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## Keeping Medical Practice Overhead Down

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By [Karen Appold](#) [5]

In light of rising costs to do business, physicians are looking for ways to cut costs while sustaining quality patient care.

**Source:** Physicians Practice

According to the 2016 *Physicians Practice* Physician Compensation Survey, 40.4 percent of survey respondents said their overhead is 41 percent to 60 percent of medical practice revenue. In comparison, 32 percent of respondents from last year's survey cited the same percentage of overhead. That means, over a period of one year, 8.4 percent more survey respondents said they were experiencing overhead costs that were close to or exceeding half of their practice revenue.

"Expenses related to goods and services always seem to go up, such as employee salaries, rent, utilities, and supplies," says Steven Fisher, an internist at Fairfield County Medical Group in Trumbull, Conn. "Therefore, the cost of doing business goes up. But unlike most businesses that can pass along increased expenses to consumers, primary-care physicians can't do that because of governmental regulations and the way that health insurance companies operate."

Paying staff to perform administrative duties probably tops the list of overhead expenses. "Physicians and their staff spend a growing amount of time ensuring that quality and performance measures are collected, documented, and reported," says Marc Mertz, vice president of El Segundo, Calif.-based GE Healthcare Camden Group. "Due to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), requirements will continue to increase. Practices have also invested in EHR systems that support data collection and reporting, resulting in more administrative work."

What's more, "primary-care physicians are tasked with providing referrals and getting pre-authorizations for diagnostic testing and prescriptions," Fisher says. "In addition, given that many health plans now have high deductibles, practices have to chase patients to pay for services — sometimes billing them multiple times. In the past, insurance companies paid them directly."

### Lowering overhead

According to the survey, overhead is going up while personal income is staying the same (40 percent) or going down (28.7 percent). So what can practices do to keep overhead down?

Fisher recommends examining every line item on your profit and loss statement, and seeing where you might be able to spend less or where you might be wasting money. For example, you can shop around for better prices on malpractice insurance. Physicians at Fisher's practice saved \$5,000 on

malpractice premiums, and gained CME credit by taking courses on reducing malpractice risk that were offered by the insurer.

Another strategy Fisher's practice employs is requiring all patients with high-deductible plans to keep a credit or debit card on file. "This way, we don't have to bill patients; instead, we can charge their card," he says. "We always collect everything we're entitled to while keeping administrative costs down. If a patient doesn't want to provide a card, he is required to pay the estimated amount of the visit at the time of service or he can't be a patient. Most patients don't have a problem with this because we explain that this keeps costs down by not having to bill and rebill them."

Charlene K. Mooney, a consulting executive with Halley Consulting Group, a practice management and consulting firm in Columbus, Ohio, is also a proponent of implementing a policy to collect payments at the time of service. "Train staff how to ask for money, since this can be uncomfortable, yet effective," she says. "Don't ask 'Do you want to pay your copay today?' Instead, say 'Your copay is this amount. How would you like to pay it today? We take cash, check, or credit card.'"

Mooney also recommends asking staff to offer suggestions and help create a plan of action for patient collections. "Without [staff] buy-in, it can be difficult to bring about improvement," she says.

Take a good look at your office — are you using all available space? Could you use more space? If you can afford to expand your office, perhaps you could add another exam room or sublease some space to another provider, Mooney says.

She also suggests tracking charges from companies that provide equipment, supplies, and services — such as laundry or waste management. "Periodically look at renegotiating the contract or even checking out other [service] providers," Mooney says. "If you need equipment, leasing versus purchasing may be more economical."

When hiring staff, make good decisions so that you don't have to incur turnover costs, Mooney says. Cross-train employees so when absences occur, staff can fill in for each other. Then, employ measures to retain good staff members by making sure that you offer a pay scale and benefits package that is competitive with your market.

"Consider ways to decrease [staff] health insurance costs, such as increasing deductibles, co-pays, or premiums, or making adjustments in types of coverage," Mooney says.

## **Increasing revenue**

One way to boost your revenue is to retain existing patients. In order to achieve this, you must offer outstanding customer service. "Every staff member from the receptionist to the provider must be committed to serving each patient to their best ability — making them feel welcome, communicating with them at every encounter, and providing quality care and treatment," Mooney says.

Consider adding advanced practice providers. A nurse practitioner or a physician assistant can increase patient volume and free up physicians to see more complex patients, Mooney says.

Another strategy to get more money coming in is to assess your scheduling methods. "Optimize time slots to reflect a good flow of patients," Mooney says. "Training your staff to schedule more effectively is beneficial."

It's also important that patients keep their follow-up appointments. "Have someone make sure patients who need regular appointments for testing, bloodwork, and medication refills come in as necessary," Mooney says. "Call no-shows to make sure they know they missed an appointment and reschedule them."

Another tip is to offer new services. "Adding imaging and laboratory services can provide convenience as well as eventually bring in additional revenue," Mooney says. Furthermore, consider performing in-office tests, such as hearing, asthma, and drug screens.

Michael Munger, president-elect of the American Academy of Family Physicians, and practicing family physician at Saint Luke's Medical Group in Overland Park, Kan., advises making sure you code for as many services and procedures as possible. For example, make sure Medicare patients receive an Annual Wellness Visit every year, which is a reimbursable service through CMS. When seeing a patient following a hospitalization, use a code for transitioning of care.

### **Surviving as an independent practice**

With medical practices facing such high overhead, independent practices are finding it more challenging to survive. "We're already beginning to see the impact of rising overhead and population health/value-based reimbursement on independent practices," Mertz says.

Mertz says small practices that cannot afford to invest in information technology, reporting, and other population health capabilities are at a disadvantage as more of their revenue is placed at risk under performance and value-based contracts.

John Meigs, Jr., president of the American Academy of Family Physicians and practicing family physician at Bibb Medical Associates, Centreville, Ala., believes that some physicians left independent practice for employed practice due to the uncertainty of transitioning from volume- to value-based payment as required by MACRA, because they desired the stability of employed status. "However, *after the transition* and *when* family physicians are paid commensurate with the value they bring to the healthcare system, then I think some physicians and practices will opt to return to independent practice," he says.

Munger is also optimistic. "Moving forward, it will be helpful when independent practices, particularly small ones, start to receive payments for care coordination," he says. Care coordination involves managing Medicare patients with chronic conditions, which includes the transition of care from a hospital or another healthcare facility to a community setting. It also involves advance care planning for Medicare beneficiaries whose medical and/or psychosocial problems require moderate- to high-complexity medical decision making. "As primary-care practices evolve and incorporate these services into their infrastructure, payment will follow," Munger says.

### **Traditional independent physician models change**

Looking ahead, Mooney expects more independent practices to become affiliated with other groups or practices. "It might be beneficial for a practice to enter into a contract with a hospital or health system to provide services," she says.

Along these lines, Mertz says, "I think there will be opportunities for independent practices to develop population health service organizations that can support smaller practices with cost-effective solutions that will help them survive under value-based care models."

Mertz advises looking for contracting opportunities that provide financial incentives for reporting quality and performance measures. "Joining a network, such as a clinically integrated network, can help a group access these contracts," he says. "Clinically integrated networks can also provide some of the population health tools and resources that a group needs to be successful under these contracts, often at a lower rate than the group would otherwise pay." Also, be sure to look into CMS' new payment models, such as Comprehensive Primary Care Plus (CPC+) and Chronic Care Management (CCM) services, which provide enhanced primary-care reimbursement.

Munger also sees strength in numbers, and predicts that independent practices will develop partnerships and networks revolving around quality of care. This might be through an arrangement with an independent practice association, in which a practice could associate with other independent practices to leverage economies of scale for contracting. Practices might also join together to increase their power to purchase supplies at discounted rates or obtain better rates for employee benefits.

There's also been a shift toward a direct primary care model. Meigs points to a 2015 survey by AAFP that reports nearly 3 percent of independent family physicians said they opted to work within a direct primary care model. Another 1 percent said they were in the process of transitioning to direct primary care. "Direct primary care rewards family physicians for caring for the whole person while reducing overhead and negative incentives associated with fee-for-service, third-party payer billing," he says. "Other benefits to physicians include fewer medical errors and less exposure to risk, improved practice collection rates, more time with patients, reduced patient volume, and zero insurance filing."

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