospital billing, insurance filing and payment posting. In addition, they developed a policy and procedures manual for each physician that includes the steps to complete the various job functions within the practice. This allows for effective cross-training, new employee training and the ability for other employees to pick up the work when another is out sick or on vacation.

Biweekly team leader/staff meetings spur discussions on issues important to the practice. Together they work out plans to help the various aspects of the practice meld to become a more efficient workplace. Communication is key to motivating employees to fix issues and perform at their peak. Employees also attend Medicare meetings and payer meetings to keep current with upcoming changes.

**Marketing the practice**

Digestive Health Specialists markets to primary care physicians and staff, not to patients directly. The practice relies on referring physicians for much of their business. Donaldson and staff build relationships with the primary care physicians by hosting golf outings, lunches and, most recently, a colon cancer awareness program.

**Final thoughts**

The key to success, according to Donaldson, is the ability to adapt to change.

“No healthcare overall is not very innovative,” Donaldson says. “Healthcare has found new procedures and technology, but we haven’t re-evaluated how we deliver healthcare. We are in the break/fix mode and not in prevention or early detection mode and resist change. This needs to improve, and we must look at the big picture to remain successful and provide the best care to patients.”

**BEST PRACTICES**

Contracting and managing your payers can be an overwhelming process. Provided you have an adequate practice management software application, a calendar and a file cabinet you can conduct very effective contract management, monitoring and renegotiation with your payers.

Here’s a summary checklist to help you with payer contracting:

- Organize your contracts and calendar them for review annually;
- Consider issues other than reimbursement when evaluating an agreement. If a payer asks something of your practice, ask for something in return;
- Know your value to the payer before initiating recontracting;
Know the payer’s value to your practice, and know your bottom line before initiating recontracting;

Know your cost of doing business before negotiating. Your costs are your costs, and nobody can argue them with you. If it costs you $35 for a patient to come in the door, why would you take less for an office visit? Physician practices are not immune to the laws of economics;

Establish fee schedules for your contracts, and monitor them. Be vigilant and insist on being paid appropriately; and

Watch for denials. If you are being paid per the terms of your agreement, but denials are reducing the overall reimbursement of the contract, and those denials are not consistent with Medicare’s correct coding initiative (CCI) or other generally accepted rules, question whether or not you wish to remain contracted with the payer.


Negotiating higher reimbursement from an insurance company

By Marc Mertz, FACMPE

This excerpt, taken from an article published in the MGMA Performance and Practices of Successful Medical Groups: 2004 Report Based on 2003 Data, provides a realistic view of working with payers.

The cost of providing medical services (staff salaries, malpractice insurance, medical supplies, rent, etc.) continues to increase each year, the reimbursements received from insurance companies (as well as the government) remain relatively flat or have decreased.

Most medical practices accept payer contracts, and the corresponding fee schedules, without question. In fact, many practices do not know the amount that insurance companies pay them each year.

Practices that do review contracts and attempt to negotiate higher reimbursement are usually met with great opposition from the insurance company. In most cases, insurance companies convince the practice that the fees are not negotiable, and that they must “take it or leave it.” While this may be the case in some situations, there is usually room for negotiating a higher rate of reimbursement if the practice approaches the negotiations correctly.

So, where do you start? Regardless of your specialty, practice size or location, you need to start with access to data.

Collect data

To start the process, obtain a list of your most common current procedural terminology® (CPT®) codes. In primary care practices, most of your practice’s revenue will be tied to a handful of evaluation and management (E&M) codes.
Rank your codes by the dollar volume of charges and include enough in your list so that you account for at least 75 percent of your total practice charges. Many practices have computerized practice management systems that can easily generate reports of codes and their frequency of use.

If your practice bills manually, you should have a staff member track the codes that you use most frequently. This can either be an analysis of the past several months or the start of a new process. Next, using your list of top CPT codes, review explanations of benefits (EOB) that you have received from your top payers. Be sure to look at the allowed amounts, not the amounts that were actually paid, which are adjusted by copayments. You can use a spreadsheet program to create a matrix that displays each of your top payers and their reimbursement by CPT code. This will allow you to quickly compare each plan’s reimbursement level.

Although it may not be perfect, Medicare bases its fee schedule on a system of relative value units (RVU) that assigns a level of work and practice expense to each code. As a result, it is the best indicator with which to compare insurance companies’ reimbursement levels. Include a column in your spreadsheet for Medicare and its allowed amounts. You can then use a simple formula to calculate each insurance company’s current reimbursement as a percentage of Medicare.

**Pick a “winner”**

Now that you have an idea of your current situation as well as a reimbursement target, you should next determine with which insurance company you want to negotiate. For negotiations to be successful, you need to have leverage. In this case, your leverage will be your practice’s participation with the insurance company. If they are unwilling to increase their reimbursement level, you must be prepared to limit or end your participation with that plan. Therefore, you should not start with your largest payers. Pick a plan that represents 5 percent to 10 percent of your practice’s income. The best target would be a plan that is aggressively trying to improve market share or is new to the market. Do not focus on Medicare or Medicaid — the government will not negotiate with you. You also want to pick a plan that pays you at a below-average level.

Although an increasing number of plans base their reimbursement levels on a percentage of Medicare’s resource-based relative value scale (RBRVS) amounts, there are many that do not have a consistent method of determining their fees. As a result, many plans’ fees vary when compared to Medicare’s allowed amount. For example, while they may pay 125 percent on one code, they might only pay 75 percent of Medicare’s allowed amount on another. When contracting with physicians, insurance companies often present a portion of their fee schedule. You must be aware that these reimbursement levels might look attractive, but they may be codes that you rarely use. It is important to identify your top codes and review actual payments from your EOBs.
Your negotiations should focus on converting the insurance company to a fee schedule based on a higher percentage of Medicare’s allowed amounts. This will not only ensure you of improved overall reimbursement, but the consistency of the reimbursements will make it much easier to monitor the insurance company’s compliance with the negotiated payment amounts. Next, identify your goal reimbursement for the plan. This amount will vary based on your market, the plan’s current reimbursement and other factors. Your target rate should also make the insurance company one of your best-paying plans. In addition to your target, you should also identify a “walk-away” level. This number should represent the lowest level you are willing to accept. If the insurance company will not agree to pay you this amount, you will close your practice to new patients with that plan or terminate your participation entirely. You should be cautious to not be too aggressive. If a plan currently reimburses at an average of 110 percent of Medicare it is unlikely that they will agree to jump to 130 percent or higher.

Start the negotiations

Contact the insurance company’s local representative, in writing, stating that the current reimbursement levels are inconsistent and below the local average. The letter should request a meeting with a representative from the insurance company who is authorized to negotiate reimbursement levels. Usually, the local provider relations representative is not authorized to do this. The letter should be written so that it does not sound threatening or demanding, but it should mention the number of patients your group currently treats and the popularity and reputation that your physicians enjoy in the community. In addition, you should indicate your group’s desire to continue caring for the plan’s patients.

When your insurance company agrees to meet with you, begin the meeting by once again expressing your group’s desire to continue seeing the carrier’s patients and explain that in the current environment of increasing expenses, you cannot afford to accept the current reimbursement. To support this, you should present charts that clearly demonstrate the inconsistency of the carrier’s current reimbursement. These charts should also compare the plan’s current rates to those of other local commercial payers (without using plan names) and Medicare. Representatives frequently do not have an explanation for their plan’s lower and inconsistent reimbursement.

Next, present your group’s request for consistent and higher reimbursement. Your practice provides a valuable service to the plan’s members and should be compensated fairly. You should make it clear that your group will no longer participate with the plan should they refuse to make concessions. In return for the higher reimbursement, you can offer your group’s assistance in meeting plan goals such as formulary compliance or patient satisfaction. By doing so, you demonstrate that you are not looking for a handout, but are willing to do a little extra in return for higher reimbursement.
While the negotiation process may take many directions, you should remain dedicated to your objective. Always act professionally, but understand that the insurance company representative’s job is to try to avoid paying you more money. This is not a social encounter. Focus on irrefutable facts such as other plans pay you more for the same service, their reimbursement levels are inconsistent and lack logic and that your practice’s participation is valuable to the insurance company.

It is rare that the insurance company’s representative will be authorized to increase your reimbursement during the initial meeting, but he or she can take your request under consideration and contact you with a decision at a later date. Before leaving the meeting, be sure to establish your expectations for when you would like to receive a response.

If all goes as planned, you will receive a positive response from the insurance company. The offer may not be as high as you would have liked or requested. Do not hesitate to make a counter offer — especially if the offer falls below your “drop-dead” rate. At times, plans will request that you sign a nondisclosure agreement stating that the outcome of these negotiations not be communicated to other practices. You should be willing to sign this document. More plans look for multiyear agreements and you may wish to offer this up front, along with automatic annual increases.

In addition, be aware of the Medicare year used if the company agrees to tie reimbursement to Medicare. While it would appear to be an easy task to use the current year’s data, many plans use RBRVS scales that are more than two years old. Be sure to adjust your “120 percent of Medicare” offer based on the Medicare year used.

If the insurance company will not accommodate your requests, you must be firm and willing to close your practice to new patients or terminate your agreement with the plan. As much as physicians hate to discontinue treating established patients due to insurance coverage, it may be necessary. Explain to patients that their insurance company fails to compensate you at a market rate, and that you cannot afford to continue working with them. You may consider encouraging your patients to speak to their employers, who may contact the insurance company to express concern over losing your practice as a participating provider.

If the insurance company meets your request, you will be asked to execute an addendum to your current contract. Be sure that the effective date for your new reimbursement starts as soon as possible and not months in the future. Also, alert your staff to the new rates and effective dates and encourage them to report any inconsistencies.

Now that one insurance company has agreed to revisit and increase its reimbursement level, you can begin the process with other payers that are below your target.
Summary of steps

Your chances of successfully negotiating a higher reimbursement level from an insurance company are dramatically improved when you take the following steps:

- **Understand the situation**: Determine the reimbursement level of the insurance company for your services;
- **Present accurate and detailed information**: Generate reports that demonstrate the insurance company’s reimbursement level and compare it to other insurance companies in the market;
- **Know what you want**: Set a reimbursement goal and a minimum level that you are willing to accept;
- **Understand the market**: Payers will not agree to extreme rate increases. However, the loss of your group’s participation would create a marketing concern for the carrier; and
- **Be willing to walk away**: If the insurance company does not respond favorably, you must be prepared to close your practice to the plan’s patients. In today’s ever-tightening healthcare market, increasing your reimbursement for services can help make your practice more successful.

**EXAMPLES**

Sample budget

Budgets may also be referred to as profit plans because they show the planned activities that the business expects to do to achieve its profit goal. You should prepare a budget based on the same fiscal year as the practice’s financial statements.

<table>
<thead>
<tr>
<th>Sample budget</th>
<th>Annual budget</th>
<th>January</th>
<th>February</th>
<th>March through December</th>
<th>Year to date total</th>
<th>Year to date percent of budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service forecast</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total RVUs</td>
<td>55,000</td>
<td>4,059</td>
<td>4,300</td>
<td></td>
<td>$8,359</td>
<td>15%</td>
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<td>Physician work RVUs</td>
<td>31,000</td>
<td>2,155</td>
<td>2,459</td>
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<td>$4,614</td>
<td>15%</td>
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<tr>
<td>Encounters</td>
<td>32,000</td>
<td>2,155</td>
<td>2,210</td>
<td></td>
<td>$4,365</td>
<td>14%</td>
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<tr>
<td>Total procedures</td>
<td>50,000</td>
<td>4,099</td>
<td>4,122</td>
<td></td>
<td>$8,221</td>
<td>16%</td>
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<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fee-for-service collections</td>
<td>$3,002,177</td>
<td>222,356</td>
<td>245,788</td>
<td></td>
<td>$468,144</td>
<td>16%</td>
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<tr>
<td>Other revenue</td>
<td>42,149</td>
<td>3,100</td>
<td>3,456</td>
<td></td>
<td>$6,556</td>
<td>16%</td>
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<tr>
<td>Total practice income</td>
<td>$3,044,326</td>
<td>225,456</td>
<td>249,244</td>
<td></td>
<td>$474,700</td>
<td>16%</td>
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</tbody>
</table>

(Table continues on next page)
### Sample budget

<table>
<thead>
<tr>
<th>Sample budget</th>
<th>Annual budget</th>
<th>January</th>
<th>February</th>
<th>March through December</th>
<th>Year to date total</th>
<th>Year to date percent of budget</th>
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<tbody>
<tr>
<td><strong>Operating expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total employee salaries</td>
<td>$946,156</td>
<td>$78,846</td>
<td>$78,846</td>
<td>$157,692</td>
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<tr>
<td>Employee retirement</td>
<td>78,854</td>
<td>6,571</td>
<td>6,571</td>
<td>$13,142</td>
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<td></td>
</tr>
<tr>
<td>contributions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other employee benefits</td>
<td>69,537</td>
<td>5,795</td>
<td>5,795</td>
<td>$11,590</td>
<td>17%</td>
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<td>Temporary support staff</td>
<td>21,400</td>
<td>1,783</td>
<td>2,559</td>
<td>$4,342</td>
<td>20%</td>
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<td>Information technology</td>
<td>44,925</td>
<td>3,744</td>
<td>3,744</td>
<td>$7,488</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>depreciation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information technology</td>
<td>9,788</td>
<td>816</td>
<td>852</td>
<td>$1,668</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>supplies and maintenance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone/Internet access</td>
<td>3,200</td>
<td>670</td>
<td>201</td>
<td>$871</td>
<td>27%</td>
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</tr>
<tr>
<td>Drugs</td>
<td>136,285</td>
<td>11,400</td>
<td>11,659</td>
<td>$23,059</td>
<td>17%</td>
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<tr>
<td>Medical and surgical supplies</td>
<td>72,238</td>
<td>6,256</td>
<td>6,152</td>
<td>$12,408</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Building rent</td>
<td>208,012</td>
<td>17,334</td>
<td>17,334</td>
<td>$34,668</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Building maintenance</td>
<td>11,450</td>
<td>954</td>
<td>988</td>
<td>$1,942</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>and utilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property taxes</td>
<td>6,235</td>
<td>3,117</td>
<td>—</td>
<td>$3,117</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Furniture and equipment</td>
<td>9,340</td>
<td>778</td>
<td>812</td>
<td>$1,590</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>maintenance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furniture/equipment</td>
<td>28,650</td>
<td>2,388</td>
<td>2,388</td>
<td>$4,776</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>depreciation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative supplies</td>
<td>51,737</td>
<td>4,312</td>
<td>4,533</td>
<td>$8,845</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>and services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory equipment</td>
<td>53,666</td>
<td>4,472</td>
<td>4,472</td>
<td>$8,944</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>depreciation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory maintenance</td>
<td>35,000</td>
<td>2,900</td>
<td>3,120</td>
<td>$6,020</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>and supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology equipment</td>
<td>24,020</td>
<td>2,002</td>
<td>2,002</td>
<td>$4,004</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>depreciation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology maintenance</td>
<td>6,733</td>
<td>561</td>
<td>575</td>
<td>$1,136</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>and supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounting services</td>
<td>4,800</td>
<td>395</td>
<td>450</td>
<td>$845</td>
<td>18%</td>
<td></td>
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<tr>
<td>Legal services</td>
<td>13,287</td>
<td>1,159</td>
<td>1,100</td>
<td>$2,259</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>General liability insurance</td>
<td>6,739</td>
<td>591</td>
<td>591</td>
<td>$1,182</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>– administrative and general</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(A and G)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional liability</td>
<td>49,024</td>
<td>—</td>
<td>49,024</td>
<td>$49,024</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>insurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promotion and marketing</td>
<td>8,330</td>
<td>694</td>
<td>725</td>
<td>$1,419</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td>$1,899,406</td>
<td>157,538</td>
<td>204,493</td>
<td>$362,031</td>
<td>19%</td>
<td></td>
</tr>
</tbody>
</table>

(Table continues on next page)
### Profitability and Cost Management

#### Sample budget

<table>
<thead>
<tr>
<th>Sample budget</th>
<th>Annual budget</th>
<th>January</th>
<th>February</th>
<th>March through December</th>
<th>Year to date total</th>
<th>Year to date percent of budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount available for distribution to physician owners</td>
<td>$1,144,920</td>
<td>67,918</td>
<td>44,751</td>
<td>$112,669</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Physician salaries</td>
<td>$900,000</td>
<td>$60,000</td>
<td>$60,000</td>
<td>$120,000</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Physician distribution</td>
<td>57,255</td>
<td></td>
<td></td>
<td></td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Physician retirement contribution</td>
<td>107,700</td>
<td>6,600</td>
<td>6,600</td>
<td>$13,200</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Physician meetings and travel</td>
<td>23,750</td>
<td>1,980</td>
<td>2,562</td>
<td>$4,542</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>Physician other fringe benefits</td>
<td>56,215</td>
<td>4,848</td>
<td>4,985</td>
<td>$9,833</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>Total physician compensation and benefits</td>
<td>$1,144,920</td>
<td>$73,428</td>
<td>$74,147</td>
<td>$147,575</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Net income after physician distributions</td>
<td>$0</td>
<td>$(5,510)</td>
<td>$(29,396)</td>
<td>$(34,906)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


*Nine-part marketing model*

This action plan will help you to begin marketing your practice or enhance your current plan.

1. **Make marketing a priority.**
   
   Use this high-level checklist to stay on track with your practice’s marketing plan or help determine your strengths and weaknesses:
   
   - Marketing is a top priority for us.
   - We have a month-by-month marketing plan and budget.
   - We have a clearly defined geographic or other type of target market.
   - Our service mix is comprehensive for our target market.
   - We can describe the benefits we provide to our patients.
   - We have a well-defined, meaningful “edge” that differentiates our practice from the competition.
   - We have written an effective and compelling marketing message.
   - We have a Web site that gives good information about us and how to find us.
   - We constantly work to build and improve relationships with our referral base.
   - We have a variety of strategies to get visible in our target market.
   - Our marketing educates people about who we are and what we do.
– Our retail presence is an asset for us — visible, professional, welcoming and accessible.

– We recognize that our “brand” is built upon every interaction our patients and referral sources have with us.

– We have contracts with the largest and/or best-paying insurers in the area.

– We have strong relationships with our local hospital(s).

– We follow up with patients and referral sources to stay at the top of their mind.

2. **Lay a strong strategic foundation.**
   Answer these key strategic questions:
   – What are your goals?
   – What’s your marketplace like?
   – What’s your share of referral sources? Are there untapped areas for growth?
   – Who are your patients? Define your market as best you can by geography, payers and demographics.
   – What is your financial profile? Analyze your payer mix, accounts receivable and financial ratios to determine your profitability and where you may be losing money.
   – What is your service mix?
   – What sets your practice apart from other practices?
   – What proof can you offer to distinguish your practice? Use quality and outcome indicators, patient satisfaction surveys, awards, credentials and patient testimonials.
   – What is your marketing message?

3. **Build your referral base.**
   Be proactive. Visit with referral sources to plan ways to help each other succeed.

4. **Establish visibility in your community.**
   Build trust and credibility by informing patients and referral sources about the practice. Get involved in community issues; participate in community health fairs and screenings.

5. **Make your location welcoming.**
   The practice should be accessible and the interior comfortable and inviting.

6. **Develop your service strategy.**
   Monitor key service benchmarks, such as scheduling appointments, answering phones, registration, communication and referrals.
7. **Measure and improve your quality and utilization.**
   Quality can mean different things — measure what’s important to your practice or specialty and communicate the results.

8. **Improve hospital and insurer relations.**
   Build relationships with hospitals and insurers to gain visibility and increase revenues.

9. **Develop and follow a marketing action plan.**
   Successful practices establish annual, quarterly, and monthly marketing action plans detailing each activity, budget, and responsible party.

Reprinted with permission. Andrew Neitlich, The Healthcare Marketing Institute, Osprey, Fla. You can find more depth and detail about this topic at healthcaremarketinginstitute.com.

**Marketing strategies**

Corpus Christi Women’s Clinic (see practice success story earlier in this chapter) uses these approaches to stay in the public eye:

- Use the Yellow Pages and a Web site. Be where the shoppers look;
- Remember that word of mouth is it for an OB/GYN. Every patient visit is an opportunity for future business. Avoid bad patient experiences;
- Maximize public relations opportunities. Place physicians on “Ask a Physician” television shows, and encourage them to speak in public at civic meetings or women’s groups. Arrange media interviews with physicians about particular procedures;
- Concentrate on the right advertising spots. Calculate how many of your patients will see your message; and
- Ask for female vendor representatives. Recognize that the professional women who service your account will promote you via word of mouth.

**SUMMARY**

This chapter introduced a few concepts associated with costs, planning, managing payers and marketing your practice. You should now see that cost management can be a vital and innovative process in any medical practice and that without planning, a practice may not be able to fulfill its obligation to patients and its vision of delivering the best care.

Politics aside, insurance payer relationships remain crucial to getting paid at appropriate rates. More importantly, you can influence those relationships in a positive manner.

And, without patients your practice would not survive. Marketing tactics affect your practice’s profitability. Introducing new ideas or improving existing marketing efforts will allow you to maintain a sustainable patient base.
DISCUSSION TOPICS

Practice what you just learned with the discussion topics.

1. Review the practice's strategic plan and see how the operational plan and budget correspond to it.
2. What does your practice's marketing plan look like? What can you suggest to either create a marketing plan or improve the existing plan?
3. How many insurance payers (in addition to Medicare) does the practice work with? Are the contracts up for renewal soon? What can you suggest doing before the contracts are signed?

GLOSSARY

**Budget** – A financial plan that supports the operation plan and includes income and expenses.

**Direct Costs** – Costs that can be traced or created by a service, product or activity.

**Fixed Costs** – Costs that do not change with activity level.

**Indirect Costs** – Costs that support the practice but cannot be traced to only one service, product or activity.

**Operation Plan** – Short-term goals that support the broader goals in the strategic plan.

**Strategic Plan** – Long-term goals and objectives that cover a period of five to 10 years.

**Variable Costs** – Costs that vary with volume or activity level changes.

BENCHMARKING DATA FROM MGMA SURVEY REPORTS

Better-performing practices take steps to improve their processes. Data below shows results from the MGMA *Performance and Practices of Successful Medical Groups: 2008 Report Based on 2007 Data*.

<table>
<thead>
<tr>
<th>Business operations and financial management – survey results</th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Major capital investments made by the practice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acquired equipment and materials to provide new ancillary services</td>
<td>28.97%</td>
<td>22.60%</td>
</tr>
<tr>
<td>Acquired new practice management system/upgraded the existing system</td>
<td>15.17%</td>
<td>15.87%</td>
</tr>
</tbody>
</table>

(Table continues on next page)
### Business operations and financial management – survey results

<table>
<thead>
<tr>
<th>Action</th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquired lab equipment</td>
<td>13.79%</td>
<td>7.73%</td>
</tr>
<tr>
<td>Acquired nuclear equipment</td>
<td>4.83%</td>
<td>4.35%</td>
</tr>
<tr>
<td>Acquired new electronic medical record (EMR)/electronic health record (EHR)</td>
<td>10.27%</td>
<td>12.02%</td>
</tr>
<tr>
<td>Acquired new providers or merged with another practice</td>
<td>32.41%</td>
<td>23.67%</td>
</tr>
<tr>
<td>Built new, acquired or expanded clinic facilities</td>
<td>27.40%</td>
<td>15.38%</td>
</tr>
<tr>
<td>Installed new phone system</td>
<td>20.69%</td>
<td>10.14%</td>
</tr>
<tr>
<td>Opened and made investment in ambulatory surgery center</td>
<td>3.45%</td>
<td>2.42%</td>
</tr>
<tr>
<td>Purchased property</td>
<td>4.83%</td>
<td>4.83%</td>
</tr>
<tr>
<td>Remodeled existing facilities</td>
<td>32.41%</td>
<td>22.12%</td>
</tr>
<tr>
<td>Did not make any capital investments</td>
<td>16.55%</td>
<td>20.77%</td>
</tr>
</tbody>
</table>

**Actions taken to advertise or market the practice**

<table>
<thead>
<tr>
<th>Method</th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ad campaign</td>
<td>33.10%</td>
<td>32.21%</td>
</tr>
<tr>
<td>Articles in local newspapers</td>
<td>46.90%</td>
<td>48.33%</td>
</tr>
<tr>
<td>Community health fairs/screenings</td>
<td>45.52%</td>
<td>37.32%</td>
</tr>
<tr>
<td>Direct mail</td>
<td>24.14%</td>
<td>20.67%</td>
</tr>
<tr>
<td>Internet (practice Web site)</td>
<td>69.18%</td>
<td>58.85%</td>
</tr>
<tr>
<td>Letters or postcards to referring physicians</td>
<td>20.00%</td>
<td>13.88%</td>
</tr>
<tr>
<td>Newsletter to patients</td>
<td>13.79%</td>
<td>12.56%</td>
</tr>
<tr>
<td>Open house</td>
<td>13.79%</td>
<td>14.90%</td>
</tr>
<tr>
<td>Radio advertising</td>
<td>21.38%</td>
<td>20.77%</td>
</tr>
<tr>
<td>Television advertising</td>
<td>13.79%</td>
<td>14.01%</td>
</tr>
<tr>
<td>Visits with referring providers and their staff</td>
<td>42.47%</td>
<td>29.81%</td>
</tr>
<tr>
<td>Yellow pages – book</td>
<td>71.03%</td>
<td>72.73%</td>
</tr>
<tr>
<td>Yellow pages – online such as DexOnline</td>
<td>27.59%</td>
<td>26.79%</td>
</tr>
</tbody>
</table>

(Table continues on next page)
### Business operations and financial management – survey results

<table>
<thead>
<tr>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of the above</td>
<td>4.83%</td>
</tr>
<tr>
<td>Other</td>
<td>9.66%</td>
</tr>
</tbody>
</table>

#### Most effective means of attracting new patients to the practice

<table>
<thead>
<tr>
<th>Most effective means</th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advertising</td>
<td>3.01%</td>
<td>1.12%</td>
</tr>
<tr>
<td>High patient satisfaction</td>
<td>14.29%</td>
<td>17.88%</td>
</tr>
<tr>
<td>Market presence</td>
<td>7.52%</td>
<td>9.50%</td>
</tr>
<tr>
<td>Referrals from established patients</td>
<td>24.81%</td>
<td>18.99%</td>
</tr>
<tr>
<td>Referrals from other physicians</td>
<td>45.11%</td>
<td>44.13%</td>
</tr>
<tr>
<td>Web site</td>
<td>3.01%</td>
<td>1.68%</td>
</tr>
<tr>
<td>Other</td>
<td>2.26%</td>
<td>5.03%</td>
</tr>
</tbody>
</table>

Use the following financial measurements against those of your practice to help improve revenue and manage costs. The data table below presents median, better-performing practices data and median MGMA Cost Survey Report data for a subset of specialties\(^1,2,3\).

<table>
<thead>
<tr>
<th></th>
<th>Multispecialty</th>
<th>Cardiology</th>
<th>Orthopedic Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BP*</td>
<td>Cost Survey</td>
<td>BP*</td>
</tr>
<tr>
<td>Total gross charges per full-time-equivalent (FTE) physician</td>
<td>$1,284,930</td>
<td>$1,076,662</td>
<td>$3,114,200</td>
</tr>
<tr>
<td>Total RVUs per FTE physician</td>
<td>14,374</td>
<td>12,231</td>
<td>36,777</td>
</tr>
<tr>
<td>Physician work RVUs per FTE physician</td>
<td>6,855</td>
<td>6,024</td>
<td>12,611</td>
</tr>
<tr>
<td>Total medical revenue per FTE physician</td>
<td>$779,161</td>
<td>$690,032</td>
<td>$1,387,198</td>
</tr>
<tr>
<td>Total medical revenue after operating cost per FTE physician</td>
<td>$339,885</td>
<td>$272,460</td>
<td>$752,850</td>
</tr>
</tbody>
</table>

*(Table continues on next page)*
### Profitability and Cost Management

<table>
<thead>
<tr>
<th></th>
<th>Multispecialty</th>
<th>Cardiology</th>
<th>Orthopedic Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BP*</td>
<td>Cost</td>
<td>BP*</td>
</tr>
<tr>
<td>Total medical</td>
<td>$309,905</td>
<td>$255,064</td>
<td>$706,006</td>
</tr>
<tr>
<td>revenue after operating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and nonphysician provider (NPP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cost per FTE physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total operating cost</td>
<td>56.27%</td>
<td>61.19%</td>
<td>47.44%</td>
</tr>
<tr>
<td>as a percent of total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>medical revenue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total operating</td>
<td>$441,010</td>
<td>$428,238</td>
<td>$700,672</td>
</tr>
<tr>
<td>cost per FTE physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total operating and</td>
<td>59.41%</td>
<td>65.11%</td>
<td>51.46%</td>
</tr>
<tr>
<td>NPP cost as a percent of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>total medical revenue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total operating and</td>
<td>$469,131</td>
<td>$467,591</td>
<td>$731,751</td>
</tr>
<tr>
<td>NPP cost per FTE physician</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Better–performing practice*


APPENDIX

Visit mgma.com/lessons for interactive tools that will help you practice the concepts presented in this chapter.

Special recognition goes to our advisory board members who reviewed and approved the content:

Alan J. Beason, MS, FACMPE, Chief Executive Officer / Administrator, Cardiovascular Consultants LLP, Shreveport, LA

Emily Callaway, CMPE, Executive Director, Morton Plant Mease Primary Care Inc., Clearwater, FL

Susan Gardner, Project Manager, Northwest Permanente PC, Portland, OR

Anders Gilberg, Vice President of Public and Private Economic Affairs, MGMA, Washington, DC

Ina Roberts, Chief Operating Officer, Aurora Denver Cardiology Associates PC, Aurora, CO

Frederic Simmons, CPA, CMPE, Chief Executive Officer, Clearwater Cardiovascular & Intervention Consultants, Clearwater, FL

Lee Ann Webster, MA, CPA, FACMPE, Practice Administrator, Pathology Associates of Alabama PC, Birmingham, AL