Four-square

Practice profitability stands on four foundations

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Like a table that needs each of its four legs to remain level and solid, a medical practice’s profitability stands firmly on a quartet of attributes: physician productivity, accounts receivable (A/R), overhead costs and ancillary revenue. Weakness in any one of these areas can tip the table’s surface but keep it functional. Weakness in two of the four legs can cause a practice to collapse.

How stable is your organization’s financial furniture?

Physician productivity: Set a full table

The medical specialty will determine how many patients make a full table for a particular physician. Specialists rely on demand for their services from referral sources: other physicians, hospitals, emergency rooms. Primary care providers must be able to generate patients on their own, generally via word-of-mouth from current satisfied patients. With the exception of plastic surgeons, I’ve never seen advertising have much effect on demand for a physician’s services.
So, for example, an ophthalmologist might be able to see 30-40 patients a day, but a neurosurgeon’s table is full with 10-15 patients a day. A physician has to be willing to do what it takes to meet his/her income needs, and s/he must know those productivity numbers from the start. If doctors aren’t sure of those numbers, assist them by checking a resource such as the Medical Group Management Association Cost Survey Report.

Once a practice has patient demand figured out, you — the administrator — must decide on the most efficient way to get patients in and out the door. You don’t want big gaps between one patient and the next, but you don’t want people waiting hours to see the doctors, either. Consider techniques such as wave scheduling, which front-loads appointments at the start of each hour, or open-access scheduling, which maximizes your office’s daily capacity and eliminates a backlog of appointments. Overall, you want to keep patients happy, maintain clinical quality and maximize capacity.

Payer mix plays a key role in physician productivity. Your group’s ability to negotiate with insurers — based on specialty, practice size and reputation — will influence the number of contracts you have and the number of patients those contracts bring in. The demographics of your patient base will affect your gross reimbursement. If you’re in an area that serves mostly Medicaid patients, you’ll most likely have lower practice income than a group drawing mainly private-pay patients. Payer mix is malleable to a degree — you have a say in which payer panels you participate — but it’s also subject to demographics and to competition.

What’s the mix of new and established patients in your practice? If it’s full with established patients, it will die in short order. I like to see at least 10 percent to 15 percent new patients coming into an office over any period of time. If you don’t keep new people coming in, your support will literally die off. Every practice manager and physician needs to stay alert for the danger sign of too many established patients.

Once a practice starts to get full, physicians need to decide whom they’re going to serve. The group may want to change payer sources to keep new people coming through the door.
Controlled A/R aging pivotal

The delicate task of A/R aging plays a pivotal role in a medical practice’s financial health. Let accounts get too old and the organization’s profits decline. And the longer money stays in A/R, the less chance a practice has of collecting it.

A 2001 survey conducted by the Commercial Collection Agency Section of the Commercial Law League of America found that the probability of collecting a delinquent account drops sharply with the length of delinquency (see graph). After 90 days, a practice has only a 73.1 percent probability of collecting its money. By six months the odds drop to 57.8 percent.

When a medical group’s A/R gets out of whack, an administrator needs to find the source of the problem and fix it. Start at the big end of the funnel and work to the smaller end. First, you want to compare how much your practice has in each respective A/R bucket — current accounts, accounts 30-60 days old, 60-90 days, 90-120 days and more than 120 days — to industry standards. Look at the grand total first — how much in receivables do you have in each of those aging buckets according to your specialty? Variance might or might not be a problem.

For example, MGMA’s Cost Survey Report gives 21.51 percent as the median an internal medicine practice should have its A/R in the over-120-days bucket. If your internal medicine group’s percentage is higher than that, you need to find the source of the problem. Once you determine the out-of-range numbers, you have to get more specific and find out why they’re higher. Are there certain classes of patients whose accounts fall into that aging bucket more than average? Can you break down the problem by insurer? Is it a programming error on the part of your billing department?

Break down the patient balances, too. You may need to tweak patients’ credit balances to bring your A/R figures into line.

Don’t let practice overhead overwhelm you

When your practice’s physicians complain that they’re not making enough money, look at overhead as one possible source of the profit drain. Because your doctors’ earnings drive the bottom line, you want to maximize those dollars and protect them from loss.
The organization’s overhead is one place to look for erosion of profit. Is your overhead appropriate for the types of services your practice provides? Start by looking at overhead ratios. Again, MGMA’s *Cost Survey Report* provides benchmark figures, listing median overhead costs by expense item as well as by practice size, region and type.

Subtract the physicians’ costs from the overhead to get factors you can control, such as personnel expenses. Such costs will differ by specialty. See whether your ratios — fixed vs. variable costs — are in line with industry standards.

It’s not necessarily a problem if your group’s overhead is high compared with industry norms. Some medical groups singled out as MGMA better-performers have very productive physicians with high overhead ratios. This may indicate that a physician uses nurse practitioners and/or physician assistants to expand productivity, or that s/he has ancillary services available. These doctors’ overhead is high, but so is their net income.

Employee salaries and rent are the largest costs in any medical practice. Some specialties, such as ophthalmology, will have hefty expenses for office medical equipment; others, such as neurosurgery, will have low equipment costs. Figure the percentage of physician salary vs. overall revenue, rent vs. revenue, nonphysician salaries vs. revenue, and so on. Compare your status for each expense against an established benchmark.

Some specialties, such as family practice, can have overhead that is too low. Too few employees may unnecessarily stretch the capacities of the workforce. Appropriate overhead is a good thing for the revenue you’re generating. It’s an art to know when to hire as overhead increases.

Therefore, review your overhead figures frequently. An administrator should regularly share with physicians the overhead percentages. Put these numbers on the practice’s profit and loss statements — for two years running — so that readers can make comparisons. Doctors need to look routinely and often at those costs.

**Ancillary services keep the cash register ringing**

The fourth leg of a practice’s financial table is revenue from ancillary services. What additional income can you produce without your physicians personally performing the services? Depending
on the type of practice, ancillary services may include diagnostic testing, X-ray, laboratory tests, magnetic resonance imaging (MRI), computerized axial tomography (CAT) or specialty clinics. Establishing ancillary services may call for a joint venture with a hospital or another group practice. You may need to build, buy or rent an additional facility. Ancillaries may increase your overhead ratio but can offset that with higher profit.

Keep in mind that physician extenders — such as physician assistants and nurse practitioners — can serve as ancillary service providers, freeing physicians for direct patient care.

Ancillary opportunities will most likely come with various issues:

- **Management** — Will you need to give staff specialized training? Hire additional staff? Adjust scheduling for employees?
- **Legal/regulatory** — Could your ancillary service(s) violate the Stark law? Antikickback provisions? Will you need to obtain licenses or certificates?
- **Payer** — Will insurers cover the new services you want to provide? Some ancillary services will require your group to establish special contracts with payers.
- **Moral/ethical** — Will your new services take business away from current providers, such as community health centers? Will your group be seen as a community raider?
- **Quality** — Can competitors — such as local hospitals — provide the same service at higher quality? Will stretching the capabilities of your staff compromise your group’s quality?

Check with a good health care attorney before taking on supplementary services to ensure that your endeavor remains above board.

Close and consistent attention to the four foundations of practice profitability will keep your group’s financial table level and strong.

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**Ancillary services can cushion the bottom line**

An MGMA Information Exchange — an informal survey of medical practices with at least one MGMA member — reveals that groups derive an average of 14.5 percent of their revenue from...
ancillary services. Of the 159 practices surveyed, laboratory tests, X-rays and ultrasounds composed the most common supplemental services. Other popular ancillary services (varying by practice type) included:

- Electroencephalograms;
- DEXA scans (bone density);
- Stress tests and echocardiograms;
- Nuclear medicine procedures;
- Physical therapy;
- Mammograms and biopsies; and
- CAT, MRI scans.

Source: MGMA’s Information Exchange "Ancillary Services"