

Business Basics for Physicians

Crystal Zuzek

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Practice Management Services



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with

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Physicians Caring for Texans

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Business Basics for Physicians

Dear Doctor,

Physicians face more regulatory and administrative burdens than ever before, and with those challenges comes the need to better understand the intricacies of the business side of medical practice. The Physicians Foundation is dedicated to advancing the work of practicing physicians and to strengthening the patient-physician relationship by developing practical education and tools that empower physicians and help them maintain a successful practice while focusing on their passion: caring for patients.



Louis J. Goodman, PhD

In the current atmosphere, it is imperative that physicians are able to identify and utilize key performance indicators in order to assess and manage the financial health of their practice. This is particularly true for solo and small practices, which often must implement cost control measures, master payer and regulatory hassles, and continuously increase revenues while relying on limited business training or support staff.

Business Basics for Physicians helps physicians make strategic business decisions about the future of their practice to ensure the practice's financial viability. In addition to this publication, The Physicians Foundation is proud to support related initiatives including a financial dashboard tool, which provides snapshots of key performance measures and benchmarks most indicative of a practice's vitality, as well as seminars and webinars that teach physicians how to make practice improvements based on those measures.

We hope that you find the publication and other resources useful in navigating the business side of the ever-changing health care environment.

Sincerely,

A handwritten signature in black ink that reads "Louis J. Goodman". The signature is written in a cursive, flowing style.

Louis J. Goodman, PhD

President

The Physicians Foundation

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CME Accreditation

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The Texas Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

TMA designates this enduring activity for a maximum of 3.5 *AMA PRA Category 1 Credits*[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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This credit is available for the period of March 1, 2014, through March 1, 2017.

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Course Objectives

Upon completion of this self-study program, the reader should be able to:

- ◆ Develop leadership skills and undertake the business responsibility of owning a practice;
- ◆ Understand, monitor, and assess the revenue cycle; and
- ◆ Make decisions pertaining to managing an efficient medical practice.

Audience

This course is appropriate for physicians, nonphysician practitioners, and office staff in all specialties.

CME Instructions

This copy of *Business Basics for Physicians* is complimentary.

To claim CME for this publication:

1. Read the course in its entirety. Go to www.texmed.org/businessbasicsCME.
2. There will be a CME processing fee. Sign in, add the item to your cart, and complete the purchase.
3. Complete the online post-test with a minimum 70-percent passing score and the evaluation.
4. CME credit will be recorded upon completion of the test. Documentation will be sent to the reader's email inbox, or you can print it directly from the website.
5. Direct questions or concerns to the TMA Education Center at (877) 880-1335 or support@inreachce.com.

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Business Basics for Physicians

Introduction

The art of medicine has compassion and healing at its roots. The business of medicine has money at its core. In training, physicians focus on the art and science of medicine but have little time to study the business side of their profession. This reality of medical education is unfortunate, given the countless innate complexities and regulations of the business of health care and their potential impact on a physician's bottom line. Physicians need a crash course in business now like never before. After graduating from medical school and completing residency, newly licensed physicians confront an industry characterized by declining revenues and the uncertainty of health system reform. To survive and thrive in today's health care environment, physicians need to understand how to control costs and increase revenue for their business while navigating an ever-changing managed care and regulatory atmosphere. Whether a physician has a solo practice or works in a large specialty group, knowing how to measure the business' fiscal health is just as important as managing patients' physical health.

Hiring and managing staff, developing and adhering to a budget, crafting administrative policies and procedures, monitoring expenses, and promoting the practice represent foreign territory for many physicians. A grasp of fundamental business principles will benefit physicians financially and help them establish a competitive advantage in the health care marketplace. The Texas Medical Association *Business Basics for Physicians* guides physicians in setting the vision, direction, and policies that help ensure practice viability. This book will help them gain a basic understanding of financial management, business planning, working with payers, and adopting an electronic health record (EHR) system.

CHAPTER ONE

Establishing the Medical Practice

OVERVIEW

Corporate Structures

TIN or EIN

Functions of Practice Leaders

Selecting a Corporate Structure

Whether their governing structure is established independently of other organizations, owned by a hospital, or set up as a partnership of shareholders, physicians usually have supervisory and administrative responsibilities to fulfill within their practice.

Typical practice legal structures are:

- ◆ Sole proprietorship,
- ◆ General partnership,
- ◆ Limited liability partnership (LLP),
- ◆ Corporation,
- ◆ Professional limited liability company (LLC).¹

The choice of legal organization will have financial, legal, and tax ramifications. The decision of what structure to use will depend on the needs of the physician and the group. Competent legal counsel can help the physician determine which option fits best — sole proprietorship, partnership, or corporation.

Sole Proprietorship

A sole proprietorship is not a separate legal entity; it is one owner (also can be a husband and wife) with an unincorporated business. Income and losses are part of the physician's personal tax return. Although the proprietorship may obtain a separate tax identification number for payroll tax purposes, creating a sole proprietorship requires no national or state filings. This type of entity has no personal liability protection from claims against the practice. The largest risk of exposure for most physicians is medical liability, and no entity protects physicians from their own acts that result in medical liability claims.

1. Pavlock, Ernest. *Financial Management for Medical Groups* (2nd Ed.). MGMA Center for Research, 2000, Pg. 20.

No one else can own a part of the sole proprietorship; if the physician plans to add partners or expand, this entity would not be the best choice. Health care payment plans identify physicians through the tax identification number, and changing the legal structure would require starting over with enrollment and credentialing. The sole proprietorship is not subject to Texas franchise taxes.

General Partnership

Partnerships are unincorporated businesses involving multiple owners. Although partnerships are easy to form, the more time and expense spent during formation, the less time, money and potential litigation will be involved in dissolution. General partnerships are not subject to Texas franchise taxes, and each partner pays tax on his or her shares of the partnership income and loss whether received or not. The partnership files an “information federal income tax return” but pays no tax. Limited medical deductions are allowed to the partners, and retirement plans also have limited deductions. When physicians form partnerships, each general partner is fully liable for the business debts, liabilities, and torts of the partnership. For example, if one partner is sued for medical liability/personal injury and the claim names the partnership, all the partners’ assets will be subject to seizure. General partnerships are rarely an appropriate entity for medical practices.

Limited Liability Partnership

This form of general or limited partnership registers with the state to obtain limited liability for its partners. A partner in an LLP is not individually liable for torts arising from the actions of another partner. The partners are liable for the contractual debts and other liabilities and obligations of the partnership. At the time of this publication, the LLP must maintain liability insurance coverage with a minimum limit of \$100,000. Ideally, each partner should be represented by his or her own health care attorney when negotiating partnership agreements.

The LLP does not pay income taxes; income and losses are passed on to the individual partners, typically based on the percentage of ownership. The LLP files a tax return to report the amounts passed through to the individual partners. In this arrangement, new owners purchase interest in the partnership from the existing owners. Each time a new partner is added to the partnership, there will be tax consequences for each partner. LLPs are subject to Texas franchise taxes.

Corporation/Professional Association

In Texas, a professional association (PA) is similar to a corporation except that it is the form under which physicians can choose to practice medicine. The business organization is a legal entity separate and distinct from its owners. It is fairly complex to form and dissolve, with fees due upon filing with the Texas secretary of state. Corporations can be structured as C- or S-corporations, which are subject to Texas franchise taxes, or as 501(a) nonprofit health care corporations.

Owners (shareholders) are shielded from corporate liability including the debts of others and the medical liability for professionals not directly supervised by that

shareholder. Corporate bylaws, rather than a partnership agreement signed by the owners, provide the entity's governance. A PA is often a good option for a solo physician who plans to expand the practice over time. It is easy to add new physicians with no tax consequences because the corporation issues new stock directly to the new owner.

TIP

General partnerships are rarely an appropriate entity for medical practices.

C-Corporation. A C-corporation is required to file income tax returns at the corporate level. The corporation will seldom have a significant taxable income because salaries paid to the corporation's staff (including the physician owners) are tax-deductible expenses. For C-corporations, medical expenses are fully deductible, and retirement plans have greater deductions available.

S-Corporation. A corporation can be structured as an entity that elects to be taxed under Subchapter S of the Internal Revenue Code. Called an S-corporation, this entity files an information federal income tax return but pays no tax. The shareholders are taxed on their shares of the corporate income and loss, regardless of whether it is received. There are strict limitations on the types of shareholders; the maximum number of shareholders allowed is 35. As with partnerships and proprietorships, there is limited deductibility of medical expenses and for retirement plans.

501(a) Corporation. The 501(a) was established as a nonprofit corporation under Section 501(a) of the Texas Medical Practice Act. It was allowed as an exception to the Texas "corporate practice of medicine doctrine," which ordinarily would preclude nonphysicians from owning an interest in a medical practice. Typically, one of the shareholders (members) is a hospital, and the officers and directors are physicians. While the nonphysician shareholder(s) may exercise decisionmaking authority over financial matters, by law the physicians must make all the medical decisions. The corporation is exempt from Texas franchise taxes and also may qualify as a nonprofit organization for federal income tax purposes. If qualified, the corporation pays no federal income tax. Employees are taxed on their shares of corporate income and loss.

Professional Limited Liability Company

This hybrid entity has attributes of partnerships and corporations. It has greater flexibility than corporations in allocating distributions, and the owners (members) are not liable for LLC liabilities, including the torts (medical liability/personal injuries) and debts of others. An operating agreement governs the rights and duties of the individual owners of the LLC. This entity is subject to Texas franchise taxes.

If structured as a partnership for federal tax purposes, the LLC (also referred to as PLLC or LC) files an informational federal income tax return but pays no tax. Members are taxed on their shares of LLC income and loss regardless of whether they have received it. For tax purposes, this is treated as a proprietorship, and there is limited deductibility for medical expenses and retirement plans.

If structured as a corporation for federal tax purposes, the LLC pays federal income tax on the LLC income, and owners are taxed on the income and/or dividends they received. As with corporations, medical expenses are fully deductible, and greater deductions are available for retirement plans.

Solo physicians who form an LLC can expand their practice and bring in new owners. However, new members must purchase interest from existing members, which will trigger tax consequences for the existing members.

Tax Registration and Identification

Regardless of the business structure, once the physician has decided on the legal organization, the next step is to obtain a federal tax identification number (TIN) or an employer identification number (EIN). Medicare and other health care payment plans will use the TIN/EIN to identify the physician and the organization for tax purposes. To obtain a number, the physician must file Internal Revenue Service (IRS) Form SS-4 in person, by mail, online, or by fax. Processing by mail takes four to five weeks. If the physician uses the services of an attorney to incorporate the business, the law firm must complete the TIN/EIN on the physician's behalf.

Form SS-4 is available from a Social Security office or IRS office, or at www.irs.gov/Forms-&Pubs, or by calling the IRS at (800) 829-4933.²

Tax Planning and Implications

Running a medical practice like a business is even more important in today's environment of greater regulations, increasing costs, and shrinking revenues. Proper tax planning from inception of the practice can greatly help keep more revenue in the hands of the physician. Physicians should base their choice of taxable entity for their medical practice on sound advice from tax professionals and legal advisors.

While the PLLC and the LLP seem to be common choices, they may not be the best for minimizing taxes. If a medical practice has or will have physicians or other professionals who bill for their services and who don't own the business, an S-corporation might be the best choice. An S-corporation may provide a lower net-income payroll tax to the owner or shareholder physician of the S-corporation. In this arrangement, the physician owners should not have to pay themselves as large a salary as the net income of the practice. The owner or shareholder would earn a salary for a portion of the S-corporation net income and take the remaining net income (after the salary expense) as a corporate distribution not subject to payroll taxes. While this arrangement doesn't result in income tax savings, a substantial payroll tax savings is possible in that the remaining net income is not subject to payroll taxes. For owners in a PLLC or LLP, the net income of the practice is subject to the income tax and the self-employment (payroll) tax. The payroll tax for many doctors is significant in addition to the income tax.

2. Stern, Michael Z., Law Office of Hubert Bell, Jr., Austin, Texas.

Some medical practices operate as sole proprietorships with no separate legal entity status. This may not be appropriate for medical liability risk on some levels of service the practice provides to patients. Physicians should seek legal counsel. In addition, the self-employment tax (comparable to the payroll tax for Medicare and Social Security taxes paid by employers and employees) may be unnecessarily high because all of the sole proprietor's net income is subject to the self-employment tax.

Physicians need to have an understanding of the potential income tax they will face each year to ensure proper income tax withholding from salaries and/or estimated tax payments to avoid a large, unexpected, and unbudgeted tax bill. Proper, timely tax advice is important to minimize taxes each year, and diligent planning will help protect and increase assets. Physicians should keep in mind that all planning begins with having accurate and timely financial statements.

Governance

A medical practice's leadership structure governs business operations and affects the practice's long-term development and daily functions. Larger practices may choose to create a board of directors to evaluate the practice's business direction and strategy. Regardless of how a group is set up, physicians should consult an attorney and a certified public accountant (CPA) to ensure compliance with tax laws, the Stark law, antikickback laws, the False Claims Act, and antitrust laws.³

To help ensure the medical practice operates efficiently and effectively, physician leaders should perform the following functions:

1. Establish and monitor an appropriate corporate legal structure for the organization;
2. Maintain proper corporate recordkeeping of strategic decisions;
3. Integrate the practice's corporate mission statement into all aspects of the organization;
4. Develop the practice's strategic plan, and implement it;
5. Establish, communicate, implement, and monitor production and compensation standards for physicians and staff;
6. Oversee management of clinical staff, and establish performance expectations;
7. Help physician leaders grow and develop as knowledgeable, engaged stakeholders; and
8. Encourage advocacy at local, state, and national levels.⁴

3. American College of Medical Practice Executives. *Body of Knowledge for Medical Practice Management Certification Exam Workbook*, Pg. 175.

4. Medical Group Management Association. www.mgma.com/bokorganizationalgovernance.

It is wise for medium-sized and large medical practices to set up committees within the organization to oversee group operations. Depending on the size of the practice, committees could include executive, finance, personnel, recruiting, and quality review. The executive committee looks at the big picture, forming policies related to practice operations and clinical practice. The finance committee oversees the group's operating budget, expenses, and revenues. The personnel and recruiting committees handle human resources-related concerns and determine the need for new employees. The quality review committee promotes best practices and methods for improving patient care among practitioners. Additionally, an ad hoc committee would form to meet specific objectives or complete certain tasks, then would dissolve once it has met or completed its projects.⁵

5. Ibid. Pg. 181.

CHAPTER TWO

Accounting Basics

With contribution by Jim Rice, CPA, shareholder, Sol Schwartz & Associates, PC

OVERVIEW

Accounting
Methods

Statements

Analysis

The financial information the medical practice accountant and billing manager prepare is as important as the medical records maintained for the patients. Medical practice financial information can identify items such as excessive expenses and declining collections. The data also can help physicians anticipate and budget for operating expenses. Often, physicians receive financial statements regularly but do not know how to read them or use the information. Physicians need to learn to interpret financial data. They should ask the practice accountant and billing manager to sit with them and

explain how to read financial statements and other financial data and how to use that knowledge.

The most important financial statements physicians should understand and review are:

- ◆ Income statement: summarizes income and expense by category; often called the profit and loss statement or P&L;
- ◆ Balance sheet: states assets (cash, equipment) and liabilities (debts);
- ◆ Cash flow statement: tracks how cash flows in and out of the practice over a specific period; and
- ◆ Cost report: details expenses by category (like individual physicians or departments).

Financial statements should be timely and meaningful to the physician. They should prominently highlight the portion of collections going to the bottom line as physician net income. They should have benchmark indicators, such as the amount of practice collections or types of expenses, that compare the current reporting period with prior periods in addition to other practices in the same or similar specialty.

Cash Versus Accrual Methods of Accounting

Most medical practices keep their books on the cash basis method of accounting, meaning that the books reflect mainly activity representing cash in and cash out. It is important to know the method of accounting used. Following is discussion of the two main methods of accounting and the traditional types of financial statements accountants prepare.

Cash-Based Accounting

The cash basis method of accounting is the method most used in reporting income and expenses on tax returns filed with the government. The cash basis method records cash in, cash out as it occurs. The practice records income when it receives cash from a patient or insurance carrier, and records expenses when it uses cash to pay a vendor. In cash basis accounting, income and expenses are not always matched from month to month. Expenses are not recorded until cash is actually laid out, even if the expenses were incurred in previous months. The same applies for income. The income is not recorded until the cash is in hand. Patients receive services in one month but typically do not pay for them until the following month or longer.

Since the cash basis method does not record patient receivables and vendor payables, this method typically generates financial statements that do not reflect all of the practice's financial activity. If the practice is more established, and patient receivable balances do not fluctuate materially from month to month, the financial statements likely would not appear substantially different from accrual basis financial statements.

Accrual-Based Accounting

Accrual-based accounting generally provides a more accurate picture of the financial status of the practice. That is because the accrual method reports all accounting activity, whether it is a cash activity or other accounting activity not reflected in a cash-in or cash-out transaction.

The accrual method may involve more time to record activity than the cash-based method, but the accrual method may be more appropriate for a growing or declining practice. For example, a patient receivables balance that declines from period to period could be a sign of a reduction in patient load, or it might indicate that the practice is not properly recording receivables, resulting in lost billings.

Physicians also should be aware of aging patient receivables, such as 30-day-old receivables. Increasing, older receivable balances may be a result of inadequate collection and/or billing practices. As for vendor payables, if the balances owed are increasing when compared with the last financial statement, it may indicate the practice is not paying debts timely and is having a cash shortage problem.

Traditional Financial Statements

Income Statements

Income statements indicate the practice's bottom line by reflecting expenses, revenue, and net income for a specific period. By subtracting expenses from revenues, a practice can determine its net income or loss. The sections of an income statement are operating revenues, operating expenses (staff salaries, vendor services, supplies, and general expenses), other income, and nonoperations expenses (investment income and income expenses).⁶

The income statement should clearly indicate the sources of collections of revenue (patient services, ancillary services, other sources of income) and the types of expenses (employee salaries, rent, supplies, and the like) and should be compared with the corresponding prior period. The period can be a month, a quarter, a half-year, or an entire year.

The income statement should provide a clear understanding of physician efforts by listing the compensation to the owner separately. This compensation is from salary, fringe benefits, retirement plan contributions for the physician, payroll taxes paid by the practice for the physician, vehicle allowances, and more. Isolating this compensation information on the income statement allows physicians to see what they are truly collecting.

It is important to understand how the financial statements would read differently if prepared on the accrual method of accounting. In that case, the estimated collectible portion of outstanding patient receivables would be included as income, and the unpaid expenses incurred up to the date of the income statement would be included as expenses.

Balance Sheets

As explained by the Medical Group Management Association (MGMA), the balance sheet lists the assets and liabilities

in the order of their liquidity (how quickly they convert to cash). The most liquid assets and liabilities are called current assets and liabilities because they are expected to convert to cash in less than one year. Examples of current assets include cash and accounts receivable (A/R). Examples of current liabilities include accounts payable, payroll withholdings, and current maturities of long-term debt.⁷

Long-term assets, shown in a separate section of the balance sheet, typically include medical and office equipment. Long-term liabilities are those that will take the practice at least one year to pay off.

6. Medical Group Management Association. *Medical Practice Management Body of Knowledge Review Financial Management Vol. 2*, 2009, Pg. 102.

7. *Ibid.* Pg. 98.

The equity portion of the balance sheet represents the owners' claims on net assets. These amounts are the result of capital contributed by the owners, as well as the undistributed profits of the practice. The accounts in this section will vary depending on the type of entity. For example, corporate entities will show all classes of stock separately at par value beginning with common stock, followed by any contributed capital in excess of par, and retained earnings. Limited liability entities, partnerships, and sole proprietorships generally combine these amounts as members' capital, partners' capital, or proprietor's capital, respectively. Although one amount usually appears in these entities' balance sheets for capital, practices should keep detailed subaccounts of each owner.

The balance sheet is usually prepared on the cash basis method of accounting. Therefore, it does not list patient receivables and regular accounts payable (utilities and supplies, for example) because they have not yet been paid in cash. The patient receivables are payments for physician services not yet collected from the patients or from payers. The receivables represent revenue that needs to be collected, and the receivables balance is what is owed to the practice as of a certain point in time.

Knowing the receivables is important in case the receivables balances over time are declining, which can be a sign of a practice's patient flow declining. It also can indicate receivables are aging, i.e., the practice is not adequately pursuing them for collection or write-off. Knowing the change in the payables balances is equally important to make sure the practice is paying recurring expenses on time. The payables balances are the amounts the practice still owes vendors and others as of a certain time, which is typically the date of the financial statement's preparation. Those liabilities can be an indication of financial problems that a cash basis balance sheet does not note. Therefore, it can be important to know how the balance sheet would look if prepared on the accrual method of accounting wherein patient receivables and accounts payable would be included in the financial statements.

Cash Flow Statements

A cash flow statement shows the money coming into and out of a medical practice as it relates to operations, investing, and financing. This statement is difficult to interpret at first glance, so the accountant should explain how to read it. Physicians can use cash flow statements to determine future cash flow.⁸

The cash flow statement is designed to show where the cash came from by category and where cash was used by category, for the same defined period as that of the income statement. For example, a year-end cash flow statement would report the cash sources and cash payments by category for the 12 months of that year.

8. Pavlock, Ernest. Op. cit. Pg. 134.

Financial Analysis

Analyzing the financial results of a medical practice is an involved process. Before beginning, it is important to note that analysis of financial statements will be meaningless without having an experienced bookkeeper timely maintaining the books and records while also engaging the expertise of health care consultants, CPAs, attorneys, bankers, and other advisers.

TIP

Effective financial analysis involves financial statement comparison.

Developing a routine of reviewing financial statements each month will help curtail employee theft. Additionally, omitting personal, nonbusiness expenses from the practice's financial statements will ensure these documents truly reflect the financial health of the business. The key to analyzing financial statements is learning how to read the different types of financial statements accountants prepare. CPAs can explain in detail to physicians and office staff how to read financial statements properly.

Effective financial analysis involves financial statement comparison. For example, the income statement should list income and expenses for the current period and also list the same income and expense categories for the prior period, side by side. This comparative income statement allows a practice to see quickly how it's performing now and compared with the prior year, and whether any revenue or expense items look unusual or out of line. The same can be said for the balance sheet, as it shows current cash balances, equipment expenses, and more as compared with the prior period.

Analyzing the income statement to include budgeted numbers can be a useful tool. Budgeted numbers typically reflect what the practice would like to achieve for the period in terms of patient revenue collections and limits on certain expense categories, such as salaries or practice overhead. Comparing the budgeted numbers with the actual results reveals how the practice is doing based on goals set.

Financial analysis also should include using benchmark data that give a practice an idea of how it compares with other, similar medical practices in terms of various categories, including revenue generated by size of practice, certain types of expenses, and overall profitability.

When properly prepared, the cash flow statement is the best source of understanding for a certain period (one year, for example) how much cash came into the practice by category (revenue, loans, sale of equipment, capital invested by the owners) and how much cash went out of the practice by category (salaries, rent, supplies, payback of loans, purchases of equipment). Knowing how much of the cash collected ultimately ended up contributing to business operations is empowering and helps physicians run their business as efficiently as possible.

The practice manager should prepare a weekly management report such as the one below to analyze and monitor these key numbers for the practice: charges, adjustments, revenue, expenses, number of patient encounters, and billing days outstanding.

WEEKLY MANAGEMENT REPORT	
Practice Management System (week ending)	1/6/14
Total Charges Posted	\$96,034.23
Total Adjustments	\$32,038.27
Accounting Software (week ending)	1/6/14
Total Payments	\$35,947.71
Total Other Income	\$136.50
Total Revenue	\$36,084.21
TOTAL INCOME	\$36,084.21
Operating Expenses	\$28,393.29
Physician Salary & Bonuses	\$5,209.58
TOTAL EXPENSES	\$33,602.87
NET INCOME BEFORE PHYSICIAN COMPENSATION	\$7,690.92
NET INCOME	\$2,481.34
OPERATIONS (week ending)	1/6/14
# New Patients	8
# Established Patients	64
# Procedures	12
# N/S	5
Billing Days Outstanding	
Charge Entry	2
Payment Posting	1

CHAPTER THREE

Billing and Collections Basics

OVERVIEW

Monthly Reports

Formulas

Minimizing Risk

In an increasingly complex and regulated practice environment, physician involvement in financial matters has never been more crucial. Proper billing for services, complemented by a well-managed collections process, can make or break the business. Collecting every cent an insurance company owes the medical practice requires diligence on the part of physicians and staff.

THREE

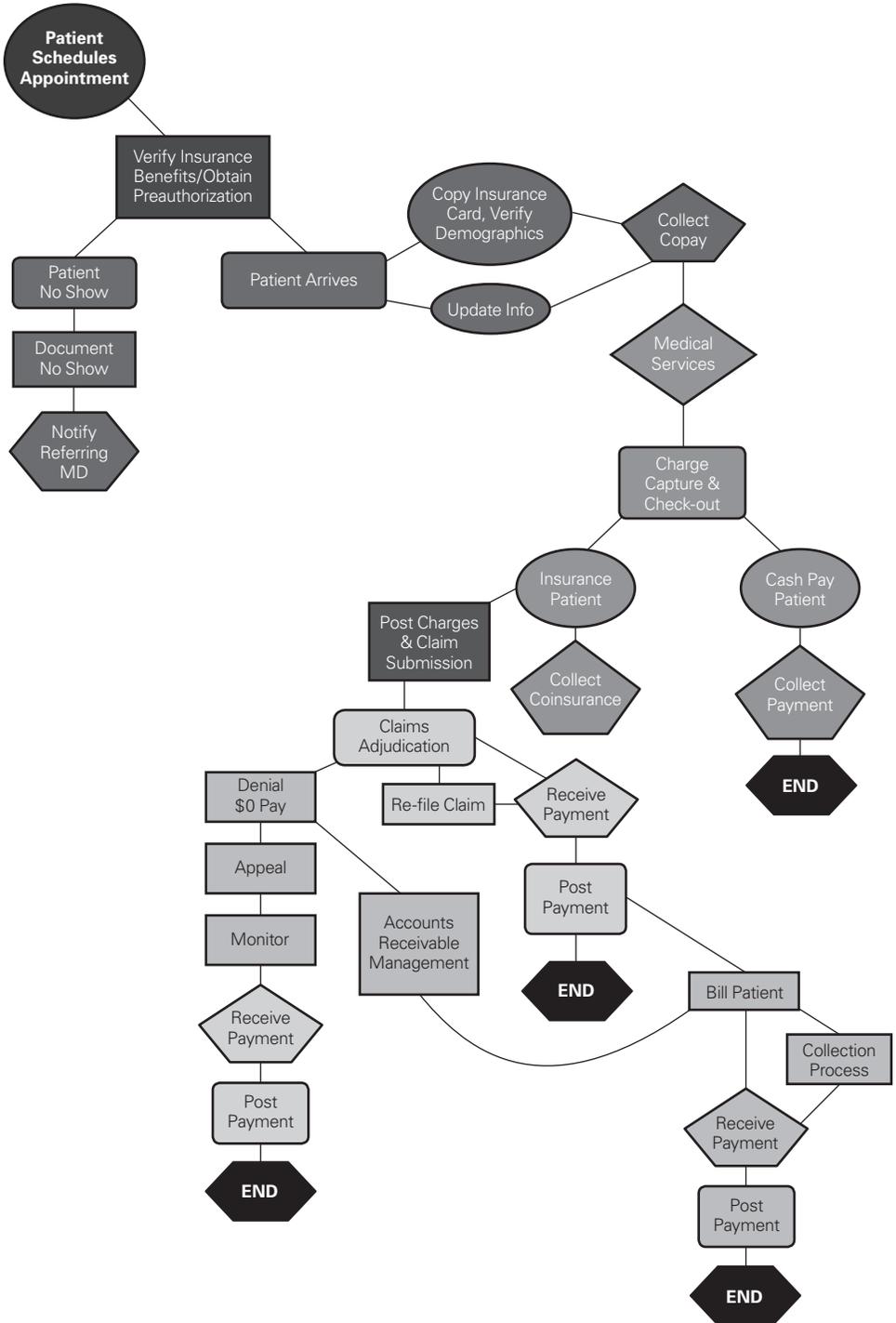
Revenue Cycle Overview

Understanding the revenue cycle will help physicians know the questions to ask to ensure everyone is doing his or her part.

All points of the revenue cycle are not covered in this publication, but it is important to recognize the complexities of collecting revenue for services provided. Monitoring key metrics, measuring production, making necessary contractual adjustments, monitoring the payer mix, and instituting internal controls is critical to the financial success of the practice.

The flow chart on the following page illustrates the many aspects of a medical practice revenue cycle.

Medical Practice Revenue Cycle



Traditional Billing Reports

Whether the practice outsources billing or bills in house, staff should prepare, and physicians and practice manager should review, the following monthly reports.

- ◆ Practice summary: reports charges, payments, and adjustments for a specific period.
- ◆ Accounts receivable aging: reflects revenue due from patients and payers, usually for each payer category; shows how long the accounts have been outstanding (current, 30 to 60 days, 60 to 90 days, and so forth).
- ◆ Revenue analysis: tracks where revenue is coming from, how it was generated, and who generated it.
- ◆ Procedure analysis: shows which physicians or midlevel professionals performed what procedures.
- ◆ Payer mix: reflects charges or collections per payer category.

Additional reports that should be reviewed on a quarterly, semi-annual, or annual basis are:

- ◆ Incurred but not reported (IBNR) claims/lag report:⁹ identifies services completed for which the practice has not processed claims or statements.
- ◆ Credit balances: provides summary and detailed outstanding credit balances for which the practice owes refunds.

Key Metrics

Ideally, the physician and practice manager should monitor all the key metrics (see chart on pg. 18) on a monthly basis, but at minimum they should monitor the gross collections ratio and net collections ratio. Gross collections are the percentage of what the practice collects compared with what is billed. Net collections are what the practice can collect after the contractual adjustments are made to the amount billed. As an example, if the practice collected \$60 when it expected to collect \$60 of a \$100 charge, the gross collection would be 60 percent, and the net collection would be 100 percent.

The possible causes of a low gross collections ratio include a shift in the practice payer mix, failure to follow up on unpaid accounts, failure to collect from patients at the time of service, failure to send patient statements on a timely basis, or a change in insurance company payment rates. The practice specialty and fee schedule also have an impact on gross collections. The possible causes of a higher gross collections ratio include a better payer mix, more follow-up on unpaid accounts, or collecting more at the time or service than the benchmark practices.

The possible causes of a low net collections ratio include a rise in accounts receivable (not receiving payment), incorrect posting of payments and/or adjustments, or failure to write off uncollectible amounts. A high net collections percentage is most likely the result of writing off collectable amounts on the remaining accounts.

9. Ibid.

Key Metrics and Formulas

Gross Collection Ratio (GCR)

The percentage of *charge* dollars collected

$$GCR = Total\ Collections \div Total\ Charges$$

Net Collections Ratio (NCR)

The percentage of *collectable* dollars collected

$$NCR = Total\ Collections - Refunds / Total\ Charges - Adjustments$$

Days of Gross Fee-for-Service Charges in Accounts Receivable

How long it takes, on average, to collect a day's worth of gross charges

$$Days\ in\ A/R\ (Gross) = Total\ Accounts\ Receivable \div (Gross\ FFS\ Charges \times 1/365)$$

Days of Adjusted Fee-for-Service Charges in Accounts Receivable

How long it takes, on average, to collect a day's worth of adjusted charges

$$Days\ in\ A/R\ (Adjusted) = Total\ Accounts\ Receivable \div (Adjusted\ FFS\ Charges \times 1/365)$$

Average Service Entry Lag Time

The amount of time between the date of a service and entry of the charge into the practice management system. Delays in charge entry may create lost charges, increased past-filing-deadline denials, and potential lost revenue.

$$Avg.\ Service\ Entry\ Lag\ Time = Sum\ of\ Lag\ Times \div Count\ of\ Charges$$

Clean Claims Rate

The number of claims rejected by the payer/clearinghouse or edited for missing/incorrect data compared with the total number of claims submitted during the month

$$Edit/Reject\ Rate = Number\ of\ Edits\ or\ Rejected\ Claims \div Total\ Claim\ Count$$

Denial Rate

The number of claims denied compared with the total number of claims submitted during the month

$$Denial\ Rate = Number\ of\ Denied\ Claims \div Total\ Claim\ Count$$

Collections and Accounts Receivable

Medical practices are in the business of getting paid by third-party payers and patients. Ensuring timely, accurate payment is vital for a practice to stay afloat financially. MGMA has the following tips for competent management of accounts receivable:

- ◆ Gather all patient information when patients call for appointments;
- ◆ Obtain insurance information, and verify it prior to service;
- ◆ Tell patients that balances are due at the time of service;
- ◆ Collect all copayments and deductibles at patient check-in;
- ◆ Work with patients who owe past due amounts by setting up payment plans and explaining what their insurance does and doesn't cover;
- ◆ Accept payment via credit and debit cards;
- ◆ Educate the staff about the most effective methods of obtaining payment from patients; and
- ◆ Create a collection process that takes into account the time and amount payments are past due.¹⁰

Further, MGMA says that to manage cash flow from health care payment plans, physicians and/or staff need to:

- ◆ Understand payer contracts and the amounts negotiated for Current Procedural Terminology (CPT) codes billed;
- ◆ Thoroughly document patient encounters to ensure accurate claims submission;
- ◆ Review claims for errors before submitting them;
- ◆ Submit claims in a timely manner;
- ◆ Create reports that reflect past due accounts and assign collection procedures to them; and
- ◆ Review unpaid claims.¹¹

Physicians should be involved in developing a collections policy and making sure front office staff understand and adhere to it. Having a written collections policy helps the practice keep track of the accounts receivable balance and revenues paid by third-party sources.¹²

Asking patients for money at the time of service is a delicate but necessary process. Staff members can create a pleasant patient experience by respecting the patient's privacy, making eye contact, addressing the patient by name, explaining the services and charges, offering payment options for those who can't pay in full, and saying thank you. Physicians should instruct employees not to ask whether a patient would like to pay, confront the patient, or berate the patient.¹³

10. Medical Group Management Association. *Lessons for Financial Success*, 2009, Pg. 3.

11. *Ibid.* Pg. 4.

12. American Medical Association. *The Physician's Guide to Survival and Success in the Medical Practice*, 2008, Pg. 154.

13. *Ibid.* Pg. 148.

When it comes to collecting payment from patients, MGMA has developed a code of ethics office staff members can follow. Among its principles, the code urges physicians to investigate collections-related complaints from patients immediately and to instruct collectors to attempt to determine the reason for late payments and to offer payment options when warranted. The code warns physicians to use caution when pursuing payment from patients who have complaints about the medical care they received.¹⁴

Contractual Adjustments

For a medical practice to run successfully, billing staff must detect and record contractual adjustments and other write-offs. CPA and author Reed Tinsley defines a contractual adjustment as “the difference between what a practice bills and what it is legally entitled to collect.”¹⁵ For instance, when the practice fee is higher than the payer’s contracted fee, the practice adjusts off the patient account the difference between the two fees.¹⁶

Categorizing contractual adjustments by payer allows medical practices to recognize drastic charge reductions if they occur. It may not make good business sense to continue contracting with a specific plan if a practice finds itself making an excessive amount of adjustments for the plan. Practice managers or administrators should investigate contractual adjustments that appear unreasonable; they may be denied charges that mistakenly were written off.¹⁷

The American Academy of Orthopaedic Surgeons offers the following tips for tracking contractual adjustments:

- ◆ Load all carrier contracted allowable amounts and payment schedules into the practice management system. Each time a payment posts, staff can determine whether the correct amount has been paid. Many payers display their fee schedules on their websites.
- ◆ Compile an adjustment code list. Physicians and practice managers or administrators can monitor plan profitability more easily.
- ◆ Ensure staff have been trained on posting adjustments. Populating the practice management system with payment schedules and adjustment codes won’t suffice. Physicians and practice managers or administrators need to train employees and monitor their progress.
- ◆ Create policies and procedures for overseeing adjustments.
- ◆ Review monthly adjustment summary reports. Physicians and practice managers or administrators should compare the reports and make note of high and low adjustment totals.¹⁸

14. Medical Group Management Association. Op. cit. Pgs. 13-14.

15. Tinsley, Reed. *Medical Practice Management Handbook: Complete Guide to Accounting, Tax Issues, Managed Care, and Daily Operations*. Aspen Law & Business, 2002, Pgs. 13.04-13.05.

16. O’Brien, Jennifer A. No such thing as minor adjustments. American Academy of Orthopaedic Surgeons. www.aaos.org/news/aaosnow/feb09/managing3.asp.

17. Tinsley, Reed. Op. cit. Pgs. 13.04-13.05.

18. American Academy of Orthopaedic Surgeons. Op. cit.

Shifts in Payer Mix

Physicians and practice managers can stay on top of revenue trends through regular review of the practice's percentage of patients covered by health care payment plans, commercial insurance, Medicare, Medicaid, other payers, and self-pay. For instance, a change in patient demographics could result in the practice's payer mix shifting from commercial insurance policies that pay at higher rates to health care payment plans that pay less. That will signal declining revenue, which the practice needs to be aware of and respond to appropriately.¹⁹

To stay abreast of the practice's payer mix, staff should use practice management software to generate a payer mix analysis. It's also a good idea for the physicians and the management team to perform a payer mix analysis when payer contracts are up for renewal. Billing software can produce customized reports. Generating accurate reports requires incorporating the data the practice wants associated with each account, entering uniform data by patient, and appropriately updating data.²⁰

In the absence of such technology, billing staff should provide an estimate to physicians. If the practice needs to reconfigure its payer mix to increase the percentage of patients covered by plans that offer higher payment rates, physicians should consider creating a marketing plan to accomplish the goal of attracting a specific payer class. Practice area demographics and physician participation in the marketing plan will influence success in shifting the practice's payer mix.²¹

Identifying Production Problems

Established medical practices should have consistent production, while new medical practices should experience growth in production month to month. Potential causes of production problems are:

- ◆ Failure to bill patients in a timely manner,
- ◆ Lack of expertise among billing personnel, and
- ◆ Declining service volume.

The medical practice should ensure all physicians are credentialed with the health care payment plans serving the area. In addition, physicians and staff should review claim forms prepared each day to determine adequacy of claim filings.²²

Outsourcing Versus In-House Billing

One way to alleviate the hassles associated with everyday billing and collections follow-up is to outsource a practice's billing function. Some outside companies can simply access a practice's electronic health record system to capture daily charges and, in turn, provide physicians regular reports on pending charges and status updates on claim

19. Tinsley, Reed. Op. cit. Pgs. 2.06-2.07.

20. Foehl, Angela. Payer and Patient Mix: Keys to a Healthy Private Practice. American Speech-Language-Hearing Association. www.asha.org/Publications/leader/2009/090811/090811i.

21. Tinsley, Reed. Op. cit. Pgs. 2.07-2.08.

22. Ibid. Pgs. 2.03-2.05.

denials. It's important to do some research on the front end to choose a legitimate company and avoid billing and collections headaches down the road. Questions to ask billing companies before signing a contract include:

- ◆ Does your company charge any setup fees?
- ◆ Do you provide an EHR?
- ◆ Is your billing system compatible with the practice's existing EHR system?
- ◆ Does your billing system include a practice management component?
- ◆ How long is your contract, and what are my options if I'm not happy with your company's services?
- ◆ Does your company provide training on the billing system for my office staff?
- ◆ How long have you been in business?
- ◆ What medical specialties do you have experience with?
- ◆ How many clients and employees do you have?
- ◆ Is your staff capacity sufficient to handle my account? If not, how soon can you ramp up staff volume to meet my needs?
- ◆ How many employees will be assigned to support my account?
- ◆ Who would be my point of contact at your company?
- ◆ What is the flow of information from the physician's office to the company?
- ◆ How often are claims submitted for payment?
- ◆ How is patient information stored, and what security and privacy measures do you have in place?
- ◆ How soon do you follow up on accounts receivable and claim denials?
- ◆ How long will setup time take before you can start sending claims?
- ◆ What do you need from our office daily, weekly, and monthly to ensure efficient collections?
- ◆ Is your company willing to adjust the percentage it collects as my billing volume increases?

Once a practice has chosen an outside billing service, it can minimize risk by taking the following measures:

- ◆ Request a copy of the service's compliance plan;
- ◆ Exchange a business associate agreement to ensure the confidentiality of protected health information as required by the Health Insurance Portability and Accountability Act (HIPAA);
- ◆ Ask if the service has periodic audits performed by an outside auditing firm;
- ◆ Inquire about continuing education and training of billing staff;
- ◆ Request three references of current medical practice clients, and call them to ask about the company's performance;

- ◆ Inquire about the qualifications and certifications of the service's billing staff;
- ◆ Have an attorney review the contract;
- ◆ Request a redacted copy of the standard financial reports the service gives its clients; and
- ◆ Ensure the service has insurance coverage for errors and omissions.²³

If the medical practice decides to handle billing and collections in house, physicians should be aware of some common accounts receivable mistakes and how to correct or even avoid them. One common pitfall involves failure to collect complete, accurate financial information from patients. This could include insufficient information about benefits or simple mistakes in data entry. Physicians can help their front office staff improve by offering additional education and by re-evaluating workloads to ensure each employee can manage individual responsibilities while producing quality work.

Another all-too-common mistake occurs when office staff forget to update patient demographic and insurance information at each office visit. Staff should inquire at each visit about the patient's current phone number, address, employer, and primary and secondary insurance coverage. Another way medical practices can lose money is by mismanaging patient balances. Office staff should be trained to audit patients' accounts and to collect copays, coinsurance, deductibles, and past due balances at the time of service. Physicians should consider setting up an online payment system to expedite patient payment.

In addition to submitting insurance claims and requesting payment from patients, physicians must ensure someone is monitoring collections and paying attention to the practice's overall financial performance. This requires regularly reviewing month-end reports that detail unpaid claims, aging reports, aging by payer class, patient balances, and payer performance. Once the practice has analyzed these reports, physicians can make necessary changes in processes and put them in writing so the entire staff is operating from the same plan.²⁴

23. Texas Medical Association. *TMA Practice E-Tips*, www.texmed.org/Template.aspx?id=1930.

24. Capko, Judy. Patient Collections: 5 Mistakes Your Practice Can Make. *Physicians Practice Pearls*. www.physicianspractice.com.

CHAPTER FOUR

Managing Expenses and Projecting Cash Flow

OVERVIEW

- Operating Expenses
- Employee Management
- Financial Planning

Physicians need to be aware of how every penny is spent within the medical practice. Cost management is essential for practice profitability. Two of the largest operating costs for a practice are space and staffing. To get the most out of office space, physicians should ensure they are using it efficiently and should explore various arrangements, such as sharing space, extending operating hours, and outsourcing some administrative functions.

High employee turnover in a medical practice can increase staffing costs. Providing staff members time to attend to personal matters may reduce turnover. Another way to manage staffing costs involves ramping up and scaling back staff volume based on demand throughout the year. As an example, a practice may consider increasing staffing during flu season or at the start of the school year.

Additional operating expenses include telecommunications, EHRs, medical liability insurance, and medical supplies. Physicians should review their vendor contracts annually and either shop around for better prices or negotiate better rates.²⁵

Operating Overhead

Managing increasing overhead costs in an uncertain economic climate is a real challenge medical practices face. It is no surprise that keeping a practice financially afloat is no easy task. Operating expenses are costs incurred in the process of providing services to patients, and understanding them helps medical practices determine their net operating income.²⁶ Additionally, says the American Medical Association, a medical practice's overhead "should be that percentage of total revenue that allows the practice to operate efficiently and still allows a margin or profit acceptable to the physician."²⁷

FOUR

25. Medical Group Management Association. *Performance and Practices of Successful Medical Groups*, 2001, Pgs. 64-65.

26. Pavlock, Ernest. Op. cit. Pg. 153.

27. American Medical Association. Op. cit. Pg. 146.

The six main operating expense categories for a medical practice are:

1. Salary,
2. Services and general expenses,
3. Clinical expenses,
4. Occupancy expenses,
5. Cost of goods sold, and
6. Purchased services and management fees.²⁸

If a medical practice has a low patient volume, a high level of waste, or too many employees, overhead likely will be on the high side. On the other hand, inadequate staffing, low employee salaries, and high fees may cause low overhead percentages. Highly productive practices often have high costs per physician but also may have higher revenues and better profitability. AMA has the following suggestions for controlling medical practice overhead:

- ◆ Save on leasing and installment payment fees by checking for and eliminating underuse of diagnostic equipment.
- ◆ Avoid having to hire temporary help during employee vacations by cross-training staff to provide coverage.
- ◆ Cut benefit costs by paying more employees on an hourly basis rather than a salary.
- ◆ Ensure appropriate salary allocation by using merit and performance guidelines for determining staff salary increases.
- ◆ Keep the practice's margins balanced by awarding wage increases in line with inflation rates.
- ◆ Control costs by providing well-defined employee benefits.
- ◆ Help recoup staff overhead costs by charging insurance companies for staff time to prepare lengthy medical reports.
- ◆ Eliminate impulse buying for supplies by using an order list.
- ◆ Keep vendor costs competitive by obtaining references and using bid lists for comparison.
- ◆ Find lower insurance premiums by reviewing policies regularly.
- ◆ Prevent paycheck padding by requiring overtime preapproval by practice management.
- ◆ Reduce accounting costs by using an independent payroll service.
- ◆ Maximize savings by consulting a financial advisor before leasing equipment or making significant purchases.
- ◆ Lower costs by negotiating collection agency fees and bank card rates.

28. Pavlock, Ernest. Op. cit. Pg. 117.

- ◆ Keep spending in line by reviewing revenue and expense ratios at least quarterly, then comparing them against the prior year's and current year's budget.

AMA also encourages practice administrators or managers to answer the following questions to determine a practice's profitability:

- ◆ Does the medical practice get a complete picture of the business' financial health based on recordkeeping?
- ◆ Is there a method for reviewing expenses in an effort to reduce costs?
- ◆ Does the practice's CPA review financial statements at least quarterly?
- ◆ Is communication between management and office personnel effective?
- ◆ Are the practice's billing policy and insurance processing procedures clearly outlined for patients?
- ◆ Do staff members understand and follow the practice's billing policy?
- ◆ Is the appointment scheduling process efficient and effective?
- ◆ Is patient volume optimal?
- ◆ Is the collections level adequate?²⁹

Personnel and Payroll

With contribution by Betty Black, Manager, General Business Services, Sol Schwartz & Associates, PC

Personnel costs, including staff salaries, are among medical practices' largest expenses — typically 25 percent to 30 percent of collected revenue.³⁰ Assessment of staffing needs and examination of potential cost savings will aid medical practices in controlling costs. For example, assigning receptionists, appointment staff, and medical records personnel to more than one department helps keep costs in check.³¹

Setting up an office and managing employees are major responsibilities. Physicians may opt to hire a payroll processing company to take care of payroll needs and compliance. Hiring a reputable firm is pivotal. Practices that plan to undertake payroll processing and reporting themselves need to follow some essential steps and need to become familiar with state and federal tax laws and required filings.

First, physicians should complete an SS-4 form to request an Employer Identification Number (EIN). Federal and Texas law require employers to report new hires and rehires within 20 calendar days from the date in which the employee starts earning wages. Physicians can report new hires online to the Employer New Hire Reporting Operations Center in the Texas Office of the Attorney General.³² (Physicians in other states should check with their state's employment agency for state-specific new-hire laws.) Next, new employees must fill out Form W-4, Employee's Withholding Allowance

29. American Medical Association. Op. cit. Pgs. 146-147.

30. Pavlock, Ernest. Op. cit. Pg. 475.

31. Ibid.

32. Report new hires at <https://portal.cs.oag.state.tx.us/wps/portal/EmployerHome>.

Certificate. Physicians must verify that each new employee is legally eligible to work in the United States by completing Form I-9, Employment Eligibility Verification. The form is available from the U.S. Citizenship and Immigration Services website, www.uscis.gov.

Each payday the practice will withhold from each employee's paycheck federal income tax based the employee's Form W-4 as well as the employee's share of Social Security and Medicare taxes. These amounts, along with the employer's portion of Social Security and Medicare taxes, need to be deposited periodically. The due date of the deposit depends on the practice's deposit schedule, which will be monthly or semiweekly. Monthly depositors must pay the taxes withheld by the 15th day of the month following the issuance of paychecks. All tax deposits must be made by Electronic Federal Tax Payment System, which is a free service of the U.S. Department of Treasury. Information and enrollment are at www.eftps.gov.

Each quarter, all employers who pay wages must file Form 941, Employer's Quarterly Federal Tax Return. This report is due the last day of the month that follows the end of the quarter. Form 941 reports all Social Security, Medicare, and withheld federal income taxes deducted from employees' paychecks.

Medical practices also must fill out Form 940, Employer's Annual Federal Unemployment Tax Act (FUTA). This return is due annually by Jan. 31 for the previous calendar year. The FUTA for 2014 rate is .6 percent of the first \$7,000 paid to each employee.³³

In addition, the Texas Workforce Commission requires businesses to report employee wages on a regular basis to calculate how much state unemployment tax the employer must contribute based on employees' wages. The first \$9,000 a year employers pay each employee is taxable. Employers' tax rate and the taxable wages they pay determine the amount they owe. New employers generally pay at a rate of 2.70 percent. Employers receive an experience rate after six calendar quarters. Their experience rate will vary depending on taxable wages reported and individual claims charged against their account.³⁴ (Physicians in other states should contact the appropriate state agency for more information and to determine tax rates.)

Also due at year end is Form W-2, Wage and Tax Statement. Every employer who pays wages for the year for services performed by an employee must file a Form W-2 for each employee. Physicians must furnish each employee a copy of the completed Form W-2 by Jan. 31 for the previous calendar year. The W-2 not only informs employees of their salary and tax deductions for the year but also outlines certain benefits received and amounts withheld. Physicians also must file a Form W-3 to transmit Copy A of forms W-2 to the Social Security Administration (SSA). The W-3 and Copy A of forms W-2 are due to SSA by the last day of February.

Payroll calculation and reporting involve more than one report and more than one governing agency. Payroll compliance is an important aspect of medical practice, and

33. Internal Revenue Service. (*Circular E*), *Employer's Tax Guide*, 2014, Pg. 34.

34. Texas Workforce Commission. www.twc.state.tx.us/ui/tax/taxfaq.html#a8.

failure to adhere to regulations can result in penalties and interest assessed against the practice. For additional guidance on employment taxes, consult the IRS *Employer's Tax Guide* at www.irs.gov/publications/p15/index.htm.

Inventory Control

Inventory control increases efficiency and reins in costs for all purchases. Such a process helps practices avoid ordering supplies they already have or ordering too many supplies. The employee in charge of making supply purchases should have a solid understanding of the ordering system and should know which supplies the staff actually uses and how much they use them. AMA suggests two methods to help practices control supply costs:

1. The order point system helps to minimize overstocking and prevent shortages. With this method, the purchasing employee determines the quantity of items used in 30 days, the amount of time between purchase and receipt of items, the quantity of items needed while the goods are on order, and the level of buffer stock needed if a supply interruption occurs.
2. Creating order logs helps practice managers or administrators track supply purchase dates, quantities, and costs. Logs allow a practice to cross-check packing slips with log order entries and monthly statements with packing slips. Order logs also help practices appropriately stock generic drugs and note the correlation of generic to name-brand drugs.³⁵

The Budget Process

For a medical practice to achieve its goals, it must have a financial plan. Physicians should plan for how the practice will respond to changes over the next five to 10 years. A good plan takes a long view of the practice's success but includes short-term, achievable goals along the way. Operations plans examine weekly, monthly, or yearly activities such as determining staffing needs for the next month or setting the week's production level.³⁶

The following steps will help medical practices plan for the future:

- ◆ Perform an environmental scan inside and outside the practice by examining the changes and trends in the health care landscape.
- ◆ Develop goals and objectives while considering the need to redefine or re-establish them as circumstances change.
- ◆ Establish short-term operating budgets consistent with the goals and objectives.
- ◆ Compare actual results with budgets, and consider the need for corrective action.³⁷

Environmental scanning entails examining "all events, institutions, social policies, and governmental regulations and programs" that affect health care delivery.³⁸ The

35. American Medical Association. Op. cit. Pg. 195.

36. Pavlock, Ernest. Op. cit. Pgs. 368-369.

37. Ibid. Pgs. 369-370.

38. Ibid. Pg. 370.

environmental scan allows a medical practice to identify trends and forces that can affect operations and to assess their potential impact. What medical services should the practice deliver, given the environment that exists?³⁹ What financial and other resources can the practice use to adapt? Answering questions like these helps practices respond to changing needs in the marketplace.⁴⁰

Developing long-term goals and short-term objectives gives the members of the practice team a mission to work toward. Answering these additional questions will help medical practices set goals:

- ◆ What patient groups will the practice serve?
- ◆ What will be the practice's role and position of leadership in the medical community?
- ◆ What impact will changes in technology have on patient care?
- ◆ How large a professional staff does the practice want in five years, 10 years?
- ◆ What impact will changes in the local health care market have on the practice's share of the market?
- ◆ Is the general population growing or contracting, and is the mix of the physician population changing?
- ◆ Will the government and others play a greater or lesser role in the provision of health care than they have in the past?⁴¹

Objective statements should focus on the short term and address specific targets, such as gross charges, physician compensation, or operating hours. When aligning the practice's goals and objectives, it's important to get staff input. Physicians can use questionnaires to elicit the type of information they need for setting goals and objectives. The questionnaires also can ask employees to list priorities that need immediate action, focusing on the following practice areas:

- ◆ Professional services,
- ◆ Human resources,
- ◆ Facilities and equipment,
- ◆ Financial resources,
- ◆ Innovation,
- ◆ Productivity,
- ◆ Social responsibility,
- ◆ Salary requirements,
- ◆ Management information systems, and
- ◆ Compliance and accountability.⁴²

39. Ibid.

40. Ibid. Pg. 371.

41. Ibid. Pg. 372.

42. Ibid.

After all responses have been gathered, staff members and physicians should meet to devise goals.⁴³ The input of staff members and the results of the environmental scan form the basis for the medical practice's goals. A specific objective should complement each goal. For example, a professional services goal to offer comprehensive medical care may have an accompanying objective of adding three primary care physicians in the next six months.⁴⁴

TIP

Forming objectives is the last step in the financial planning process.

Forming objectives is the last step in the financial planning process. MGMA recommends that each department in the medical practice “develop its own goals, objectives, and budget proposals that will lead to fulfillment of higher-level objectives and progress toward the primary goals.”⁴⁵

Medical practices should devote time annually to developing an operating budget that outlines how the group will go about achieving its financial goals. Budgets are beneficial because they:

- ◆ Help physicians and management make and coordinate short-term plans and communicate these plans to all staff;
- ◆ Motivate staff to achieve the goals of their departments by providing target indicators;
- ◆ Authorize staff to use and acquire resources during the coming period and to expand existing or carry out new activities;
- ◆ Enable staff to anticipate favorable conditions so they can capitalize on them or, if unfavorable, take steps to minimize their impact.
- ◆ Establish benchmarks to control ongoing activities, and set criteria for evaluating staff performance.⁴⁶

MGMA describes a comprehensive budget as consisting of cash and “other short-term resource management systems” and a profit plan, a cash budget, a capital expenditures budget, and a projected balance sheet.⁴⁷

43. Ibid. Pg. 374.

44. Ibid. Pgs. 375-376.

45. Ibid. Pg. 378.

46. Ibid. Pgs. 381-382.

47. Ibid. Pg. 382.

Assessing Capital Needs and Expenditures

Practices often need bank loans, leasing, or funds from outside sources to achieve their business goals. Physicians' 10 most common needs for capital include:

1. Growing and optimizing the existing practice,
2. Adding physicians and sites,
3. Investing in new profit centers,
4. Adding facilities and equipment,
5. Adding or updating information systems,
6. Developing single-specialty networks,
7. Accepting and managing medical risk,
8. Providing an exit strategy for older physicians,
9. Covering cash flow shortages, and
10. Insulating against risk.⁴⁸

Lack of available funding may restrict practices from increasing revenues and growing. Capital is necessary to hire staff, add locations, market to potential patients, and more.⁴⁹ Using capital to add physicians and practice sites is becoming increasingly necessary in today's medical environment.

Investing in new profit centers, such as outpatient surgery centers, medical offices, or equipment, can be risky but is justified in certain situations. Investment in new profit centers may be a good idea when a practice purchases diagnostic equipment or when a practice and its management company develop a hospital together. Outside capital is likely necessary for these kinds of investments. Because these ventures have the potential to generate large revenues, practices can likely attract outside investors.⁵⁰

Medical groups should look for these qualities in a capital partner:

- ◆ An operational focus, not a quick-profit mindset;
- ◆ The ability to provide buying power, management expertise, and commitment to the practice's specialty;
- ◆ A physician-friendly orientation; and
- ◆ A desire to collaborate with the practice, not control it.⁵¹

48. Ibid. Pg. 590.

49. Ibid. Pg. 591.

50. Ibid. Pgs. 592-593.

51. Ibid. Pg. 614.

Banking, Lines of Credit, and Loans

With contribution by Jon Shaw, director of the Healthcare Segment for BBVA Compass

Daily deposits are a fundamental part of managing a practice's finances. Office managers or administrators should use standard bank deposit slips and endorse each check. In addition to a checking account, the practice can deposit payments in a money market account to generate interest until the money is needed. Physicians should ask if the bank charges fees for account-to-account transfers before opening both types of accounts.⁵²

Physicians should choose a bank with services that allow for expedient processing of both electronic payments and check payments via multiple platforms, and quick access to credited funds. Payment processing can be through a third-party merchant or through the bank. Banks should have the ability to handle all types of patient payments with an emphasis on lower-cost electronic payments (accepting cards and Internet portal payment systems).

In addition, physicians should consider whether they'd like to process mailed payments through a lockbox or by handling all mailed payments directly. Volume of expected mailed payments will help determine if this service is cost effective because lockbox services can be expensive. Another time-saving service is remote deposit capture, which allows practices to scan and deposit checks and eliminate trips to the bank. Careful research and planning can make a significant impact on the practice's revenue cycle and reduce aged collections and bad debt.

Selecting a bank requires physicians to research potential funding sources, interview bank officers, and evaluate candidate financial institutions.⁵³ Physicians should ask their professional colleagues and practice management consultant for bank references. Accountants and attorneys also can provide medical practices a list of reputable banks in the community. Once the practice has narrowed down the list of banks under consideration, the practice manager or administrator should ask the institutions about the types of loans offered and request copies of financial statements. The Federal Deposit Insurance Corporation has information about lenders on its website at www.fdic.gov/bank/statistical/index.html. Analyzing this information will help physicians determine a bank's financial solvency and ability to serve the practice's credit needs.

Next, physicians and the practice administrator or manager should meet with bank officers at the most promising institutions to review a list of the practice's banking requirements. Once all meetings have been concluded, the practice should evaluate all information compiled on each bank and weigh impressions from each interview in making the final decision. It's important for the practice to choose a financial institution that can meet its banking needs and provide the level of service the practice requires.⁵⁴

52. Tinsley, Reed, Op. cit. Pgs. 13.12-13.13.

53. Pavlock, Ernest, Op. cit. Pg. 606.

54. Ibid. Pgs. 606-607.

Top bank candidates might possess the following characteristics:

- ◆ Experience, knowledge, and interest in meeting the practice's needs;
- ◆ Financial and managerial strength;
- ◆ Business-oriented programs targeted to the health care industry;
- ◆ Competitive interest rates and loan packages; and
- ◆ Good reputation in the community.⁵⁵

Establishing personal, business, savings, and pension accounts with the selected bank will help the practice build a strong relationship with the lender.

Borrowing money from a bank often requires physicians to personally guarantee the loan. Most practices are fully reliant on the physicians to generate revenue. Personal credit history and financial health are important aspects of establishing credit with banks.

Medical practices obtain short-term loans and lines of credit to cover operating expenses like payroll, supplies, utilities, and rent. Before granting short-term loans, banks examine a practice's cash flow projections as an indicator of the borrower's net worth or equity in the practice and how it may change over time. Short-term loans typically have variable interest rates, and lenders may require borrowers to maintain compensating balances. It's not unusual for banks to ask borrowers to pay short-term loans and lines of credit in full periodically. Doing so for loans "demonstrates the borrower's ability to pay off the loan and shows that the debt is not a 'permanent working capital loan,' " says MGMA.⁵⁶ For lines of credit, this is called "resting" the line. It demonstrates borrowers' ability to use the line of credit appropriately for short-term needs (one year or less).

Physicians are typically eligible for short-term, intermediate-term, and long-term loans. Short-term credit is predominantly unsecured in that no collateral is held as a back-up source of repayment. Most banks will place a blanket lien on all practice assets that aren't already pledged as collateral for other debt obligations. This includes the accounts receivable in most cases. Some banks will do accounts receivable lending in which they tie the credit limit directly to receivables in the practice. Accounts receivable lending can counter slow payers, but it also places restrictions on a practice's cash flow. Smaller lines of credit are often evaluated based on the credit of the primary borrowers (physicians) and typically do not require a full set of financial statements from the borrowers. Larger lines of credit (typically \$100,000 and up) will usually require two to three years of each of the following:

- ◆ Practice tax returns,
- ◆ Personal tax returns for primary borrowers and owners,
- ◆ Practice balance sheets, and
- ◆ Practice income statements.

55. Ibid. Pg. 607.

56. Ibid. Pgs. 607-609.

Keeping accurate financial records is critical for any practice seeking to establish larger credit lines.

Intermediate-term loans range from one to eight years and are based on assets such as equipment or leasehold improvements. The life of the assets being financed generally determines the length of the loan. Banks require repayment in installments. Should a practice default on any payment, the loan contract may include a clause that requires the practice to pay all installments at once. When determining interest rates on intermediate-term loans, lenders assess the credit risk. Variables that affect intermediate-loan interest rates include loan amount, borrower's credit rating, the length of the loan, and the lender's relationship with the borrower.⁵⁷

Another intermediate-term need may be financing a practice startup. Depending on the experience level of the physicians and the assets needed, this can be structured in a variety of ways. The Small Business Administration (SBA) assists borrowers with intermediate-term lending, and some banks will require an SBA guarantee for startup financing. This gives the lender flexibility in the terms and requirements for the loan. Many banks also offer conventional loans that finance 100 percent of the practice startup expenses. Lenders often will offer payment options that include interest-only payments for the first six to 12 months of the loan. Proper planning is the key to success in starting a practice. A detailed business plan and financial projections for at least five years are essential when meeting with lenders.

Physicians seek long-term loans — generally in the form of mortgages — beyond eight years to fund large undertakings like building construction. Lenders typically require installment payments and consider the following when negotiating loan contract terms:

- ◆ The value of the asset and its useful life,
- ◆ Whether the asset is highly specialized or has more general potential uses,
- ◆ The borrower's earnings and cash flow,
- ◆ The practice's management capability,
- ◆ The practice's track record in servicing prior long-term loans, and
- ◆ National and local health care industry prospects and the practice's market and competitive position.⁵⁸

Criteria for obtaining loans and lines of credit are fairly straightforward. Most banks will quote the five C's of credit when making lending determinations:

- ◆ Character,
- ◆ Capacity,
- ◆ Capital,
- ◆ Conditions, and
- ◆ Collateral.

57. Ibid. Pg. 609.

58. Ibid. Pgs. 609-610.

Banks look at borrowers' character to determine their professional reputation in the community. Banks examine capital to assess how much money physicians have invested in their practice. When banks refer to conditions, it means they're analyzing the current economy and determining how the medical practice will fare. In addition to reviewing a practice's cash flow, banks likely will require physicians to pledge collateral or alternative forms of repayment. Collateral can include real estate, office equipment, or inventory, for example.⁵⁹

Capacity is important as banks need to evaluate the borrower's ability to repay the loan. Banks typically want primary, secondary, and sometimes tertiary sources of repayment on loans. This reflects the risks associated with operating a business effectively. There are a variety of considerations, but foremost in this evaluation is determining the practice's ability to cover the annual debt service, which includes all debt the practice has and often the personal debt of the primary borrowers. This calculation usually includes a cushion that allows for unexpected events, risks associated with the purpose of the loan, and more. The calculation starts with earnings before interest, taxes, depreciation, and amortization, so profitability is important. Unsecured lines of credit or short-life collateral loans often will require a higher capacity due to the rapidly depreciating asset or lack of collateral.

59. PNC Bank. <https://www.pnc.com/webapp/unsec/ProductsAndService.do?siteArea=/pnccorp/PNC/Home/Small+Business/Financing+Your+Future/The+Five+Cs+of+Credit>.

CHAPTER FIVE

Payer Mix Management

OVERVIEW

Payer Mix

Contract Questions

Provision Checklist

A diverse payer mix that maximizes payment while allowing the practice to serve as many patients as possible is an important factor in a medical practice's financial stability.⁶⁰ To formulate the most advantageous payer mix for a practice, physicians and practice managers or administrators should analyze each plan's employer presence along with its payment rates, productivity, and profitability. First, practices should identify the top payers by charges and compare those payments with the payers' percentage of the total accounts receivable. The

next step involves the same examination method for CPT codes.

When analyzing productivity, practices can use a unit cost approach based on relative values,⁶¹ or they might simply determine the number of patients they see each day and then calculate the number of patients they see per hour. Physicians also can estimate the average length of patient visit by payer. It's likely, for example, that Medicare patients require more time with physicians. With this knowledge, practice managers or administrators can maximize productivity by tweaking a physician's daily schedule to include a balance of patients by type of visit and payer.

Defining a payer class involves determining payment levels and collection methods for each plan. Payer class categories may include:

- ◆ Medicare and Medicaid set fee schedules;
- ◆ Medicare minus coinsurance and Medicare Advantage Plus minus copay;
- ◆ Medicaid minus coinsurance or copay;
- ◆ Contracted, discounted managed care;
- ◆ Capitation;
- ◆ Workers' compensation;

60. PGM Healthcare Blog, www.pgmbilling.com/2011/04/25/the-importance-of-payor-mix-and-fee-schedule-examination.

61. See Medicare physician fee schedule relative value files at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html.

- ◆ Indemnity insurance; and
- ◆ Self-pay, uninsured, other.⁶²

Costs vary from payer to payer. Billing and claims processing costs by payer may include:

- ◆ Transparency of and adherence to published fee schedules;
- ◆ Denial rates;
- ◆ Payment turnaround time; and
- ◆ Hassle factors, such as response to appeals and authorization processes.

The amount of time staff members spend accessing information, processing appeals, submitting referrals, and seeking authorization with each payer plays a role in practice profitability. In addition to examining payers, practices should analyze local patient demographics. The age and socioeconomic status of a community's residents and the rate of chronic disease may call for a practice to change its payer mix. Before restructuring payer mix, physicians should review their health care payment plan contracts to ensure compliance.⁶³

Payment Models

Traditional health care models allow patients to choose any physician (specialists may need preapproval), but they pay more out of pocket in the form of copays and deductibles. Upon meeting deductibles, patients are responsible for paying a portion of the bill. For example, an insurance company may pay 80 percent of the bill and require the patient to pay the remaining 20 percent. Patients continue paying their share of the bills until they meet their maximum out-of-pocket expenses. At that point, the insurer pays 100 percent of expenses. Insurance companies will pay usual and customary expenses and will require patients to pay for additional charges or expenses.⁶⁴

It is important for physicians to become familiar with emerging health care models, which can affect payment, the practice payer mix, the way physicians practice medicine, where patients receive care, and patient payment responsibility. Among the emerging care models is the patient-centered medical home. The medical practice serves as the patient home from which care is coordinated. The concept revolves around rewarding physicians for practicing preventive medicine. The idea is that physicians can help reduce health care costs and improve outcomes for patients by achieving evidence-based targets in an environment of coordinated care. Payers may share the cost savings with physicians in the form of payment. This model encourages physicians to educate their patients about their health conditions, use evidence-based treatments, and work to ensure appropriate outcomes. Some payers and government plans offer payment incentives for practices that successfully execute the patient-centered medical home model.⁶⁵

62. PMRG. www.medicalpmrg.com/resources/payor-mix-analysis.html.

63. Schechter, Karen S. Analyze payer mix before deciding how to change it. American Medical Association *amednews*. www.ama-assn.org/amednews/2008/01/28/bica0128.htm.

64. Lahey, James. Health Care Plans — Traditional Health Care Plans. [ezinearticles.com/?Health-Care-Plans — Traditional-Health-Care-Plans&id=2928546](http://ezinearticles.com/?Health-Care-Plans—Traditional-Health-Care-Plans&id=2928546).

65. Madden, Susanne. Understanding New Practice Payment Models. *Physicians Practice Pearls*. www.physicianspractice.com.

Accountable Care Organizations

The Affordable Care Act (ACA) established a new breed of health care delivery system known as the accountable care organization (ACO). An ACO is a collaboration of physicians and health care professionals who accept responsibility for the costs, quality, and effectiveness of care they deliver to a defined patient population, such as Medicare, Medicaid, or commercial health plan patients. In some cases, payers give ACOs a single payment based primarily on population health and other factors, and the ACO determines how to use those funds to pay the physicians and health care professionals within the organization.⁶⁶ This model is gaining popularity among hospitals, independent practice associations, and other large organizations able to bring physicians under the umbrella of one ACO.

The emergence of ACOs illustrates the shift away from fee-for-service payment to payment based on patient care outcomes. Chapter 8 addresses ACOs further.

Concierge Medicine

Some physicians have found a different way to practice medicine in an attempt to get around Medicare cuts, decreased payments, increased patient loads, and bureaucratic hassles. The concept of concierge medicine is gaining traction among physicians. In this model, patients typically pay physicians a yearly membership or retainer fee for access to services not covered by insurance. Concierge medical services commonly include same-day or next-day appointments, house calls, accompaniment by a doctor to appointments with other physicians, and wellness advice, among others. The model is popular with family physicians because it allows them to scale back their patient load, provide greater one-on-one attention, and focus on preventive care — not just treat illnesses. Some physicians stop taking insurance altogether after switching to a concierge medicine practice; others continue to contract with plans, which can be risky.

Physicians considering switching to concierge medicine should have an attorney review their insurance contracts and help them determine the contractual limitations on what they can charge patients. Physicians can get into serious legal trouble for billing Medicare patients and other insured patients for services already covered by insurance. Attorneys also can help physicians determine how to terminate their contracts with health care payment plans.

Health Savings Accounts

The rise of consumer-driven health care will have an impact on medical practices. In this model, patients use a health savings account (HSA) or other product to pay for care and have a high-deductible health plan to cover catastrophic medical expenses. Patients who end up with a balance in their account at the end of the year can carry over the money and allocate it toward future health expenses. Patients enrolled in consumer-driven health plans tend to be savvy about medical costs and budgeting, so physicians should be prepared to discuss such topics with these patients. Additionally, patients

66. Ibid.

on these plans prefer to go online to gauge cost and quality of procedures, tests, labs, treatments, and other care. Physicians should expect to converse about quality data with these patients.

Because high-deductible health plans require out-of-pocket payments from patients, practice management staff should develop processes for requesting payment from patients covered by these plans and educating them about services the plans cover.⁶⁷ For example, the practice can:

- ◆ Verify insurance eligibility and benefit coverage electronically or by phone;
- ◆ Estimate total expected charges and calculate patients' financial responsibility at registration;
- ◆ Call patients as early as possible to inform them of their payment responsibility; and
- ◆ Add/train staff to help patients with Medicaid and financial assistance applications, and early qualifications for charity care.⁶⁸

Negotiating Payer Contracts

Physicians should never sign a contract without first reading it and ensuring they understand its provisions. In reality, contracts with insurers will contain some conditions that are not in the best interests of patients or physicians. Contract negotiations are part of doing business in today's health care industry. To properly prepare to negotiate with insurance companies, physicians should assess their position in the marketplace by evaluating their competition, set realistic and attainable goals, develop a negotiation mindset, and know when to compromise and when to walk away.⁶⁹

When negotiating, physicians shouldn't assume their efforts will be fruitless. They should provide an opportunity for payers to make a counteroffer. Staying focused on the issues being negotiated is pivotal, as is accepting concessions that help move physicians to their final goal. For each concession made, physicians should seek something in return from payers.⁷⁰

Before participating in a health care payment plan, or managed care organization (MCO), physicians should explore many concerns in great detail. Certainly, the contract is important, and someone competent to do so should evaluate it carefully. But other factors that will not appear in the contract will be critical in determining how physician-friendly or patient-friendly the plan is. Below is a list of questions to ask the MCO representative before signing a contract.

- ◆ Will I have a dedicated representative who will know my office and its needs?
- ◆ How often can I expect to see a representative in my office?
- ◆ How easily can I reach my representative if I have a question or a problem?

67. Health Leaders Media. *Population Health Insider*. www.healthleadersmedia.com/HOM-224118-4625/Five-questions-about-physicians2019-role-in-CDHPS.

68. *Ibid.*

69. Howrigan, Ron. Negotiating Payer Contracts. *Oncology Issues*, July/August 2008, Pg. 27.

70. *Ibid.* Pg. 29.

- ◆ Will the plan provide a physician manual (and/or online resources) that gives clear instructions, resources, and information about how my office staff and I can treat patients covered by the plan?
- ◆ How will I verify coverage status of a patient?
- ◆ What services require that I contact the plan for approval, and what services can I arrange without approval from the plan based on my own judgment?
- ◆ How will I get preauthorization to provide services (by phone, fax, email, website access)?
- ◆ How do I get an approval for referrals to a specialist (by phone, fax, email, website access)?
- ◆ What information will I need to secure a referral or authorization?
- ◆ Who must request the referral — doctor, nurse, administrative staff?
- ◆ Who will be available to take and evaluate referral requests — nurses, physicians, others? If others, what training will they have had?
- ◆ What are the procedures for appealing a denial of authorization for services?
- ◆ Is the independent review organization process available to patients and physicians?
- ◆ Who will notify the patient when the plan approves the referral — plan or referring provider?
- ◆ How long do I have to submit a claim?
- ◆ What is the claim payment time?
- ◆ Who will help me if I have a question or problem regarding a claim payment?
- ◆ What is the contractual payment? Is the contract paid on a percentage of billed charges, percentage of Medicare, or a fee schedule? If the rates are based on a percentage of Medicare, is it current-year Medicare or tied to a specific year? If it is tied to a current year of Medicare, how quickly do you update your fee schedules after Medicare has an update?
- ◆ Is a copy of the fee schedule available to me and attached to the contract?
- ◆ Can it be changed unilaterally?
- ◆ How often are immunizations and other drug costs updated, and on what methodology do you set your drug payment?
- ◆ How often do you update the fee schedule?
- ◆ Will the plan provide me a representative fee schedule to review?
- ◆ Can I bill the patient directly for services the plan does not cover?
- ◆ Are there certain services for which the plan will refuse payment (such as pathology, laboratory, flu, or other rapid tests or radiology services)? That is, if I provide these services, will I receive zero payment from the plan and be prohibited by contract from billing the patient?

- ◆ What criteria are used in determining the medical necessity of a requested treatment? Is a physician involved in that determination?
- ◆ Are practice guidelines and utilization review protocols available to physicians contracted with the plan? How do I obtain a copy?
- ◆ What review criteria are used in assessing and profiling quality and cost efficiency of physicians' care? How are these criteria developed? Are practicing physicians involved? Will I have access to my data for analysis?
- ◆ What is the composition of your Physician Advisory Committee and the Quality Improvement Committee?
- ◆ What limits of liability coverage is the practice required to have?
- ◆ Will I be required to purchase a "tail" policy if I terminate my participation?
- ◆ Does the plan require participation on a quality assurance or utilization review committee? If so, does the plan have insurance that will indemnify me from any lawsuits related to these functions?
- ◆ How will I be rated on quality and cost? What appeals process is available?
- ◆ What type of on-call coverage is required?
- ◆ Does the contract require 24-hour-per-day, seven-day-per-week availability?
- ◆ What is the plan's policy on confidentiality?
- ◆ What is the plan's marketing plan for this area?
- ◆ How many members does the plan currently cover in how many markets?
- ◆ Which other doctors and hospitals in the area are participating in the plan program? Does the plan intend to contract with other providers?
- ◆ What has been your financial success — profit or loss?
- ◆ What is the plan's medical loss ratio?
- ◆ Will the plan provide audited financial statements of its operations? Does the plan own its own network, or does it rent out the network to other insurance companies or payers? Will I be notified of these rentals?⁷¹

These are a few of the questions that can help in understanding what it will be like to care for patients under the health care payment plan program. Certainly, there are many more areas to consider, but the contract should be the pivotal influence. Physicians should ask for physician references and talk with doctors and front office staff who have worked with the MCO. Careful investigation can help physicians find the best plan for the practice.

The following checklist describes some common problems of which physicians should be aware, based on some of the more troublesome provisions that continue to plague many of today's managed care agreements. They identify possible areas of legal and regulatory concern that may require legal advice and consultation.

71. Stern, Michael Z. *Managed Care Contract Guide*. Texas Medical Association, 2011, Pgs. 2-5.

Because of the frequent changes, complexity, and scope of the many laws and regulations, as well as differences in drafting and wording of various agreements by different plans, this list of suggested concerns and the examples that follow are by no means exhaustive. Practices should seek independent legal advice as to particular agreements and matters of concern.

- ◆ The contract should sufficiently identify the party (or parties) responsible for payment. The contract also should offer the physician or practice the right to reject specific payers, plans, panels, groups of patients, fee arrangements, and the like without having to terminate the contract in its entirety.
- ◆ The contract should prohibit assignment, a process by which an MCO can sell or transfer plans, panels, groups of patients, fee arrangements — or the contract in its entirety — to another managed care company, payer, or administrator without notice or consent.
- ◆ The contract not only should require payment of the physician(s)' fees within the statutory period but also propose meaningful incentives for the payer's compliance with this requirement (for example, interest on past-due amounts or waiver of any discount).
- ◆ The contract should give the practice a reasonable amount of time to submit completed bills, and allow the practice to submit bills after the deadline when extra time is required due to circumstances beyond the physician's control.
- ◆ When permitted by law, the contract should allow the practice to bill patients: (a) when the company or the payer fails or is unable to pay, (b) for services not covered by the contract, and (c) when the physician has advised the patient that plan has determined that proposed services are not medically necessary.
- ◆ The physician(s) should obtain and understand the health care payment plan's procedures for verifying patient eligibility and coverage. The contract also should require the payer to pay for any services the physician renders when relying on mistaken verification by the payer.
- ◆ The practice should receive detailed descriptions of the plan's utilization review, quality assurance, and other policies and procedures. The contract should state that the plan's policies and procedures may not be amended without notice to the practice. The contract also should request that the practice have the opportunity to object to any undesirable amendments.
- ◆ If the contract requires the physician's participation on committees, it also should supply the physician with adequate liability insurance and reasonable compensation for such activities.
- ◆ The contract should specify the amounts and types of insurance that the physician is required to carry. The contract also should indicate the amounts and types of insurance coverage that the payer(s) and other parties to the contract are required to carry.
- ◆ The contract should not require the physician to obtain "tail" insurance upon termination of the contract.

- ◆ The contract should not require the physician to “indemnify” or “hold harmless” other parties for the physician’s actions. The contract should not contain “provider solely responsible” or “independent medical judgment” language.
- ◆ The contract should not call for the physician to “use best efforts” or to render “the highest quality care.” Instead, the contract could require the physician to “use reasonable efforts,” and to hold the physician to the standard of “a reasonable physician acting under the same or similar circumstances.”
- ◆ The contract should not allow the MCO to unilaterally amend the contract and/or fee schedule(s) without notice. The contract also should allow the practice the opportunity to object to undesirable amendments.
- ◆ The contract should not contain provisions that force physicians to significantly alter their practice with respect to availability, referral practices, staffing, and the like (for example, back-up and on-call coverage requirements).
- ◆ The contract should assert that the physician shall comply with the health care payment plan’s referral requirements only if “medically appropriate in the physician’s judgment.” Alternatively, the practice should try to get assurances or a warranty about the quality of the process for credentialing participating physicians.
- ◆ The practice should obtain, review, and understand the plan’s fee schedule, including bundling and rebundling policies and procedures.
- ◆ The contract should not contain a “lowest fee schedule” provision by which the plan can choose among its fee schedules with the physician and pay according to the lowest of the schedules.
- ◆ The contract should allow for termination of the contract without cause by the physician upon 30 days’ notice, and should provide that any termination without cause by the MCO be in accordance with statutory procedures.
- ◆ The contract should declare that any “for-cause” termination of the contract by the MCO be allowed only after notice and a reasonable opportunity to cure, and should only be as a result of “material cause related to the physician’s performance of services under the contract.”
- ◆ The contract should allow for prompt referrals of patients after termination of the contract, and should not require the physician to continue services to members for an extended period after contract termination except as required by statute.
- ◆ The contract should prohibit the company from disclosing any information given by or about the physician in connection with any credentialing or peer review deliberations, unless such disclosure is otherwise required by law.
- ◆ The physician(s) should carefully review and consider provisions in the contract pertaining to dispute resolution. Specifically, what are the MCO’s internal dispute resolution procedures that must be completed prior to initiating arbitration or litigation? Is there a shortened contractual limitations period? What arbitration processes are prescribed, and are there any limits on the extent of the ability to arbitrate or litigate? Are there limitations on the damages or remedies that may be awarded? Does the contract prohibit class-action lawsuits?

- ◆ The practice should obtain and review all documents that relate to the contract or are referred to in the contract. Also, the contract should expressly incorporate all representations, promises, inducements, and warranties that are made to the physician(s) (i.e., verbal assurances and representations that were a material influence in convincing the physician to enter into the contract).

The following are actual provisions commonly found in MCO, agreements that may impose additional liability or exposure on the physician. Physicians should seriously consider whether it is advisable to execute contracts that contain provisions such as the following:

- ◆ **Offsets.** Provider agrees that MCO and/or the applicable payer may deduct monies that may otherwise be due and payable to MCO or the payer from any outstanding monies that provider may, for any reason, owe to MCO or the payer. Provider agrees that MCO and applicable payers may make retroactive adjustments to the payment arrangement provided herein.
- ◆ **Noninterference with members.** Provider shall not advise or counsel an enrollee to disenroll from MCO's or any payer's plan, or to seek such services from another company or payer, nor shall the provider directly or indirectly solicit any enrollee to enroll in any other health care service plan or insurance program.
- ◆ **Indemnification.** Provider shall indemnify MCO and hold MCO harmless against any and all loss, damage, liability, and expense, including court costs, with respect to this contract resulting from or arising out of the negligent, dishonest, fraudulent, or criminal acts or omissions of the provider, including the provider's employees, contractors, agents, shareholders, officers, and directors acting alone or with others.
- ◆ **Noninterference with patient-physician relationship.** Nothing in this contract shall be construed to interfere with the patient-physician relationship.
- ◆ **Physician solely responsible.** The parties agree that all decisions made by the MCO relate solely to the MCO's obligation to make payment for medically necessary services under this contract, and in no way are meant to influence the scope or nature of medical services rendered by the provider. The provider is solely responsible for all health care decisions respecting the members who are eligible to receive services under this contract.
- ◆ **Termination without cause.** The MCO may terminate this contract without cause upon at least 90 days' notice. (The physician may determine that termination without cause is acceptable as long as both parties have the right to terminate the contract without cause.)
- ◆ **Post-termination.** Upon termination, the provider shall continue to offer services under this contract for up to one year or until the enrollees are transferred to another provider.
- ◆ **Liability.** Notwithstanding anything herein to the contrary, the MCO's liability, if any, for damages to the provider for any cause whatsoever arising out of or related to this contract, regardless of the form of the action, shall be limited to the provider's actual damages, not to exceed the amount actually paid to the provider by the MCO under this contract during the 12 months immediately prior to the

date the cause of action arose. Further, the MCO shall not be liable for any indirect, incidental, punitive, exemplary, special, or consequential damages of any kind whatsoever sustained as a result of a breach of contract or any action, inaction, alleged tortious conduct, or delay by the MCO.

- ◆ **Limitation on action.** Notwithstanding anything herein to the contrary, no action, regardless of form, arising out of or relating to this contract may be brought by the provider against the MCO more than 12 months after such cause of action has arisen.
- ◆ **Governing law.** This contract will be controlled, construed, and enforced in accordance with the laws of the state of the MCO's principal offices.
- ◆ **Venue.** Any action brought to enforce or interpret this contract shall be brought in the county of the MCO's principal offices.⁷²

Individual Versus Group Contracts

Because claims must be submitted with the tax identification number of a contracted entity, physicians who anticipate billing under a separate tax identification number must contract individually. Physicians who credential through a group, independent practice association (IPA), or physician hospital organization (PHO) must be recredentialed upon leaving the contracted entity if they want to continue as network providers. If a group practice adds or relocates a service such as urgent care, physical therapy, or an imaging center, additional credentialing, and possibly additional contracting, are required if physicians will submit under a separate tax identification number.

IPAs typically take the form of not-for-profit corporations, limited partnerships, or limited liability companies that bring “physicians together to negotiate and contract directly with managed care plans and contract directly with employers.” IPAs contract with health care payment plans on a capitated or fee-for-service basis and with physicians to care for individual plan enrollees.⁷³ Note, there are legal restrictions on nonintegrated IPAs negotiating contracts on a fee-for-service basis. Physicians should consult a health law attorney prior to engaging in such negotiation.

Hospitals and their medical staff members typically make up PHOs. These large delivery systems can be successful in negotiating health care payment plan contracts when the hospital's interests align with the interests of physicians on the medical staff. PHOs must also be integrated to negotiate contracts for physician services on a fee-for-service basis. Before joining a PHO, physicians should determine whether being a member of the organization allows them to independently contract with payers. They should also determine whether the contract terms are more or less favorable through the PHO or directly with the payer.⁷⁴

IPAs, PHOs, and other group structures can have strength in numbers when negotiating managed care contracts. Successful negotiation depends on whether the IPA or group

72. Stern, Michael Z. *Managed Care Contract Guide*. Texas Medical Association, 2011, Pgs. 2-11.

73. Tinsley, Reed. *Managed Care Contracting: Successful Negotiation Strategies*, American Medical Association, 1999, Pg. 21.

74. *Ibid.* Pg. 25.

has possible leverage through geography or documented clinical quality. The numbers strategy in managed care negotiations requires physicians to be mindful of antitrust concerns. For more information on antitrust, visit the Department of Justice Antitrust Division website, www.justice.gov/atr/index.html, and the Federal Trade Commission antitrust website, www.ftc.gov/bc/healthcare/antitrust/index.htm.

Working With Government Payers

Medicare

Physicians have three Medicare contracting choices:

1. Sign a participating agreement and accept Medicare's allowed charge for all patients covered by the program,
2. Elect to be a nonparticipating physician and bill patients for more than the Medicare allowed charge for unassigned claims, or
3. Forego any payments from Medicare.

Before deciding Medicare status, physicians should review their contracts with hospitals, health plans, and others for provisions that obligate them to participate in Medicare. Physicians should also check whether laws in their state prohibit them from balance billing their patients. Those who want to switch from being a Medicare-participating physician to a nonparticipating physician have the opportunity to do so annually. To opt out of Medicare completely, physicians must give 30 days' notice before the first day of the quarter in which the contract goes into effect. Medicare opt-out must be renewed every two years to stay in effect.

Medicare provides physicians the following participation incentives:

- ◆ Medicare-participating physicians receive payments that are 5 percent higher than the payment nonparticipating physicians receive.
- ◆ Medicare-participating physician directories are available upon request.
- ◆ Medicare-participating physicians have access to toll-free claims processing lines and have the advantage of faster claims processing.

It is important to note Medicare participation agreements do not require physician practices to treat every Medicare patient seeking care. However, Medicare-participating physicians cannot balance bill patients for amounts that exceed the Medicare allowance.

While nonparticipating Medicare physicians can charge more than the Medicare allowance, the program limits charges to 115 percent of the Medicare-approved amount. AMA advises that when deciding whether to be nonparticipating, physicians should calculate whether "their total revenues from Medicare, patient copayments and balance billing would exceed their total revenues as participating physicians, particularly in light of collection costs, bad debts and claims for which they do accept assignment."⁷⁵

75. Society of Nuclear Medicine and Molecular Imaging. <http://interactive.snm.org/docs/11-07-2005-AMAMedicareParticipationOptions.pdf>.

Physicians should carefully weigh their options before deciding to opt out of the Medicare program. Once opted out, physicians cannot bill Medicare for any enrolled patients for two years. It is an all-or-nothing endeavor. To opt out, a physician must file a special affidavit the Medicare carrier must receive least 30 days before the first day of the next calendar quarter. Physicians have 90 days after the effective date of the first opt-out affidavit to revoke the opt-out and return to Medicare as if they had never opted out.⁷⁶ For more information on Medicare, visit the Centers for Medicare & Medicaid Services (CMS) website, www.cms.gov/Medicare/Medicare.html.

Medicaid

According to the Kaiser Commission on Medicaid and the Uninsured, Medicaid provides health coverage to more than 60 million low-income Americans. States administer the program and jointly finance it with the federal government. In Texas, the Texas Health and Human Services Commission (HHSC) administers Medicaid; for information, see the HHSC website at www.state.tx.us/medicaid. Because Medicaid rules and regulations vary by state, physicians in other states should contact the Medicaid administrator in their state for information on program participation. Visit www.medicaid.gov for Medicaid information by state.

Children, disabled adults, and senior citizens make up a large proportion of Medicaid beneficiaries. Kaiser reports Medicaid finances 16 percent of all personal health spending. The Affordable Care Act provides states the opportunity to expand Medicaid eligibility. Medicaid provides acute health and long-term care for enrollees. It's becoming common for states to enroll Medicaid recipients who are disabled and who qualify for Medicaid and Medicare in managed care plans. According to Kaiser, state Medicaid programs must cover:

- ◆ Inpatient and outpatient hospital services;
- ◆ Physician, midwife, and nurse practitioner services;
- ◆ Laboratory and x-ray services;
- ◆ Nursing facility and home health care for individuals aged 21 and older;
- ◆ Early and periodic screening, diagnosis, and treatment for children younger than 21;
- ◆ Family planning services and supplies; and
- ◆ Rural health clinic or federally qualified health center services.

Some state Medicaid programs include optional services, such as prescription drugs, dental care, durable medical equipment, and personal care services.⁷⁷

76. American Academy of Family Physicians. www.aafp.org/online/en/home/practicemgt/mcareoptions.html.

77. Kaiser Family Foundation. www.kff.org/medicaid/7235.cfm.

Pay for Performance

Pay-for-performance programs (also known as value-based purchasing) are payment models that reward physicians, hospitals, medical groups, and other health care practitioners for meeting certain performance measures for quality and efficiency.⁷⁸ While the programs promise payment increases, better efficiency, and high-quality care, they have some disadvantages. Physicians need to be aware of technology costs, data collection responsibilities, and guidelines associated with pay-for-performance programs.

AMA has developed guiding principles for patient-centered, pay-for-performance programs that help ensure financial incentives have evidence-based performance measures at their foundation. AMA's five pay-for-performance program principles are:

1. Ensure quality of patient care through evidence-based measures that physicians create.
2. Foster the patient-physician relationship.
3. Offer voluntary physician participation.
4. Use accurate data and fair reporting, and allow physicians to review, comment on, and appeal results prior to reporting.
5. Provide fair and equitable program incentives that support the quality improvement goals among all participating physicians.⁷⁹

AMA's pay-for-performance guidelines complement the principles outlined above and help physicians evaluate programs. To read the complete guidelines, visit www.ama-assn.org/resources/doc/psa/guidelines4pay62705.pdf.

Medicare has been a pioneer in the pay-for-performance landscape, having created the Physician Quality Reporting System (PQRS) in 2007. PQRS is a voluntary reporting program that pays bonuses to physicians and other eligible health care professionals who satisfactorily report data on quality measures in treating Medicare Part B patients. The program's intent is to get physicians used to documenting and reporting the care they already provide to patients.

In 2007 and 2008, the bonus equaled 1.5 percent of a physician's total allowed charges for physician fee schedule services. That increased to 2 percent in 2009 and 2010. Under the ACA, however, the bonuses dropped to 1 percent for 2011 and .5 percent for 2012 through 2014. In 2015, physicians who do not report data to PQRS will see a 1.5-percent cut in their payments. That penalty increases to 2 percent in 2016 and subsequent years.

To participate in PQRS, physicians can report data via claims, a qualified registry, or EHRs. Physicians who have adopted an EHR should check with their vendor to see if their system is capable of reporting their PQRS data to CMS. This is often a free service

78. Texas Medical Association. Performance Improvement Programs. www.texmed.org/PerformanceImprovementPrograms/

79. www.ama-assn.org/resources/doc/psa/principles4pay62705.pdf.

and does not require staff time to review charts and to re-enter patient information.

Physicians who have not adopted an EHR can use a registry to report to CMS. Qualified registries have undergone a CMS vetting process that includes checking their ability to provide the required PQRS data elements, ensuring the registry calculates the measure's reporting and performance rates correctly, and transmitting the required information in the requested file format. Reporting via registry has proven to be more successful than via claims. It simplifies the process and allows the physician to report on just the required 30 patients rather than having to remember to include the special quality code on every claim submitted.

Information on the CMS website, www.cms.gov/PQRS, can help PQRS participants review feedback reports, as well as prepare practices that are considering participation in PQRS. Starting Jan. 1, 2013, CMS began publishing physician performance information, including measures collected via PQRS, on the Physician Compare website, www.medicare.gov/find-a-doctor/provider-search.aspx.⁸⁰

Fee Schedules

Failure to set appropriate fee schedules for physician services will result in lost revenue for the medical practice. Fees for service should be fair and reasonable for the medical specialty and according to community standards. Practice managers or administrators can perform a fee schedule analysis to determine whether physicians' fees are in line with market rates. Fee schedule information by specialty and location is available for purchase at www.context4healthcare.com/data-products/physician-fee-reports. See also www.FairHealth.org for data tools.

To begin an analysis, the practice should examine explanation of benefits (EOB) documents for commercial insurance carriers, which don't pay physicians a contracted fee. The usual, customary, and reasonable fees these plans pay will give physicians an idea of whether their fees are too high or too low. The practice also should review managed care EOBs. These plans pay physicians discounted fees. If the managed care plans or the commercial insurance companies paid the physician's billed fee in full, that's an indication the fee for that service is too low.

When raising fees, physicians should keep in mind the patient's share of the charges is usually small. A practice's fee schedule should be revised annually to help ensure fees are set appropriately.⁸¹

80. Texas Medical Association. www.texmed.org/Verondi/Templates/TierTwo.aspx?pageid=20994.

81. Tinsley, Reed. *Medical Practice Management Handbook: Complete Guide to Accounting, Tax Issues, Managed Care, and Daily Operations*. Op. cit. Pgs. 8.01-8.03.

CHAPTER SIX

Financial Managers' Roles and Responsibilities

OVERVIEW

Administrative Needs

Physician Profiling

Financial Manager Involvement

Medical groups need a qualified financial manager who is adept at third-party and government payer procedures and accounting, and familiar with applicable regulations.

The administrative needs of medical practices may vary based on certain factors, including the following:

- ◆ Size: Small practices with one or two physicians may need only a seasoned office manager, while larger practices may need a professionally trained administrator.
- ◆ Goals and strategic planning: Do the physicians have a long-term strategy to grow the practice or just want someone else to run the business? Do they have short-term goals or also think about the “big picture” (three years or beyond)?
- ◆ Transition: Is the practice going through a merger or downsizing or experiencing new growth? The practice may need a different type of manager or skill set as it expands or downsizes.
- ◆ Billing and collections: If improving billing and collections is a goal, the practice may need an office manager or administrator with expertise in the management of front and back offices.
- ◆ Authority and decisionmaking: Are the physicians willing to give a nonphysician the authority to manage day-to-day operations? How much decisionmaking are they willing to share?⁸²

Larger practices may designate the CEO or chief financial officer (CFO) as the financial manager. A nonphysician typically holds the CEO position, which directs senior management and overall practice operations. The CEO reports to the board of directors of the organization. CFOs develop and implement financial policies. The organization's senior financial officer manages the budget; reviews the organization's

82. Texas Medical Association. *Your Guide to Hiring a Practice Manager*, 2011. Pg. 2.

financial performance; and handles accounting, billing, payer contracts, collections, taxes, annual reports, and funding. The CFO reports to the senior administrative officer or the governing body of the organization. Additionally, medical practices may hire a controller, practice administrator, or office manager to oversee finances.⁸³

Financial Management Competencies

Financial managers need to stay abreast of new developments in health care. They should have a comprehensive understanding of the following:

- ◆ Financial ramifications of the ACA,
- ◆ Continuous quality improvement measures,
- ◆ Cost accounting for pricing and managing the practice,
- ◆ Government payment regulations,
- ◆ Capital budgeting and acquisitions,
- ◆ Financial analysis and benchmarking,
- ◆ Outcomes-based research,
- ◆ Fraud and abuse compliance, and
- ◆ Accountability perspectives.⁸⁴

Financial managers also should be familiar with physician profiling. The American Academy of Family Physicians defines physician profiling as “an analytic tool that uses epidemiological methods to compare physician practice patterns across various quality of care dimensions.”⁸⁵ Payers use physician profiling “to steer their members to in-network physicians who, by their measures, are the most cost-efficient and provide the highest quality of care.” It’s crucial that financial managers track physicians’ profiling reports and either validate or refute them. Failing to act on poor physician profiling scores could result in patient loss and a hit to the bottom line.⁸⁶

Practices should provide pay, or help pay, for financial managers to participate in related professional organizations and attend their conferences. Physician leadership should encourage financial managers to keep abreast of ongoing changes in the health care environment by:

- ◆ Attending professional education courses,
- ◆ Joining and becoming active in professional associations and societies,

TIP

Financial managers need to stay abreast of new developments in health care.

83. Pavlock, Ernest J. Op. cit Pgs. 5-8.

84. Ibid. Pg. 8.

85. American Academy of Family Physicians. www.aafp.org/online/en/home/policy/policies/p/physicianprofiling.html.

86. Madden, Susanne. Physician Profiling. www.physicianspractice.com/payers/physician-profiling.

- ◆ Reading health care and medical group publications to learn of the latest developments in financial management,
- ◆ Networking with other financial managers to obtain information and assistance,
- ◆ Requesting assistance from the accounting firm the medical group uses, and
- ◆ Hiring and working closely with a financial management consultant to help establish new systems or revise old systems.⁸⁷

87. Texas Medical Association. *Op. cit.* Pgs. 8-9.

CHAPTER SEVEN

Embezzlement Prevention and Internal Controls

OVERVIEW

Preventive Steps

Red Flags

Additional Insurance

According to the Association of Certified Fraud Examiners (ACFE), small businesses with fewer than 100 employees are hardest hit by fraud. Many physician practices fall into this group, which suffered a fraud rate of 31.8 percent and a median loss of \$147,000 in 2012. Their larger counterparts with 100 to 999 employees had a median loss of \$150,000 due to fraud at a rate of 19.5 percent. The report blames the higher frequency of fraud in small businesses on their limited resources for antifraud efforts.⁸⁸

ACFE projects U.S.-based companies lose 5 percent of their annual revenue due to fraud, including embezzlement. With minimal funds to pour into theft prevention, solo and small physician practices face some challenges. Luckily, physicians can take the following 10 simple steps to help avoid becoming victims of employee embezzlement:

1. Segregate employee duties.
2. Pre-number charge tickets.
3. Monitor refunds and payables.
4. Perform regular audits.
5. Sign checks personally.
6. Write receipts for cash payments.
7. Check potential employees' backgrounds.
8. Bond employees.
9. Audit payroll records.
10. Trust their own instincts.

88. Association of Certified Fraud Examiners. *Report to the Nations on Occupational Fraud and Abuse*. www.acfe.com/uploadedFiles/ACFE_Website/Content/rtrn/2012-report-to-nations.pdf.

Physicians need to pay attention to increased refunds or write-offs, checks that lack supporting documentation, payments to unusual vendors, and questionable credit card charges. These are just a few of the indicators that something may be amiss in a practice's finances. Physicians should trust their employees, but they also should be aware of some of the common embezzlement schemes and understand the red flags that may indicate they're victims of theft.

According to ACFE, the most costly embezzlement schemes are check tampering, skimming, billing, and noncash misappropriations. Check tampering involves employees writing company checks to themselves or stealing outgoing checks and depositing them in their own bank accounts. Skimming involves stealing cash from an organization before it is recorded on the books. Billing schemes may involve an employee setting up a shell company and billing an employer for services never rendered. Noncash misappropriations could include theft of office supplies and equipment or misuse of confidential patient financial information by an employee. Another well-known scheme occurs when employees make personal purchases with the office credit card. Some embezzlers create fake vendors and have physicians sign checks to pay for fake invoices.

In addition, employees often display certain behaviors or characteristics that signal they may be engaged in some fraudulent activity. Employees may claim to work weekends and overtime to catch up on tasks, but they're actually using the opportunity to steal.

ACFE's top five red flag behaviors are:

- ◆ Living beyond means (35.6 percent);
- ◆ Financial difficulties (27.1 percent);
- ◆ Unusually close association with vendor or customer (19.1 percent);
- ◆ Control issues, including an unwillingness to share duties (18.2 percent); and
- ◆ Divorce or family problems and wheeler-dealer attitude (both 14.8 percent).⁸⁹

Other common indicators that an employee may be embezzling include refusal to take vacations so someone filling in will not discover his or her misdeeds; irritability, suspiciousness, or defensiveness; past employment-related problems; and complaints about inadequate pay and lack of authority. While these warning signs don't necessarily mean an employee is guilty of embezzlement, physicians and office managers should understand and recognize them.

Physicians should avoid giving one employee complete control of practice finances and should sign all checks and regularly review bank and credit card statements. It's a good idea for physicians to separate job duties, ensuring not just one person is in charge of opening the mail, posting cash and check receipts, approving adjustments, preparing and making deposits, and preparing refund checks. Another deterrent to theft involves thoroughly vetting potential employees and checking their work history.

89. Ibid.

Physicians should personally interview candidates and pay them competitive salaries. Employees who feel their boss appreciates them can be the greatest control against theft and can make the practice more profitable.

Another way to protect the practice against embezzlement is to purchase employee dishonesty insurance. The coverage insures a practice against financial loss from employee theft and allows it to recoup the loss. The coverage can be added to a general liability policy and protects against employee theft of money, property, or securities. Fidelity bonds, which provide the same type of coverage as employee dishonesty insurance, also offer protection. They safeguard a practice not only from employee theft but also from theft by a third party, such as a vendor or independent contractor. Physicians should contact their insurance agent for coverage limits.

Physicians should consider engaging a practice management consultant or their CPA to perform a review of the practice's internal controls. The review can be detailed and include written suggestions for improvement. Should a medical practice fall prey to employee theft, physicians should begin collecting supporting documentation that shows evidence of theft and then contact their attorney, accountant, and the local police to prosecute the thief.

TIP

Another way to protect the practice against embezzlement is to purchase employee dishonesty insurance.

CHAPTER EIGHT

Strategic Planning

OVERVIEW

12-Step Process

Marketing Plan

Physician Employment
Arrangement

Unlike the business plan for the practice, the strategic plan takes a shorter view of the venture's future. The strategic plan for the business is a continual work in progress that focuses on the most immediate concerns and helps guide physicians to their goals by creating a road map to achieving them. Strategic plans aid managers in making decisions and solving problems; developing marketing, product, and service plans; and defining growth tactics. Involving all staff members in the strategic planning process and in executing strategic

initiatives is critical to the practice's success.⁹⁰

Long- and Short-Term Planning

Before a practice develops a formal strategic plan, physicians and practice managers or administrators need to examine the marketplace and analyze the medical group internally. One way to accomplish this is to distribute a list of questions to physicians and staff members in regard to the health care industry, external market, and the practice. Common questions include:

- ◆ What services does the medical group provide?
- ◆ How does the size of the practice compare with others in the area?
- ◆ What is the medical group's major competition?
- ◆ What is the state of the economy?
- ◆ Are there any market trends that could positively or negatively affect the practice or its strategy?
- ◆ What is the practice's mission?

90. Medical Group Management Association. *The Medical Practice's Ultimate Business Planning Workbook*, 2008, Pgs. 103-104.

- ◆ What are the strengths and weaknesses of the medical group?
- ◆ What opportunities and potential threats does the practice face?⁹¹

Using information gathered from the questionnaires, the practice can begin the following 12-step process with physicians and senior managers to develop a strategic plan:

1. Analyze the external market to identify new and existing opportunities for products and services. Practices should focus on “economic, competitive, technological, governmental, and market forces.”
2. Analyze the medical group internally by reviewing balance sheets, the past five years’ operating statements, profit and loss reports, capital purchases, and lawsuits.
3. Identify the strengths and weaknesses of the medical group. Doing so will allow the practice to pinpoint competitive advantages and possible threats to success.
4. Consider managers’ personal values, which represent “guides and constraints upon the direction of the business.”
5. Review the medical group’s mission, values, and vision to ensure they move the practice toward achieving its goals.
6. Identify needs for products and services in the marketplace that the practice can fulfill.
7. Define services, products, and market scope to help reduce the amount of time spent making decisions related to new acquisitions and investments.
8. Define the group’s competitive edge by evaluating “unique group skills, position, market advantages, and other competitive factors.”
9. Establish goals, objectives, and measures of performance to clearly define the practice’s strategy. Measuring the practice’s performance may involve examining annual revenue growth rate, profits, return on investment, and other indicators.
10. Decide whether to focus resources on acquisitions or internal growth. Appropriate allocation of staff, equipment, and supplies is vital to success.
11. Communicate the strategic plan internally and externally to ensure all involved parties understand how the goals affect them.
12. Develop action plans in each department by crafting employee goals that are “specific, measurable, achievable, results-oriented, and time-bound.”⁹²

91. Medical Group Management Association. *Aligning the Team with Practice Goals: A How-To Guide for Medical Practices*, 2009, Pgs. 36-37.

92. *Ibid.* Pgs. 37-39.

In addition to conducting strategic planning in the start-up phase of the medical practice, physicians also should do so at least annually and when developing new products or services. Practice management experts also recommend a quarterly review to make sure the practice is adhering to its strategic plan.⁹³ If the practice is falling short of its goals, management needs to answer the following questions:

- ◆ Will we be able to achieve the goals in accordance with the strategic plan's timeline?
- ◆ Should we change completion deadlines for goals?
- ◆ Do staff members have appropriate resources to achieve the goals?
- ◆ Are the goals realistic?
- ◆ Should we shift priorities to put more emphasis on achieving the goals?
- ◆ Should we change the goals?
- ◆ What can we do to improve future strategic planning?

Practice managers or administrators should record the answers to these questions, then document and communicate required action. Upon evaluation, the practice may determine it's wise to change some of the goals within the strategic plan. When doing so, leadership should articulate why the changes are necessary and what the specific changes are.⁹⁴

Developing Action Plans

The final step in creating the practice's strategic plan involves developing an action plan that determines the following:

- ◆ Specific actions to accomplish the strategies,
- ◆ Priority of actions,
- ◆ Timing of actions,
- ◆ Responsibility designated to each department, and
- ◆ Cost of actions.⁹⁵

For example, a practice may have a goal to expand access to care in the community by hiring a new physician and opening a new practice. For the expansion to be successful, the practice must promote the new physician's presence and the new practice location in the area. To achieve the goal, the practice may decide to launch a marketing campaign targeted toward area physicians, patients, influential leaders, and the community at large.

93. Ibid. Pg. 41.

94. Ibid. Pgs. 46-47.

95. American Medical Association. Op. cit. Pg. 271.

To begin, the practice identifies potential referral sources and drafts a list of potential patients, influential community leaders, and media contacts. As part of its action plan, the practice might employ these marketing strategies:

- ◆ Write and disseminate news releases announcing the hire of the new physician and the opening of the new practice;
- ◆ Run an announcement ad in appropriate media outlets;
- ◆ Create materials, such as stationery and business cards, displaying the practice's logo and new office address;
- ◆ Develop a direct mail list of potential patients in the surrounding area; and
- ◆ Mail a postcard to people on the list announcing the new office location and new physician.

Regardless of the action plan, a practice should produce a timeline and establish a budget to carry it out.⁹⁶

Marketing and Public Relations

A medical practice in the community that no one knows about isn't going to last long. Practices that understand how to create and communicate a positive impression of the business have a competitive advantage in a dynamic health care marketplace. Identifying what makes a medical group unique and spreading the word are essential for healthy business survival. Marketing can be an effective way to cultivate and maintain long-standing relationships with patients who are becoming increasingly savvy about the health care industry. Developing a robust patient base and sustaining it requires practices to understand the following attributes of modern health care consumers. Compared with their counterparts of the past, today's health care consumers:

- ◆ Know more about consumer health products,
- ◆ Are more knowledgeable about health care alternatives,
- ◆ Are more critical and independent,
- ◆ Have more choices and are willing to research alternatives,
- ◆ Are less tolerant of delays,
- ◆ Are less likely to develop long-term relationships,
- ◆ Are more prone to changing loyalties,
- ◆ Ask questions and seek second opinions,
- ◆ Don't want inconveniences, and
- ◆ Are concerned about the future structure of health care and the government's involvement in health care.⁹⁷

96. Medical Group Management Association. *Ready-Set-Market!* 1999, Pgs. 212-214.

97. American Medical Association. Op. cit. Pg. 267.

Once a practice grasps the traits of today's patients, physicians can begin thinking about the marketing mix, made up of these elements:

- ◆ **Product:** physicians' expertise, training, services, office staff, and hours;
- ◆ **Place:** office location, accessibility, and parking availability;
- ◆ **Price:** fee schedule, financing and credit policies, insurance assistance, free screenings, and discounts; and
- ◆ **Promotion:** public relations, practice brochures, and educational materials.⁹⁸

TIP

HIT combined with a major redesign of workflow can reduce practice expenses.

Crafting a marketing plan is a team effort. Physicians and office managers or administrators should certainly be involved. If the practice has money in the budget, working with an independent marketing consultant can be beneficial. If not, practice leadership should select one or more employees who can serve as a marketing representative to help draft the plan. Before finalizing any marketing plans, all those involved should become familiar with Texas Medical Board (TMB) regulations on advertising, including the rules on websites, found in Chapter 164 of the TMB Rules at www.tmb.state.tx.us.

Developing the marketing plan is a four-step process:

1. **Assess the practice.** What differentiates the practice from others in the community? For instance, does it offer extended hours or vaccine clinic services? The marketing team should examine how the practice promotes these and other benefits, whether the practice tracks its competition, and how the practice determines whether patients are satisfied with referring physicians and the practice. The marketing team should scrutinize this information to uncover the practice's strengths and weaknesses.
2. **Create marketing strategies.** An effective marketing strategy has a specific focus, like retaining patients, introducing new services, or attracting new patients. The marketing team will need to identify targeted patient groups, the needs of those groups, essential services that will meet the needs of targeted groups, services that distinguish the practice from its competition, the practice's benefits to patients, and/or managed care areas that best influence the practice's revenues. There's no generic recipe a practice can follow to build the perfect marketing strategies. The plan should be adaptable, and the marketing team should be prepared to make adjustments to help ensure the practice meets its marketing objectives.
3. **Develop an action plan.** See Developing Action Plans on page 61.
4. **Measure results.** This helps illuminate the success or failure of the marketing plan. Depending on what it was trying to accomplish, the

98. Ibid.

practice can measure its results by distributing and evaluating patient satisfaction surveys; determining the increase or decrease in patient visits; monitoring the levels, types, and numbers of procedures and surgeries; and/or examining the change in referral patterns, sources, and numbers.⁹⁹

Here are some simple marketing tips that will help physicians succeed in creating a positive brand identity to retain and attract new patients:

- ◆ Ensure staff members greet each patient by name upon the patient's arrival.
- ◆ Publish a periodic practice newsletter for patients highlighting changes in your practice, and/or information and good health practices related to your specialty.
- ◆ Create and distribute a practice handbook that informs patients of policies, services, and procedures.
- ◆ If appropriate, produce a surgery information packet that includes pre-op and post-op instructions for patients, as well as follow-up care recommendations.
- ◆ Call patients the day after a surgery or office procedure to check on their condition.
- ◆ Distribute an annual satisfaction survey to a sample of patients to determine their service needs and expectations.
- ◆ Consider expanding office hours to make it more convenient for patients to be seen.
- ◆ Develop media contacts at area newspapers, magazines, and broadcast stations.¹⁰⁰

Marketing and public relations (PR) can work hand in hand. PR professionals can help medical practices convey to existing and potential patients a message of safe, convenient, and compassionate care. If a practice has room in the budget to contract with a PR firm or consultant, the relationship can have lucrative benefits.

Another successful PR strategy involves creating press kits that communicate the practice's unique selling points, available procedures, policies, and advantages over competitor medical practices. These materials can be shared with advertisers and members of the media. Medical practice websites are an effective PR tool. In addition to featuring basic information about the practice and its physicians, the site is also an ideal place to promote the group's services and, if applicable, products. HIPAA-compliant patient portals are common electronic medical record features that allow patients to securely make appointments and ask questions. (See Chapter 9 for more about this technology.)

Working with a PR firm or professional who understands the health care market and the unique needs of medical practices is important. Physicians should hire PR experts who have extensive media contacts, a good reputation with journalists, and an impressive professional portfolio.¹⁰¹

99. Ibid. Pgs. 268-271.

100. Medical Group Management Association. Op. cit. Pgs. 47-52.

101. SalesVantage.com. www.salesvantage.com/article/1049/Medical-Practice-Marketing-All-Doctors-Need-PR.

Market and Employment Trends

A new day has dawned for physicians. They must choose whether to continue historical arrangements of private group practices or accept the overtures of corporate employers, such as large hospital systems, which may offer better pay, security, and enhanced work-life balance. In recent years, the landscape of physician employment has changed, and continues to change, seismically.¹⁰²

Many private medical practices embrace the concept of employing physicians. Whether physicians desire to be employees in the long term or temporarily as a step toward acquiring an interest in the practice or striking out on their own, they have several options for employment type and arrangement. AMA defines employment as “a physician being subject to a full- or part-time work commitment wherein that individual is subject to all of the terms and conditions inherent to employment, including withholding of income taxes and the provision of fringe benefits.”¹⁰³

Physicians can be full-time employees who work exclusively for a medical practice, hospital, or other organization. They also can work as independent contractors subject to professional services agreements that stipulate the terms and conditions of the employment arrangement. It's a good idea for physicians to have an attorney review any contract prior to signing it. The following is a list of common physician employment arrangements:

- ◆ Employed by a private practice,
- ◆ Employed by a hospital,
- ◆ Employed by an independent management company,
- ◆ Employed by a corporation,
- ◆ Employed by an HMO or insurance company,
- ◆ Employed by an entity not providing professional services but using expertise as a physician,
- ◆ Employed as a medical director,
- ◆ Employed by an educational institution as a member of the faculty or administration,
- ◆ Employed by a hospital in a nonclinical role, and
- ◆ Independent contractor for a private practice free to work for various medical practices.¹⁰⁴

Hospitals, in particular, are employing physicians at ever-increasing rates. However, it is not clear that these new and emerging models of care will be the panacea that physicians seek. It may well be that the trade-offs in treating the practice of medicine like a business outweigh the perceived freedom from the tyranny of bureaucracy and

102. Kreager, Michael. *A Comprehensive Guide for Physician Employment: Considerations for Employment*, Texas Medical Association, 2012, P. i.

103. American Medical Association, Op. cit. Pgs. 397-398.

104. Ibid.

management. In addition to directly employing physicians where possible, hospitals and health care systems are buying medical groups.

The challenge now facing health care professionals is how to contain costs while maintaining the quality of their care. Consolidation, integration of health care delivery systems, and employment of physicians are key elements in the coming cost-containment efforts. One cost-containment tool of particular importance to physicians is the ACO. The main advantage of ACOs for physicians is the potential for shared savings. ACOs certified by CMS to participate in the shared savings program for Medicare beneficiaries could reap direct financial benefits for lowering their patients' medical costs. Noncertified ACOs also may qualify for some shared savings distributions. The precise manner of shared savings distribution has not yet been determined, but basically, if an ACO meets certain quality and cost-control benchmarks, it will receive some percentage of the savings as determined by CMS.

However, ACOs also would bear the risks of repaying to Medicare a portion of any financial losses should they fail to rein in costs. In addition to shared risk, the ACO would bear the costs of the increased data collection, management, and reporting requirements necessary to satisfy CMS.

Before joining a Medicare ACO, physicians need to be aware that under law they have no recourse in the following situations:

- ◆ If they disagree with the government's decision about whether their ACO is eligible to share in any cost savings,
- ◆ If they disagree with the amount of shared savings the government decides to pay them for their patients under an ACO,
- ◆ If they disagree with the Medicare patients the government assigns to their care under an ACO,
- ◆ If they disagree with how the government plans to measure the quality of care they provide their patients under an ACO,
- ◆ If they disagree with the government's assessment of the quality of care they are giving patients under an ACO, and
- ◆ If the government terminates the ACO from participating in the shared savings program.¹⁰⁵

While it's clear that doctors, hospitals, and health care systems are rushing to jump on the ACO bandwagon, only time will tell if their efforts yield commensurate profits.

In addition to uncertainty about whether physicians will reap financial dividends from ACOs, they also must recognize they likely will give up at least some control over practice management and care decisions. If physicians elect not to create their own ACOs but rather seek employment in an ACO created or controlled by a hospital, the controlling party will capture the largest share of any savings.¹⁰⁶

105. Texas Medical Association. www.texmed.org/Template.aspx?id=19188.

106. Kreager, Michael. Op. cit. Pgs. 1-9.

New Technologies

OVERVIEW

HIT Products

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As a practice gets closer to purchasing an electronic health record, decisions about system features will become much more specific — especially if seeking American Recovery and Reinvestment Act (ARRA) incentives. In February of 2009, President Obama signed ARRA, with the intent to stimulate the economy through investments in infrastructure. ARRA includes significant funding earmarked for the development of information technology for health care and the improvement of the quality of care provided to patients, while bringing down costs. In the hopes of swaying more

physicians to adopt and use EHRs, ARRA set aside almost \$20 billion under the U.S. Health and Human Services Department (HHS) to help physicians purchase and use health information technology (HIT) systems.¹⁰⁷

Practice Management Systems

Working through, in detail, exactly what the practice needs in its EHR system is important.¹⁰⁸ Here are a few examples:

1. A physician wants to download her schedule to her smartphone, so she purchased a system that will sync with it. When she ran the sync for the first time, her schedule for the next 30 days and the patient charts were downloaded to the smartphone. However, she expected and wanted to see her schedule for the entire year, and she wanted the ability to download only selected charts. The technology she selected would not do so.
2. Document scanning might be particularly important to another physician because he has many patients who have records from other

107. Texas Medical Association. *Electronic Medical Record Implementation Guide The Link to a Better Future 2nd Ed.*, 2009, Pg. 18.

108. For further guidance on EHR selection and implementation, see the Texas Medical Association website at www.texmed.org/EHR/.

practices. But when a patient presented a 12-page chart for scanning, the system generated a single, 12-page image file instead of generating 12 one-page images. The EHR system he chose did support scanning but not multi-page scanning.

These examples illustrate the importance of seeing a demonstration of any system features necessary to the practice. The generic description of a system's ability to, say, download to a smartphone or scan files does not provide enough information to make an informed decision.

HIT products fall into one of two categories: best-of-breed or fully integrated. In a best-of-breed model, several products that each excel in a specific function are joined to work as one. A practice might choose one practice management product and combine it with a different EHR product, another for document scanning/management, and yet another for electronic faxing. One aspect of best-of-breed solutions is linking the components of the legacy practice management system (billing software, for example) to the new HIT system. One or more communication products can be added to this mix to transmit information among the different applications. For example, when a patient's demographic information is entered into the practice management software, it automatically transfers the information to the EHR. Once the chart is complete, billable services the physician assigns at the point of care are automatically ported back into the practice management software for billing.

The main advantage of the best-of-breed approach traditionally has been cost. Depending on the exact combination of products, the cost of software and training (excluding hardware) is typically less than \$15,000, and often less than \$10,000 for each of the first five users in a practice.

On the other hand, this approach has its shortcomings:

- ◆ **A break in data linkages.** The best-of-breed scenario involves multiple products built by different software developers in different languages that must communicate reliably with one another. The most common problem is that the transfer of data between programs stops. Typically, the solution is simple but disruptive. Everyone has to stop working, exit the system, restart the program or network service, and verify that data are flowing the way they should be.
- ◆ **No single point of accountability.** Merging many software products implies many points of accountability. When one part of the system stops working, it can be difficult to determine which program is faulty and who the appropriate person is to call. The practice management vendor tells the physician to call the EHR vendor; the EHR vendor tells the physician to call the communications vendor; the communications vendor tells the physician to call the practice management vendor. Even if the practice purchased all the products through a single reseller, getting to the root of a problem can be challenging.
- ◆ **Weaker integration with third-party services or software.** Products in the best-of-breed model tend to lag behind the fully integrated products in terms of their ability to assimilate with productivity-enhancing services such as online

insurance eligibility, lab interfaces, and smartphones for hospital charge capture. Generating complex reports also is a problem because the practice management and clinical data are separate, and data have to be captured from several sources and manually integrated into one report.

- ◆ **Problems upgrading best-of-breed systems.** As the multiple products within a best-of-breed system need upgrading, the upgrading process can introduce incompatibilities among the different versions of each product.

Generally, fully integrated products are built from the ground up on a single platform and are designed to function as an EHR and perform billing, scheduling, document imaging, document management, electronic prescribing, and electronic faxing in a self-contained system.

Fully integrated systems tend to be more reliable. Because these systems are developed on a single platform, data flow seamlessly between software functionalities. One developer means a single point of accountability for software issues. Reporting on practice management and clinical data is easily accomplished. Finally, fully integrated products tend to integrate effortlessly with labs, smartphones, and other productivity-enhancing services.

But there are downsides to fully integrated systems as well:

- ◆ **Higher cost.** Software and training expenses for some fully integrated products can be two to three times more than for best-of-breed solutions.
- ◆ **Disruptive technology updates.** Updates invariably invite challenges even in integrated systems. A system can be running fine until the next “upgrade.” Immediately thereafter, new features have slowed down the system, changed something that users liked, or broken features that used to work. These expected hitches almost are always resolved fairly quickly.
- ◆ **Lapses in integration.** Many times, fully integrated products are portrayed as being more fully integrated than they actually are. The classic example is faxing. Many products use simple faxing software to fax prescriptions from the practice to the pharmacy. In some cases, however, this does not include the ability to easily receive and share all faxes electronically, which is how the functionality is portrayed.

In summary, costs of fully integrated systems have dropped significantly in recent years, making it difficult to justify best-of-breed solutions on a cost basis alone. A fully integrated system can be more expensive initially but offers a large productivity advantage due to its single-platform nature and ability to integrate with outside services and technology. Starting with fully integrated solutions will provide the practice the maximum return on technology investments over the long term, but either paradigm is viable.¹⁰⁹

Physicians can access HIT software through two different models: client server and application service provider (ASP). In the client-server model, HIT software is installed

109. Ibid. Pgs. 37-39.

on a server located in the physician's office and is accessed through the practice's input devices. The practice is responsible for maintaining a secure data center and for providing technical support for the servers and service operating systems. The client-server model is costlier up front due to hardware and installation expenses.

Alternatively, in the ASP model, the software is located on a server at a remote location and accessed most commonly via the Internet. The advantages of the ASP model are lower initial costs, the reduced need for ongoing network monitoring and support, and less responsibility for data backup and security. The medical practice pays a monthly per-physician fee for access to the software, storage of the practice's medical records on the software company's server, and cost of the high-speed Internet connection. The practice must have reliable high-speed Internet service (such as DSL, cable, or T1). Physicians should consider having a backup Internet connection available on site.

ASP solutions are highly attractive to small offices with fewer than 10 users. HIT software can provide the following transactions using an ASP:

- ◆ EHR including transcription and voice recognition;
- ◆ Patient scheduling and registration;
- ◆ Claims submission, eligibility inquiries, referrals, and, depending on the health plan, preauthorizations;
- ◆ Financial reporting and collections management; and
- ◆ Supply ordering.

Advantages of the ASP model include:

- **Upfront cost savings.** Practices pay \$100 to \$500 per physician per month, as long as they are using the vendor's server, for ASP-based software versus a multi-thousand dollar, per-physician initial investment plus annual maintenance costs as in the client-server model. Offices with ASPs still will incur costs to set up a networked, wired office, which is required for this model.
- **Easy upgrades.** An ASP can install software improvements at its central server overnight, and the office can take advantage of them the next day.
- **Staff or contract savings.** Most ASPs manage all of the software maintenance so that the practice will have less need to hire IT staff or outside contractors.

A disadvantage of the ASP model includes complete dependency on Internet access. Without Internet access, the practice cannot function. It is best to pay more for T1-type technologies that provide reliable Internet connectivity at high speeds. Physicians should be careful of contractual or payment disputes with the ASP provider since the data resides outside the office. There is potential for the provider to lock the system and prevent access. The contract should address these concerns.

Some HIT systems best serve small practices with no more than two physicians, and others are designed for practices with 100 or more physicians in multiple specialties at multiple sites. The key concept is scalability (i.e., the ability of the software to accommodate the number of users who can work on the system simultaneously without it either crashing or running at an unacceptably slow speed).

Now is the time to think about whether the practice will be expanding during the next three years. Are there plans to add physicians, nurse practitioners, or physician assistants? Are there plans to add a satellite office? While there is no need to purchase the capacity necessary for future expansions in the initial system acquisition, it is necessary to determine whether the system the practice purchases can accommodate an expansion.¹¹⁰

EHR Systems

Assessing data from paper medical records is time-consuming because it involves reviewing information manually — record by record. By contrast, an EHR makes data easily accessible and enables physicians to use their own data to improve quality of care. With efficient electronic access to clinical data, practices can systematically improve the quality of care in several areas:

- ◆ **Enhanced patient education materials.** Practices can customize information packets and website referrals for patients so that patients receive essential information about their health at the point of care and guidance from reputable, scientific sources.
- ◆ **Quicker turnaround times for results of lab tests and imaging studies.** Connectivity between practices and the clinical laboratories and imaging centers shortens the time necessary for diagnostic information to reach the practice and the patient. Physicians can initiate therapy more quickly and reduce patient waiting time.
- ◆ **Improved diagnostic process.** Decision support at the point of service enables a consistent, evidence-based diagnostic process.
- ◆ **Streamlined health maintenance and chronic disease management.** EHR systems can generate automated appointment reminders for periodic checkups and for monitoring chronic diseases and conditions. Monitoring patient responses to these reminders enables practices to follow up with patients who need medical attention but are not responding to the practice's automated messages.
- ◆ **Protocol-based treatment.** EHRs have the capability to incorporate treatment protocols so that physicians can track the care of individual patients within an evidence-based framework.
- ◆ **Reduced medical errors.** Intelligent e-prescribing alerts physicians to problems resulting from drug interactions and allergies. It also can help physicians avoid errors caused by the very large number of prescription drugs that have similar names.

110. Ibid. Pgs. 40-42.

- ◆ **Improved access to patient records.** EHRs can provide the physician electronic access to patient records from remote locations whenever needed. Electronic medical records are legible and up to date.
- ◆ **Improved outcomes.** The sum of all these parts is process improvement that leads to better outcomes. The incorporation of evidence-based protocols, decision support, and e-prescribing into the EHR gives the physician diagnostic and treatment-relevant information during the patient encounter. The tools for improving practice and self-monitoring are immediately at hand.

The efficiency benefits of an EHR derive from these changes that occur in practices as they move from paper to electronic:

- ◆ The reduction in expenses associated with the management of paper records;
- ◆ Significantly more efficient and accurate coding and billing of claims as a result of template-based documentation;
- ◆ Redesign of workflow so practice staff can become more productive users of the practice's HIT system;
- ◆ Real-time access to patient records from multiple computers and locations, including remote access beyond the office, without physically retrieving a paper chart; and
- ◆ Multiple people simultaneously accessing a single patient record from multiple locations, improving work flow in some situations.

Eliminating paper medical records saves both forests and money. Supply, copying, printing, and storage costs are reduced as well as transcription costs. Staff efficiency is greatly improved because the time-consuming task of physically moving paper charts around the office is eliminated, and the time needed for ordering and tracking lab tests, imaging studies, and prescriptions is greatly reduced.¹¹¹

EHRs encourage structured documentation. Commonly, EHRs are able to accommodate user-developed templates to capture services that a practice most frequently provides quickly, accurately, and in detail. In turn, the EHR influences the coding process in two ways:

1. Because electronic documentation is structured, it captures the CPT criteria that define levels and types of services more accurately than paper records. As a result, it reduces the number of coding disagreements between practices and payers. In practical terms, the increased accuracy of coding equals a shorter revenue cycle, as payers dispute fewer claims. Also, whenever payers do request additional documentation, the practice easily can send the relevant portions of the patient's EHR.

111. See Cook-Moine C, Cramer L. Financial Savings From an Electronic Medical Record in a Small Group Practice. April 2005. www.himsssehra.org/docs/caseStudies/CHARTCARE_Eden%20Park%20ROI.pdf; HIMSS Electronic Health Record Association. *The Value of Electronic Health Records*. www.himsssehra.org/docs/ValueEHRs.pdf; Wang SJ, Middleton B, Prosser LA, et al. A Cost-Benefit Analysis of Electronic Medical Records in Primary Care. *Am J Med*. 2003;114:397-403.

2. As physicians gain confidence in the accuracy of coding developed on the basis of the EHR, they begin using the full range of evaluation and management (E&M) codes. In particular, many practices have underused the higher-level E&M codes out of fear that payer coding profiles would identify them as outliers. But with the more solid EHR documentation in hand, physicians are willing to bill based on the accuracy of their records. Although this varies from practice to practice, this closer adherence to CPT standards can result in increased revenue. One study of family practices that installed HIT systems found the combination of more accurate coding and additional office visits (due to increased efficiencies) generated an additional \$23,000 per physician in annual revenue.

A word of caution: Physicians are ultimately responsible for documentation. If the EHR is incorrectly calibrated and suggests a higher service, it's up to the physician to adjust appropriately.

As practices migrate from paper to an EHR, everybody in the office, including physicians, will perform a major portion of their day-to-day work differently. Much of the economic benefit of HIT derives from the reorganization of daily tasks, as staff and physicians substitute time-consuming, manual processes with technology. HIT combined with a major redesign of workflow can reduce practice expenses.¹¹²

Transitioning to an EHR

The successful transition from a paper- to an electronic-based practice begins with developing an understanding of what HIT actually does, analyzing the practice's readiness to manage a new operating system, and preparing staff for this major change. With hundreds of EHR products, the marketplace offers a robust choice, and selecting a system that is right for the practice depends heavily on understanding the practice's needs before seriously discussing a purchase with vendors. When the time comes to buy a system, a focus on functionality and the practice's readiness can help physicians choose the product characteristics that create value for the practice.

The first step in analyzing the practice is to assess readiness in terms of culture, leadership, strategy, and technical ability. Introducing an HIT system into a practice requires a team effort, and before making any formal decisions, physicians should begin preparing the team.

- ◆ In a group practice, physicians should begin discussing with partners and the practice manager or administrator the possibility of implementing HIT. The main concerns will be, inevitably, the time and money the acquisition process will require.

TIP

HIT combined with a major redesign of workflow can reduce practice expenses.

112. Ibid. Pgs. 15-17.

- ◆ In a multiphysician setting, everyone cannot have their exact preference. Physicians should be prepared to compromise.
- ◆ A crucial element in the success of HIT acquisition is the “physician champion” who guides the change process. To introduce major changes that affect workflow and to keep the team on track, a physician in the group will need to take the lead.
- ◆ Physicians should consider in-office training using an LCD projector to provide demonstrations both before and after EHR implementation.
- ◆ Physicians should take notes, keep files, and circulate informational materials of interest within the practice. A steady stream of concise documents will help keep interest and momentum alive.

Like most small business owners, physicians who own and run their practice find the most challenging part of their work is managing and motivating office staff. In most practices, the burden of paperwork is overwhelming, and the successful operation of the typical medical practice depends heavily on the skills of the employees and their ability to multitask in an office with few automated functions. The team should understand that using HIT can help automate many routine, time-consuming tasks, as well as improve more complex processes.

HIT changes the patient experience and, therefore, the design of office workflow. Physicians and office managers or administrators should consider the following:

- ◆ Will patients enter their medical histories and/or information about the history of their present illness on a computer in a kiosk in the waiting room or over the Internet via a patient portal, or will they narrate the information to a nurse and/or to the physician?
- ◆ With the addition of data entry equipment, how should the exam rooms be arranged? Where does the physician sit in relation to the patient? How can data entry be set up so it does not intrude upon the patient-physician relationship?
- ◆ Does the practice want to communicate with patients via email? What are the requirements for HIPAA compliance in patient emails?

Developing a flow chart for how patients will move through the office can help everyone visualize the changes HIT will effect. Physicians should discuss with staff the practice’s HIT plans and get their input on workflow organization. Physicians should be sensitive to the staff’s concern that the introduction of HIT might result in a reduction in the number of practice employees.

Careful, team-based redesign of work process is mission-critical to the success of HIT acquisition. Conversely, inattentiveness to workflow commonly lies at the heart of failed installations that don’t meet expectations or that are so poorly executed that the practice has uninstalled its HIT system and returned to paper records.

Workflow redesign is the practice’s opportunity to determine how it can use the EHR system optimally to improve operational efficiencies. Practices can use tools like lists and flow charts to look closely at patient flow, point of care, documentation, and

communications. For example, the paper chart in the bin no longer will signal to the physician that the patient is ready to be seen. Physicians and staff members should determine what effective electronic processes the practice can use instead. Installing an EHR system on top of the current processes fails to take full advantage of the technology being purchased.¹¹³

Selection and Implementation

To benefit from ARRA incentives, physicians must use a certified EHR.

According to ARRA, certified technology means that a qualified EHR:

- ◆ Includes patient demographic and clinical health information,
- ◆ Can provide clinical decision support to physician order entry,
- ◆ Has the capacity to capture and query information relevant to health care quality, and
- ◆ Exchanges and integrates electronic health information with other sources.

These six additional factors are helpful in narrowing down the EHR choices:

1. The location of the practice,
2. The size of the practice,
3. Site visits to practices in the specialty,
4. Whether the practice plans to interface the HIT system with the legacy practice management system or acquire an integrated system,
5. What the practice learned from product demos, and
6. Recommendations from the specialty society.

Rather than relying solely on the certification seal of approval to narrow a vendor search, practices should begin the selection process by talking with other practices of similar size and specialty about their software experiences because of varying documentation and information needs. HIT vendors under consideration can help the practice identify and contact other practices that would be beneficial to visit.

Here are two general guidelines to follow for site visits:

1. Physicians will learn the most from practices that have been using the technology for one to two years. Those who have been using the technology less than that are still in an educational phase.
2. Physicians should only buy a system they have seen in operation in a working medical practice. Vendor demonstrations are not enough.

HIT system developers frequently include demonstrations, screen shots, or a downloadable trial version of the software on their websites. Demos serve as a useful sample of the software program, giving the prospective buyer the opportunity to get a feel for the daily use of the product.

113. Ibid. Pgs. 28-30.

Here are some questions to ask while navigating the demos:

- ◆ Are the screens attractively designed?
- ◆ Can a user look at the screens and understand intuitively what to do next?
- ◆ How difficult will it be for staff and physicians to learn this software?

Vendor demonstrations are extremely important in the HIT system selection process. To get the most benefit from this step, physicians should meet with three to five vendors. Each of the meetings will last from two to two-and-a-half hours. Because the purchase of an HIT system involves a substantial financial commitment by the practice, it would behoove all of the physicians who are partners in the practice and their practice manager or administrator to attend these demonstrations.

At or prior to the meeting, physicians should ask the vendors a series of questions. Vendors can share their answers with physicians prior to or at the presentation. This format will give the practice a uniform overview of each of the vendors and their products. The following questions are a starting point for discussions with a potential vendor:

- ◆ How long has your company been in business?
- ◆ How long has the HIT product been offered?
- ◆ What were your total sales last year, last quarter?
- ◆ What is your total customer base? Of those, how many are new within the last year?
- ◆ Does the company hold regular user meetings or have user groups?
- ◆ Is your software sold modularly, or does it need to be purchased as a complete package?
- ◆ What functions are available?
- ◆ What operating platform does the product work on?
- ◆ Will your company guarantee in the contract that the software will comply with all current and future federal and state mandates?
- ◆ How are the licenses issued?
- ◆ What is the cost per practitioner (or concurrent user) for the entire package?
- ◆ What does the price include?
- ◆ How much will ongoing maintenance and upgrades cost?

Vendors can bring a customized presentation to the office. To take advantage of this feature, physicians should prepare some clinical case studies, provide them to the vendors well in advance of the meeting, and request that they use them as illustrations. As preparation, the practice should perform a quick analysis of the most frequently used CPT codes in the practice. In the great majority of single-specialty clinical practices, the number of codes that account for 95 percent of practice revenue is

surprisingly small, rarely more than 25. The practice should ask the vendor to illustrate how a template for documenting some of these codes might look, whether users can create templates, and what is involved in constructing a template. In other words, it's important to make the sales presentation as much as possible about the practice's needs.

While the personality and appearance of the sales representative are difficult to ignore, the software itself should be the focus at an on-site demonstration. The demonstration will help resolve objective and subjective concerns. Is it a product this practice can become proficient at using relatively quickly? Will the data capability of the system generate the information necessary to enhance quality of care and accurate payment?

At the end of the vendor meetings, physicians should take no more than 30 minutes collecting the opinions and rankings from the group. The people with decisionmaking power will stay after this to narrow down the three to five products to a one and a two. This is not a decision to buy — it is a decision to get detailed proposals from the top two-ranked vendors.¹¹⁴

Once the practice has accepted a vendor's proposal, the HIT adoption process moves into the implementation phase. During this period, the most critical need is for everyone in the practice to maintain focus on the tasks critical to the success of HIT adoption: redesigning workflow, learning the new software, and moving essential information from existing paper records to the EHR. A well-planned and smoothly executed implementation period is critical to the success of HIT in the practice.

Change management involves the planned introduction of new processes and systems into an organization. This approach brings together tools for successfully dealing with the technical and people issues that arise during major change. Here are some critical elements:

- ◆ The practice leadership must all support the introduction of HIT. In a solo practice, the leadership likely consists of only the physician and the practice manager. In a group, it is all the partnering physicians. In a very large group, it may be select physicians, managers, and IT staff. While a physician champion is likely to be spearheading the effort, a unified effort among leadership conveys the clear message that the project is critical to the practice's future and will happen. In change management studies, strong support is the No. 1 determinant of success.
- ◆ Communicate regularly within the practice to strongly reinforce the process of change. Physicians should discuss the status of HIT acquisition at staff meetings and circulate plans for restructuring of workflow for suggestions; when the HIT project reaches a milestone (e.g., the practice commits to a particular system), staff should be informed. In a project that can easily take a year or more from beginning to end, reminders help maintain focus and reinforce the message of change.

114. Ibid. Pgs. 54-58.

- ◆ Seek feedback. Physicians should consider how people are experiencing change by actively seeking feedback and by considering how their reactions may be affecting the project. It's good to think in advance of strategies to deal with any resistance that might occur. As the direct supervisor of office staff, the practice manager or administrator is well positioned to act as a performance coach when a staff member is having difficulty adapting to change.

Through the entire acquisition, change management brings first a commitment to the process of change and finally an integration of the changes themselves into the daily operation of the practice.

It is tempting but dangerous to view the vendor as the HIT implementation project manager. The vendor is a project manager but will focus on specific tasks outlined in the proposal, not the success of the overall HIT adoption. To an HIT vendor, implementation means managing project deadlines for hardware installation, software setup, and training. These deadlines mark the end of the vendor's implementation responsibilities. Once the products are installed and the users trained, all subsequent activities involving the vendor fall under "support."

A vendor may offer suggestions about managing the practice's implementation of HIT but will not develop those suggestions into a comprehensive plan the practice can then use. Very simply, the vendor does not function as a consultant on practice-related questions. What a practice can reasonably expect from the vendor is that it will meet the goals set in the proposal on time and within or very near the proposed budget and will coordinate its activities with the practice to keep to a minimum any disruption to the practice. Moreover, in addition to training sessions the vendor will arrange for you and your staff, it will provide instruction in the use of technical support so that everyone knows how and when to access help.

Practices could experience an "implementation gap" after the vendor completes its set-up responsibilities. One physician, recounting how his practice had done little reconfiguration of workflow prior to implementation, compared catching up after the fact to trying to repair an airplane in the middle of a flight. Effective change management is critical. The implementation phase is perhaps the most crucial step of the entire HIT process. Unmanaged implementations often fall short of expectations. Several techniques have contributed to HIT success, including:

1. Appoint an implementer to coordinate HIT adoption. The implementer acts as a logistics manager whose job is to see that the adoption of HIT moves forward. Because there is generally little downtime within most medical practices, physicians should avoid the temptation of assigning the office manager or administrator to function as the implementer. They should consider bringing in either a temporary employee experienced at handling logistics in the medical office setting or a consultant experienced in HIT implementation. One of the great advantages of having an implementer is that the person in that role can keep both the practice and the vendor on track.

2. Monitor costs on an ongoing basis. It also is a good idea for a physician or the practice manager to talk regularly and often with the vendor about whether the costs of the project are close to the original estimate. Once a proposal has been accepted, physicians should remember their side of the bargain — changes in midstream can be very expensive. Whether the vendor recommends a change or whether the change originates with the practice, physicians should always ask how much it will cost and ask for the vendor to provide a note revising the original estimate.
3. If the practice is falling behind in workflow redesign, take immediate steps to catch up. If the implementer is a consultant familiar with HIT implementation, his or her commitment to the practice can expand to include workflow redesign. If the implementer is not skilled with workflow redesign, the practice should bring on a consultant who can move the process along. The budget for HIT implementation must include sufficient funding for staff overtime so that the preparation for HIT does not take second place to the press of handling daily practice operations. The practice should have procedures in place for exactly how a patient phone call for a prescription renewal is handled or how the availability of patient charts in the exam room terminals will be managed.
4. Training sessions should be instructional and encourage self-reliance. Instead of having trainers working with staff on site for several weeks, physicians should conduct an intensive training session, then allow all staff to start working with the software on their own. The implementer should collect questions and after perhaps 10 days to two weeks, have a follow-up session with the trainer or the vendor. When the trainers leave, the staff will have to be self-reliant. By using the software on their own immediately after the initial training, everyone in the practice quickly will gain experience and self-confidence in problem solving. In this case, there is a much smaller likelihood of feeling abandoned when the trainer and vendor finally leave.
5. Develop a plan for moving essential information from paper records to the EHR. The reality is that initially, the practice will be living with an electronic system that combines data from electronic and paper records. The office can transition to electronic recordkeeping as patients come in. That way, only active patients are in the EHR system. Staff members can then move inactive patient charts into off-site storage. Some historic information should be entered manually (e.g., medication lists and problem lists). Scanning portions of or the entire paper record into the computer offers an option for incorporation, but these scanned, handwritten documents will be regarded by the computer as a graphic, not as text documents, and therefore are unsearchable. To help alleviate or avoid this problem, the practice can set up a small, private kiosk in the waiting room with a computer. As patients come for their first visit after the adoption of the EHR, they should fill out a new medical history on the computer. Another option is to have the information from paper charts

abstracted, or summarized into key data sets and entered into the EHR. The abstracting option allows for a streamlined chart that contains key data elements searchable for quality reporting.

6. Negotiate with all of the practitioners in the group a uniform format for documentation. One of the great advantages of EHRs is that they can simplify documentation through the use of templates. Templates save physician time by structuring patient encounters and reducing the need for narrative; they also promote more accurate coding and billing of services. A uniform format allows the development of a single set of templates that everyone uses, which makes it easier to code services and generate reports. It also provides a level of clarity that justifies the more frequent use of higher-level codes. Virtually all EHR systems allow the use of customized templates, and many of the EHR developers have simplified the creation of templates to the point where medical practices can build them without assistance from the developer or vendor.
7. Celebrate successes. From beginning to end, the pathway from initial interest in HIT to successful adoption in the medical office can easily take 18 months or longer. Practices should take small breaks along the way to recognize milestones and important individual achievements.¹¹⁵

As the practice moves closer to full implementation, staff should inform patients of the EHR acquisition. It's important to communicate that there may be temporary delays in obtaining services until the practice is back to handling its full patient load. The idea of an EHR can be presented to them as a means for the practice to enhance patient quality of care and quality of service.

The practice can use the following patient communication vehicles:

- ◆ Patient newsletters,
- ◆ Email updates,
- ◆ Website communication,
- ◆ Messages on the phone system announcing the change while patients are on hold, and
- ◆ A one-page handout explaining that the practice may be closed and/or operating for a period at reduced capacity.

If the practice will be closed for installation and training, arrangements should be made with another practice to see patients who may need care urgently. It's a good idea to have an announcement put on the practice's answering system telling patients how to contact that practice.¹¹⁶

Important: See the HHS Office of Civil Rights website at www.hhs.gov/ocr/privacy/index.html for information on HIPAA privacy and security and breach notification rules, security risk assessment tools, and other guidance useful in managing electronic health records.

115. Ibid. Pgs. 81-85.

116. Ibid. Pg. 87.

Health Information Exchange

In basic terms, a health information exchange (HIE) provides a way to use technology to make patients' health information available anywhere, anytime. Developing HIE infrastructure nationwide is possible thanks to allocation of \$548 million of Health Information Technology for Economic and Clinical Health (HITECH) funds to all 50 states to establish HIEs. As more physicians adopt and implement EHRs, it's becoming increasingly important that they're able to share electronic patient information among one another in a secure manner. Depending on how a physician's state of residence has set up HIE initiatives, HIE representatives may recruit individual physicians and medical groups to join exchanges.

The Office of the National Coordinator for Health Information Technology (ONC) considers the secure sharing of information among health care professionals through HIEs essential to using EHRs in a "meaningful" way. Widespread adoption of EHRs by physicians and hospitals, along with the development of an infrastructure that allows secure sharing of medical records electronically, is necessary for physicians to get the most value out of EHRs. Exchanging patient data is required for physicians to achieve meaningful use for the federal Medicare or Medicaid incentive programs. Physicians must meet meaningful use criteria to qualify for up to \$44,000 in Medicare incentive payments from 2011 to 2016, and up to \$63,750 in Medicaid incentive payments from 2011 to 2021. Meaningful use incentives and upcoming penalties are covered in more detail on pages 83-85.

HIEs have many potential benefits for physicians and patients. Because physicians ultimately will have instant access to patient data, HIEs will help them avoid running duplicative tests. A fully functional HIE also helps to allow rapid access to hospital discharge summaries and immunization records. In some instances currently, once a patient is discharged from the hospital, it can take a long time for a hospital to fax physicians the patient records. The absence of the hospital records at follow-up visits makes it difficult to determine what procedures and tests patients received.

Another advantage of participating in an HIE is reduced cost. A 2009 survey by eHealth Initiative polled 40 operational HIEs that reported cost savings in:

- ◆ Reduced staff time handling lab and radiology results,
- ◆ Reduced staff time for clerical administration and filing,
- ◆ Less money spent on redundant tests,
- ◆ Decreased cost of care for chronically ill patients, and
- ◆ Reduced medication errors.

The survey also highlights efficiencies that practices using HIEs experience, including improved access to test results and fewer hassles associated with looking for information.

Before a practice commits to join a local HIE, physicians need to ask questions. Physician HIT experts recommend the following:

- ◆ What information will the HIE share? Some share only laboratory data, while others allow access to discharge summaries, notes, test results, and more.
- ◆ How can physicians determine the source, date, and time of the data? Physicians will need to reconcile contradictory information they may encounter, such as a “penicillin allergy” for a patient pulled from one electronic health record but “no known allergies” pulled from another.
- ◆ What are the HIE’s privacy and security mechanisms? Physicians should find out how the HIE will obtain patient consent for using the data. If a patient chooses to exclude some data from being shared, the physician should make sure the HIE discloses that fact.
- ◆ Does the HIE include the patient populations, referral networks, and the hospitals and other physicians the doctor works with? Physicians should make certain the HIE connects to the local hospitals, labs, radiology services, and other facilities.
- ◆ Will the HIE be financially viable in the future? It’s not simple to move from one HIE to another. Physicians should ensure the HIE has a thorough business plan with strategies for long-term success and should ask their colleagues about the exchange’s track record and functionality.
- ◆ Is there a fee to participate? Many HIEs are free initially, but physicians should ask about potential future fees.
- ◆ Who is on the HIE’s board of directors?
- ◆ What are the computer system requirements to connect to the HIE?
- ◆ Does the HIE use a centralized or decentralized model? A centralized model obtains a patient’s permission to have his or her records and information stored in a database. Physicians can query the database for patient information and share it with others. A decentralized model, as described by the Healthcare Information and Management Systems Society, “allows the initiator of a health record, such as a provider, to maintain ownership and control over the record while providing access to the record to authorized personnel. In this model, providers form a single administrative entity or governing body at the regional level, with each retaining control of its own internal business activity.”¹¹⁷
- ◆ Are there opportunities to provide feedback on HIE operations?

Although HITECH funding began to sunset in 2013, HIE initiatives have continued to mature.

The 2012 Report on HIE by eHealth Initiative attributes growth to the following factors:

- ◆ Following the Centers for Medicare & Medicaid Services’ release of stage 2 meaningful use requirements, HIE use has reached a turning point at organizational, local, and state levels nationwide;

117. HIMSS Healthcare Information Exchange. *A HIMSS Guide to Participating in a Health Information Exchange*, 2009, Pg. 18.

- ◆ New care delivery models have accelerated under health system reform; and
- ◆ Quality outcomes and increased efficiencies in care have been increasingly emphasized.

Improving quality and efficiency and reducing costs can't be achieved without the ability to exchange patient information among practitioners and between incongruent health care settings.¹¹⁸

Incentives and Upcoming Penalties

Two major sections of the stimulus package, Title IV and Title XIII, collectively known as the HITECH Act, provide for incentives and aid for physicians who use an EHR meaningfully. The incentive payments in this legislation may lower a big EHR hurdle that physicians face — the cost of purchasing software. Practices can use incentive payments from the stimulus package to purchase software and, more important, to pay for implementation and training.

To demonstrate meaningful use, a physician must be able to:

- ◆ Use certified EHR technology,
- ◆ Issue prescriptions electronically (physicians must use an e-prescribing system; computer-generated faxes of prescriptions to pharmacies do not qualify),
- ◆ Exchange health information electronically in accordance with law and standards, and
- ◆ Produce quality reporting measures according to U.S. Department of Health and Human Services specifications.

Physicians who use an EHR and meet the meaningful use criteria can take advantage of thousands of dollars of incentives over the next few years. The incentives do not include payments to hospital-based physicians (e.g., pathologists, emergency room physicians, and anesthesiologists), if those hospital-based physicians provide 90 percent or more of their care in the hospital. Physicians most likely are using the hospital's facilities and equipment, including qualified EHRs.

Depending on the amount of Medicare services provided, physicians who accept Medicare patients could earn up to \$44,000 in incentives over five years. Eligible physicians who work in health professional shortage areas will receive a 10-percent increase in incentive payments as compared with physicians in other areas. Note that these funding amounts are per physician; therefore, practices with multiple physicians would multiply the amounts by the number of physicians in the practice achieving meaningful use.

While ARRA offers quite a large carrot to physicians, there is a stick involved. Physicians who have not become meaningful users will be subject to reduced Medicare

118. eHealth Initiative. *2012 Report on Health Information Exchange: Supporting Healthcare Reform*, Pg. 44.

payments, beginning with a 1-percent cut in 2015. The penalties increase to 2 percent by 2016 and 3 percent by 2017. HHS may continue to decrease payments by 1 percent per year to a maximum of 5 percent, if 75 percent of office-based physicians do not achieve meaningful use by 2018. All Medicare incentive payments end in 2016.

ARRA does place some caveats on eligibility to receive incentive payments. Physicians who report using an EHR with e-prescribing capabilities forfeit their eligibility for the e-prescribing bonuses established by the 2008 Medicare Improvements for Patients and Providers Act if they seek incentive payments under ARRA. In addition, physicians may qualify for payments for using HIT under Medicare or Medicaid, but not both. The potential success of the incentives is debatable, but any funding is likely to be of assistance to physicians planning to adopt technology, as cost is frequently cited as a major barrier.

Opportunities for incentive payments and threats of penalties related to adoption and use of EHRs make it tempting to rush into implementing a system. Physicians should proceed with caution and tap into available resources to make wise decisions.

Under the Medicaid program, the following health care professionals are eligible for incentive payments:

- ◆ Nonhospital-based pediatricians and other professionals with at least a 30-percent Medicaid patient volume;
- ◆ Nonhospital-based pediatricians with at least a 20-percent Medicaid patient volume (eligible for two-thirds of the dollar amounts specified for the maximum); and
- ◆ Eligible professionals who practice predominantly in federally qualified health centers or rural health clinics and have at least 30 percent of the patient volume attributable to needy individuals. Needy patients are those covered by Medicaid, receiving services under Title XXI, unable to pay, or receiving services on a sliding scale due to inability to pay.

States administer the Medicaid incentive program. In the first year, physicians can receive up to \$21,250 for an EHR implementation or upgrade. Medicaid professionals who achieve meaningful use can receive up to \$8,500 for five years for operating and maintaining an EHR. Physicians who already have an EHR can receive the one-time payment the first year and the yearly payments thereafter by achieving meaningful use in those years. Remember: Physicians may qualify for payments for meaningfully using HIT under Medicare or Medicaid, but not both. The maximum amount an eligible physician can receive through Medicaid incentives is \$63,750 over a six-year period.

The legislation does not penalize Medicaid physicians for failing to adopt a certified technology. Unlike Medicare penalties, no reductions in Medicaid payments are to be made if the physician does not adopt EHR technology.

With the possibility of receiving incentive money from the government, physicians will be approached by many vendors offering many services or goods intended to be ultimately paid for through Medicare and Medicaid. Indeed, some vendors may offer

low-interest or no-interest loans, cash back, or other incentives for the purchase of their products that comply with program requirements. Physicians should be mindful that the federal antikickback statute prohibits any person from knowingly and willfully paying, offering, soliciting, or receiving any remuneration, directly or indirectly, in cash or in kind, to induce the referral of business covered (in whole or in part) by a federal health care program, including Medicare and Medicaid. Prohibited action also includes knowingly and willingly soliciting or receiving remuneration in an attempt to induce purchasing, leasing, ordering, or arranging for or recommending any good, facility, service, or item paid for (in whole or in part) through federal health care programs. Physicians should review such offers with retained legal counsel.¹¹⁹

Formally known as Section 1877 of the Social Security Act, the “Stark law” prohibits physicians from referring Medicare or Medicaid patients for certain designated health services to an entity with which the physician has a financial relationship, unless an exception applies. Both the Stark and the antikickback laws have specific exceptions and safe harbors. In 2006, the HHS Office of the Inspector General (OIG) expanded the exceptions to the Stark regulations and added more safe harbors in the antikickback laws. The regulations permit hospitals to offer computer health information systems (or access) to ambulatory medical practices, potentially at a significantly greater discount than the practices could obtain if they pursued the systems individually. It is important that physicians understand both the reach and limitations of these new regulations. To meet requirements, any donated system must be “necessary and used predominately” to create, maintain, transmit, or receive electronic health records. While a technology donation may be ideal and highly beneficial for the recipient physician in some cases, any physician considering whether to accept a donation from a health system must be aware of all the implications and costs of doing so. Physicians are encouraged to enter into such agreements fully informed and only after weighing the advantages and disadvantages for their particular practice.¹²⁰

In 2013, OIG extended the EHR exemption in the Stark law to Dec. 31, 2021.¹²¹

119. Texas Medical Association. Op. cit. 18-23.

120. Hill, Amanda B., JD. *Fraud and Abuse*. Texas Medical Association, 2012. Pgs. 15-17.

121. 78 *Fed. Reg.* 79202 (Dec. 27, 2013).

Appendix A

FAQs: Physician Prices, Fee Schedules, and Managed Care Contract Offer and Acceptance

What is my price? OR What is the price of medical services?

A physician's price is his or her billed charge. Like any other small business, the physician should ensure that his or her price is adequate to cover the cost to provide services, including overhead costs, nonphysician labor costs, and adequate compensation to the physician for his or her services and expertise. Furthermore, the price must be sufficient to cover all the costs of charity care and bad debt and allow a reasonable return on the investment of the practice owners. Due to antitrust concerns, any price a physician may decide upon must not be the result of agreements with other physicians who are external to the practice but instead must be his or her independent determination.

The billed charge is the amount the practice will collect from a patient for services absent an agreement (such as a managed care contract) or discount policy (if applicable).

How do I evaluate contract rates?

A physician's contract rate is generally considered to be the cash payment due for services provided pursuant to a managed care contract. The cash amount accepted from an insurance carrier and patient in a managed care arrangement is *not* the practice's price (usually referred to as the billed charge). In the context of managed care, the total economic transaction is more complex and less transparent than in a simple cash-payment arrangement.

A typical managed care contract contains various obligations that a physician must meet, such as abiding by the insurer's physician manual, providing medical services, and meeting claims filing deadlines, in exchange for payment. The contracted physician may receive other benefits, including a listing in the insurer's provider directory and other patient steerage, the ability to submit claims electronically (versus having to mail invoices to cash-pay patients), the application of Texas' prompt payment laws, and the increased ability of an insurer to pay versus individuals (as physicians grant patients and insurers credit unless payment is made prior to the provision of services). Contract

rates may vary from carrier to carrier and from physician to physician based on many factors, such as the company's business conduct in interacting with physicians, the number of enrollees in the physician's practice area, and the price that physicians accept.

Physicians should evaluate contract rates in relation to their total practice costs, including all of the practice cost components listed above. Although most businesses will sometimes sell goods or services at below their cost, that strategy is generally a limited or temporary one designed to build customer base or to reduce excess inventory or capacity. Any business that consistently sells goods or services at less than their full cost will eventually become insolvent. A practice will want to carefully review its insurance carrier contract rates to ensure they do not create a circumstance where the practice cannot meet its obligations as they become due.

I want to join other physicians and negotiate fees with an insurance company. That's legal, right? OR I dislike the current offer made by a health insurance carrier, and I want to convince my physician colleagues that they should reject the current offer. Is that allowed?

Generally, no, those actions (i.e., joint price negotiation and refusals to deal, respectively) are not permitted by or among physicians external to a practice or to combine or collude with colleagues to determine the price of services.

This prohibition is contained in federal and state antitrust laws, which prohibit any contract, combination, or conspiracy that unreasonably restrains trade.¹²² In making the reasonableness determination, some conduct has been deemed "per se" illegal for being plainly anticompetitive.¹²³ Among the activities that have been treated as per se violations of the law are price fixing¹²⁴ and boycotts.¹²⁵

If a physician is determined to meet with other physicians to discuss prices or whether particular insurer offers should be accepted, the physician should first seek the services of legal counsel with expertise in antitrust law. There are business combinations, such as financial risk-taking independent practice associations, that can facilitate joint negotiation, but they must be carefully structured and undertaken only with appropriate legal advice.

Furthermore, a physician group that can undertake joint negotiations is a group that is truly clinically or financially integrated in accordance with the highly technical standards for integration established by the Federal Trade Commission

122. See the Sherman Act, 15 USC §1 stating: "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding \$100,000,000 if a corporation, or, if any other person, \$1,000,000, or by imprisonment not exceeding 10 years, or by both said punishments, in the discretion of the court"; see also, *Standard Oil Co v. United States*, 221 U.S. 1 (1911) (regarding the reasonableness requirement and "rule of reason"); see also, Tex. Bus. & Comm. Code §15.05(a).

123. See, e.g., *National Collegiate Athletic Association v. Board of Regents*, 468 U.S. 85 (1984).

124. See, e.g., *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984).

125. See, e.g., *FTC v. Superior Court Trial Lawyers Association*, 492 U.S. 411 (1990).

and Department of Justice.¹²⁶ Physicians who merely share office space or staff or who maintain medical records in a comingled fashion do not necessarily meet the requirements for clinical integration. Physicians must be careful to comply with antitrust laws. Violations of antitrust laws are criminal in nature and punishable by fines of \$100 million if a corporation, or, if any other person, \$1 million, or by imprisonment not exceeding 10 years.¹²⁷

It is important to note that antitrust laws apply with equal force to trade associations. In fact, these laws apply to the Texas Medical Association and its advocacy activities on behalf of its physician members (which under the law will be viewed as competitors). Thus, the TMA bylaws prohibit the association from setting or negotiating fees. TMA's bylaw on this issue states as follows:

16.50 Prohibition on fee setting. No action shall be taken by the association or any of its component county societies establishing a fixed schedule of fees for the services of members.

The association shall not enter into a contract with any person, firm, or agency with respect to the practice of medicine or fee for such practice.

Is it illegal for an insurer to offer a contract rate that is less than Medicare? OR Is it illegal for me to accept a contract rate that is less than Medicare?

No, the offer or acceptance of a contract rate below the Medicare fee schedule can be perfectly legal and the contract enforceable.

Here is the provision of federal law that is generally referred to in regard to this question:

(6) Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services

Any individual or entity that the Secretary determines —

(A) has submitted or caused to be submitted bills or requests for payment (where such bills or requests are based on charges or cost) under subchapter XVIII of this chapter or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such individual's or entity's usual charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs.¹²⁸

The federal government previously attempted to further define what “substantially in excess” and “usual charges” mean in the context of this provision. In 2003, a rather

126. For more information on medical practice integration and antitrust law, see the American Medical Association publication, “Competing in the marketplace: How physicians can improve quality and increase their value in the health care market through medical practice integration,” available at: www.ama-assn.org/resources/doc/psa/competing-in-market.pdf.

127. 15 USC §1.

128. 42 USC 1320a-7(b)(6)(A).

convoluted and complex method of calculation was proposed to discern “usual charge.”¹²⁹ However, that method proved to be so unworkable the federal government withdrew the proposal and never adopted a final regulation.¹³⁰

Nonetheless, in correspondence to TMA, the then-chief of the Office of Inspector General (OIG) Industry Guidance Branch stated that the provision referenced above does not prohibit contract discounts to private carriers (citing a letter sent to the American Ambulance Association as authority)¹³¹ and referred to OIG Advisory Opinion 98-8 upon the meaning of “substantially in excess.”

According to the American Ambulance Association letter, the government asserted that the law “addresses a much narrower issue, tiered pricing structures that set one price for Medicare or Medicaid and a substantially lower price for most other customers.”¹³²

Substantially in Excess

The circumstances that OIG was analyzing in Advisory Opinion 98-8 can be characterized as follows:

“Company AB” sold durable medical equipment of which approximately 300 of the 3,000 products offered for sale were reimbursable under the Medicare program. In order to participate in the Medicare program, the company asserted it would have to meet certain regulatory standards that added cost and hassle to its usual billing processes (among other things). Company AB proposed to charge Medicare an amount equal to the maximum reimbursement amount allowable under Medicare’s payment regulations. Company AB asserted that that would mean its proposed charges to Medicare will generally be higher than its charges to its “cash and carry” customers.¹³³

OIG replied, in its advisory letter, that:

Because the amount Company AB proposes to charge Medicare is generally 21-32% higher than its “cash and carry” price for any given item, we believe that Company AB’s charges to Medicare for some products would be substantially in excess of its usual charges and potentially subject Company AB to exclusion absent “good cause.”¹³⁴

It is this OIG letter that has led many to conclude that a price differential of more than 20 percent in the price for private persons and companies risks exclusion from Medicare (or worse). However, the federal government rejected this seeming “bright-line” approach to “substantially in excess.” When withdrawing the proposed regulations discussed previously, the government stated that “we believe that a single benchmark

129. See, generally, 68 *Fed. Reg.* 53939 (Sept. 15, 2003).

130. Medicare and State Health Care Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges, Notice of withdrawal of proposed rulemaking, 72 *Fed. Reg.* 33430 (June 18, 2007); available at: <http://oig.hhs.gov/authorities/docs/FR%20Notice%20Withdrawal%20of%20Substantially%20in%20Excess%20Rule.pdf>.

131. See OIG Letter at <http://oig.hhs.gov/fraud/docs/safeharborregulations/amldiscount.htm>.

132. *Ibid.*

133. See OIG Advisory Opinion No. 98-8, dated July 6, 1998; available at: http://oig.hhs.gov/fraud/docs/advisoryopinions/1998/ao98_8.pdf.

134. *Ibid.*

for ‘substantially in excess’ is unadvisable at this time. We believe it is more appropriate to continue to evaluate billing patterns of individuals and entities on a case-by-case basis.”¹³⁵

An insurer offered me a contract rate I found unacceptable. I then made a counteroffer for a different contract rate. The insurer didn’t accept, but now I am being told I can’t accept its first offer. That isn’t legal, is it?

Yes, it is generally legal. In fact, it is traditionally how contract negotiations are conducted. First we must outline some contracting basics.

Every contract must contain several basic elements before it can be said to be legally binding. Of those elements, the most basic are mutual assent, offer, and acceptance.

In Texas, network contracts between an insurer and physician are generally in writing, and there are many required contract provisions.¹³⁶ As with any contract, both parties must demonstrate the intent to be mutually bound by the contract. This is demonstrated by the acts of “offer” and “acceptance.” An offer is a promise to do or refrain from doing some act in the future. In order for a promise to become an offer in terms of contract law, the promise must be made in such a manner that a reasonable person would conclude that his or her assent is invited. In regard to most insurance contracts, because they are generally in writing, assent to contract will be invited and evidenced by the physician’s signature and reciprocal promises. Thus, for an offer from an insurer to become a legally binding contract, the physician must sign the contract offer.

An offer is terminated by the offeree (physician) if the offeree (physician) rejects the offer or if the offeree (physician) manifests a contrary intention, *such as through a counteroffer*. At common law, a counteroffer is a response to the offer that adds qualifications or conditions to the offer. A counteroffer acts as a rejection even if the qualification or condition relates to a trivial matter.

Thus, by making a counteroffer for a different contract rate, it is very possible the physician has terminated the insurance company’s offer. This means there is no longer a “first offer” to which the physician can agree.

Readers should note that these negotiations do *not* terminate any contracts that may still be in effect at the time of negotiations. The issue discussed above merely deals with offers and counteroffers for new contracts. There is no effect on *old* executed contracts.

135. See, 72 Fed. Reg. 33430 (June 18, 2007).

136. For example, Texas Ins. Code §843.361 states, “ENROLLEES HELD HARMLESS. A contract or other agreement between a health maintenance organization and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the health maintenance organization does not pay the physician or provider for those services.”

If I terminate my contract with an insurer, must I also notify patients that I am terminating the patient-physician relationship? OR I have decided I will not agree to the health insurer’s latest offer to contract. Now must I notify patients that I will no longer be available to provide medical services?

No, your patients can continue to receive services from you even if you do not accept the contract offer from their insurance carrier. Termination of an insurance contract is entirely separate from the termination of the patient-physician relationship. A physician may want to inform patients that they can continue to see him or her on an out-of-network basis.

I have heard Texas law prohibits charging different fees. Does that mean I must offer the same contract rate for each health insurer?

No, you are not required to have the same contract rate for each health insurer because of Texas law (although you may voluntarily do so). Texas law prohibits charging a different price based upon the fact that an insurer will pay for all or part of the services.¹³⁷ Readers will also be interested in knowing that the offense occurs only in those circumstances where the insurer is charged the higher amount.¹³⁸ However, the physician’s price is always his or her billed charge. The fact that different contract rates may be accepted for payment in specific circumstances does not alter the fact that a physician’s billed charge is his or her price.

Also, the provision of Texas law discussed above applies to all lines of insurance — including property and casualty insurers. Thus, an auto repair shop can’t have a different price for auto repairs when an insurer pays but a lower price when a customer pays. That is an instance where two different prices are actually being charged and an offense may have taken place.

Does the Texas law upon “different fees” mean that I can’t offer charity care or waivers to the indigent?

The law does not prohibit such aid for the indigent. You can provide charity care without violating the law. In fact, the Texas Legislature specifically clarified the law to expressly permit these charitable policies.¹³⁹

137. Tex. Ins. Code §552.003. CHARGING DIFFERENT PRICES; OFFENSE. (a) A person commits an offense if: (1) the person knowingly or intentionally charges two different prices for providing the same product or service; and (2) the higher price charged is based on the fact that an insurer will pay all or part of the price of the product or service. (b) An offense under this section is a Class B misdemeanor.

138. Ibid.

139. Tex. Ins. Code Sec. 552.001. APPLICABILITY OF CHAPTER. (a) This chapter does not apply to the provision of a health care service to a: (1) Medicaid or Medicare patient or a patient who is covered by a federal, state, or local government-sponsored indigent health care program; (2) financially or medically indigent person who qualifies for indigent health care services based on: (A) a sliding fee scale; or (B) a written charity care policy established by a health care provider; or (3) person who is not covered by a health insurance policy or other health benefit plan that provides benefits for the services and qualifies for services for the uninsured based on a written policy established by a health care provider.

The federal government has also stated, in regard to excess charges, “that, when calculating their ‘usual charges’ for purposes of [the relevant provisions of the Social Security] Act, individuals and entities do not need to consider free or substantially reduced charges to (i) uninsured patients or (ii) underinsured patients who are self-pay patients for the items or services furnished.”¹⁴⁰

Although waivers for the sole purpose of aiding those in true hardship are not per se illegal, you will want to ensure your managed care contracts permit the practice.

NOTICE: This information is provided as a commentary on legal issues and is not intended to provide advice on any specific legal matter. This information should NOT be considered legal advice and receipt of it does not create an attorney-client relationship. This is not a substitute for the advice of an attorney. Texas Medical Association provides this information with the express understanding that 1) no attorney-client relationship exists, 2) neither TMA nor its attorneys are engaged in providing legal advice and 3) that the information is of a general character. Although TMA has attempted to present materials that are accurate and useful, some material may be outdated and TMA shall not be liable.

140. See, generally, 68 Fed. Reg. 53939 (Sept. 15, 2003).

Appendix B

Business Entity Checklist

LAW OFFICE OF
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TYPES OF BUSINESS ENTITIES

(OVERVIEW)

- I. Proprietorship: A one owner, unincorporated business (includes husband & wife).
- II. Partnership: A multiple owner, unincorporated business.
 - A. General Partnership
 - B. (Registered) Limited Liability Partnership.
 - C. Limited Partnership.
- III. Corporation / Professional Corporation / Professional Association.
A business entity that is separate and distinct from its owners.
 - C Corporation
 - S Corporation
- IV. Limited Liability Company: A hybrid entity, having attributes of partnerships and corporations.

I. Proprietorship

Proprietorship: A one owner, unincorporated business (includes husband & wife).

- (A) Easy to form and dissolve.
- (B) Not subject to Texas Franchise Tax.
- (C) No separate federal income tax on business; Owner pays all federal income tax.
- (D) Owner fully liable for all debts and liabilities of the business, including debts, liabilities, and torts (personal injuries) caused by employees within the scope of employment.
- (E) Limited medical deductions allowed to owner.
- (F) Limited deductions available for retirement plans.

II.A. General Partnership

General Partnership: A multiple owner, unincorporated business.

- (A) Can be easy to form; however more thought, effort, time, expertise, and expense utilized during formation will likely alleviate even greater time, expense, and potential litigation involved in dissolution.
- (B) Not subject to Texas Franchise Tax as long as all partners are “individuals” (i.e., people, as opposed to other business entities).
- (C) Partnership files federal income tax “information return”, but pays no separate tax. Partners individually report, and are taxed on, their proportionate shares of partnership income and loss (whether distributed to partners or not).
- (D) All partners fully liable for all debts and liabilities of the partnership, including debts, liabilities, and torts (personal injuries) caused by other partners and employees within the scope of employment.
- (E) Limited medical deductions allowed to partners.
- (F) Limited deductions available for retirement plans.

II.B. (Registered) Limited Liability Partnership

(Registered) Limited Liability Partnership (LLP or RLLP): A general partnership, but with the following exceptions:

- (A) The partnership must file an annual election with Secretary of State, and pay a \$200.00 per partner per year fee to the Secretary of State.
- (B) The partnership must maintain statutory liability insurance coverage.

(C) If the partnership complies with (A) & (B), then the partners will then be shielded from liability for the debts and liabilities caused by the partnership, its employees and other partners while the partnership is registered as a limited liability partnership.

(D) Subject to Texas Franchise Tax.

II.C. Limited Partnership

Limited Partnership (LP or Ltd.): A general partnership that has one or more general partners, but also includes one or more “limited partners” who are merely passive investors (like “shareholders”).

(A) Limited partnership has at least one general partner, as in a general partnership.

(B) General partner(s) are fully liable for all debts and liabilities of the business, including debts, liabilities, and torts (personal injuries) caused by other partners and employees within the scope of employment.

(C) Limited partnership also has one or more limited partners who are like shareholders (i.e., mere investors that are not liable for the debts and liabilities of the business).

(D) Complex to form (plus \$750.00 filing fees, and filing with Secretary of State), and dissolve.

(E) Subject to Texas Franchise Tax.

(F) Limited partnership files federal income tax “information return”, but pays no separate tax. Partners individually report, and are taxed on, their proportionate shares of partnership income and loss whether distributed to partners or not (same as general partnership).

III. Corporation / Professional Corporation / Professional Association

Corporation (Corp., Co., Inc.) / Professional Corporation (P.C.) / Professional Association (P.A.): A business entity that is separate and distinct from its owners.

- (A) Somewhat complex to form (plus \$300.00 - \$750.00 filing fees, and filing with Secretary of State) and dissolve.
- (B) Subject to Texas Franchise Tax.
- (C) Owners (shareholders) not liable for corporate liabilities, including the torts (malpractice) and debts of others.
- (D) For Federal Income Tax purposes, corporations, professional corporations, and professional associations can be structured as either “C Corporation” or “S Corporation”.

C Corporation

A “regular” corporation (including corporations, professional corporations, and professional associations).

- (A) Corporation is subject to federal income tax on corporate income.
- (B) Corporation deducts corporate losses on corporate federal income tax return.
- (C) Shareholders individually taxed on the income and/or dividends received from corporation;
- (D) Medical expenses fully deductible by corporation;
- (E) Potentially more generous deductions may be available for retirement plans.

S Corporation

A “Small Business Corporation” (including corporations, professional corporations, and professional associations).

- (A) Corporation files federal income tax “information return”, but pays no separate tax (like partnerships).
- (B) Shareholders individually report, and are taxed on, their proportionate shares of corporate income, whether distributed to partners or not (like proprietorships and partnerships).
- (C) Shareholders individually deduct their proportionate shares of corporate losses on their personal income tax returns (like proprietorships or partnerships).
- (D) Strict limitations on types and number of shareholders.
- (E) As with proprietorships & partnerships, limited deductibility of medical expenses.

- (F) As with proprietorships and partnerships, potentially less generous deductions available for retirement plans.

IV. Limited Liability Company

(Professional) Limited Liability Company (LLC or LC or, for professional entities, a PLLC): A hybrid entity, having attributes of partnerships and corporations.

- (A) Somewhat complex to form (plus \$300.00 filing fees, and filing with Secretary of State), and dissolve.
- (B) Subject to Texas Franchise Tax.
- (C) For Federal Income Tax purposes, may be structured as a “disregarded entity” or as a “partnership” or as an “S Corporation” or as a “C Corporation”.
- (D) Greater flexibility than corporations in structuring distributions.
- (E) Owners (members) not liable for limited liability company debts and liabilities, including the torts (malpractice) and debts of others.

Appendix C

Trust, But Verify: Employee Embezzlement Can Ruin You

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By Crystal Conde

Associate Editor

When one Texas physician's office manager suddenly began working Saturdays and staying late, the physician thought nothing of it. He trusted the woman who'd run his office for 10 years. But when she began complaining that the solo practice was short on cash, it concerned him. He'd been working hard and seeing more patients. It didn't make sense that he'd have cash-flow problems.

It wasn't until his patients complained about the office manager demanding cash payments that the physician truly became suspicious of his trustworthy staff member. Once he started digging, he realized his practice was in deep financial trouble. The office manager had been working overtime not to get ahead, but to have some time alone to embezzle from the physician. It turned out she'd stolen hundreds of thousands of dollars from the practice by operating a number of schemes from 2003 to 2005.

If only he'd known what to look for — something the Texas Medical Association can help teach its members.

The physician, who requested anonymity, estimates he was out \$750,000 at the hands of a deceptive office manager he trusted to manage all of his practice's financial matters. She'd been stealing cash, making personal charges on the practice's credit card, writing fraudulent checks to herself and her family, and forging the physician's signature on checks and government documents.

In addition to her embezzlement schemes, the office manager failed to pay income taxes for the practice or make office lease payments. Her position gave her the opportunity to field all calls and intercept all written communications from the Internal Revenue Service and the bank. She made occasional payments for good measure but never let the physician know how far in the red the practice was.

Once the office manager's plot had been unearthed, the physician realized he faced financial ruin. By then, he couldn't afford to hire a lawyer and file a civil lawsuit, so he pursued criminal action against his former employee.

A detective found evidence the office manager had committed a felony. She was arrested and spent one week in jail. At the conclusion of the trial, she was placed on probation.

Based on evidence such as forged checks and questionable credit card charges, the district attorney was able to prove she stole \$80,000, which she paid back. The physician says it can be difficult to nail down exactly how much money he lost because oftentimes the theft involved cash.

Despite getting back a small fraction of the money he estimates was stolen, the physician is glad he reported the activities to law enforcement. He says her crime was too serious to ignore.

Now there is a lien on the physician's house, his credit report is abysmal, and he has exhausted his retirement savings to pay back the debts accumulated by the convicted office manager.

Unfortunately, this physician's experience isn't that uncommon. According to the Association of Certified Fraud Examiners' (ACFE's) 2008 Report to the Nation on Occupational Fraud and Abuse, small businesses with fewer than 100 employees are hardest hit by fraud. Many physician practices fall into this group, which suffered a fraud rate of 38 percent and a median loss of \$200,000 last year. Their larger counterparts with 100 to 999 employees had a median loss of \$176,000 due to fraud at a rate of only 20 percent. The report blames the higher frequency of fraud in small businesses on their limited resources for antifraud efforts.

The ACFE report projects that U.S.-based companies lose 7 percent of their annual revenue due to fraud, including embezzlement.

Worse yet, the association projects that the current economic recession will give rise to greater opportunity for fraudulent employee activity, such as embezzlement.

With not a lot of money to pour into theft prevention and an economic climate that has the potential to invite employee embezzlement, solo and small physician practices face some challenges ahead. Luckily, physicians can take simple steps to help avoid becoming victims of employee embezzlement.

TMA Practice Consulting offers an embezzlement risk review and an internal controls and embezzlement continuing medical education (CME) course for physician practices.

Knowing What to Look For

TMA Practice Consulting encourages physicians to pay attention to increased refunds or write-offs, checks that lack supporting documentation, payments to unusual vendors, and questionable credit card charges as just a few of the indicators that something may be amiss in a practice's finances. Consultants stress that physicians should trust their employees, but they also should be aware of some of the common embezzlement schemes and understand the red flags that may indicate they're victims of theft.

According to the ACFE, the most costly embezzlement schemes are theft of cash, skimming, and fraudulent disbursements. ACFE says the median loss from skimming, which involves stealing cash from an organization before it is recorded on the books, was \$80,000 in 2008.

An employee committing cash larceny steals cash receipts from an organization after they've been recorded. The median loss for cash larceny in 2008 was \$75,000.

Schemes involving fraudulent disbursements of cash include check tampering, billing and payroll schemes, fictitious expense reimbursements, and fraudulent cash register disbursements. The median loss to a business runs anywhere from \$25,000 for fictitious expense reimbursements to \$138,000 for check tampering.

Colter Baker, CPA, an Austin accountant who advises small physician practices, says another well-known scheme occurs when employees make personal purchases with the office credit card.

"If a doctor buys a lot of supplies from OfficeMax, for example, an employee with the practice card can add on personal items. Those purchases may seem small, but they add up over time," Mr. Baker said.

He says some embezzlers create fake vendors and have physicians sign invoices for them. In one example, a physician approved payments to a vendor named S.W. Bell. S.W. Bell was an employee, not the phone company.

"They [embezzlers] can find ways to steal drugs, money, and other property. Physicians would be wise to pay attention to all accounts receivable and make sure the payments have in fact been written off," he said.

In addition, employees often display certain behaviors or characteristics that signal that they may be engaged in some fraudulent activity. The office manager embezzling from the physician in this article claimed she worked weekends and overtime to catch up on work, but she actually used the opportunity to steal.

The top five red flag behaviors from the ACFE report are:

1. Living beyond means (38.6 percent);
2. Financial difficulties (34 percent);
3. Wheeler-dealer attitude (20 percent);

4. Control issues, including an unwillingness to share duties (18.7 percent), and
5. Divorce or family problems (17 percent).

Other common indicators that an employee may be embezzling include refusal to take vacations so someone filling in will not discover his or her misdeeds; irritability, suspiciousness, or defensiveness; past employment-related problems; and complaints about inadequate pay and lack of authority. While these warning signs of fraudulent conduct don't necessarily mean an employee is guilty of embezzlement, physicians and office managers should understand and recognize them.

Initial detection of occupational fraud, according to ACFE's report, most often comes from tips or complaints by employees, customers, vendors, or another source. Forty-six percent of the occupational fraud cases in the report came to light this way, while 20 percent were discovered by accident. An internal audit caught fraudulent activity in 19 percent of cases, and internal controls, such as segregating job duties or monitoring refunds and payables, detected 23 percent of cases.

Taking Control

The physician in this story did something common among many small business owners: granting one employee sole authority over all things financial. He now has more than one employee handle administrative duties involving money and conducts a periodic audit.

Physicians have enough to worry about from day to day, making it difficult to pay attention to the business side of the practice. The focus should be on taking care of patients, and it's easy to put someone else in charge of all financial matters.

Mr. Baker warns against giving one employee complete control of practice finances. He suggests physicians sign all checks and regularly review bank and credit card statements. TMA Practice Consulting advises physicians to separate job duties, ensuring not just one person is in charge of opening the mail, posting cash and check receipts, approving adjustments, preparing and making deposits, and preparing refund checks.

Another internal control to prevent embezzlement that physicians can implement is purchasing employee dishonesty insurance. The coverage insures a practice against financial loss from employee theft and allows it to recoup the loss. The coverage can be added to a general liability policy and protects against employee theft of money, property, or securities.

North American Professional Liability Insurance Agency (NAPLIA) reports that employee dishonesty coverage limits vary based on the exposure and the needs of the insured. To get an idea of the limits your practice might need to cover employees, NAPLIA suggests businesses that handle cash estimate the annual volume and multiply by 20 percent. The agency reports that typical coverage limits range from a minimum

of \$100,000 up to \$500,000. Many insurance companies offer separate coverage for depositor's forgery, and computer and funds transfers, which can be purchased with additional limits.

Fidelity bonds, which provide the same type of coverage as employee dishonesty insurance, also offer protection. They safeguard a practice not only from employee theft, but also from theft by a third party, such as a vendor or independent contractor. Coverage limits are similar to those of employee dishonesty insurance.

Physician's News Digest recommends physicians receive unopened bank and credit card statements for review and be involved in reconciling them. This is a good deterrent because it allows physicians to scan statements for unusual transactions and review canceled checks, paying special attention to the endorsing party.

Once physicians detect an embezzlement scheme, Mr. Baker says, they should prosecute the offender.

"It's important that physicians prosecute embezzlers to keep them from getting hired elsewhere and stealing again," he said.

While not every case of embezzlement is reported and some fraudsters go unprosecuted, the U.S. Sentencing Commission does have Texas-specific embezzlement figures. Data released last year by the commission indicate that of the 15,849 cases reported, 1.8 percent of Texas defendants were sentenced for non-fraud, white collar offenses such as embezzlement, forgery/counterfeiting, bribery, money laundering, and tax schemes.

Nearly 65 percent of those prosecuted for embezzlement in the state received a prison sentence, and 21 percent received probation. The average prison term in Texas for embezzlement was 18 months.

TMA Practice Consulting encourages physicians to notify the authorities when employees have stolen. Physicians should begin collecting supporting documentation that shows evidence of embezzlement and then contact their attorney, accountant, and the local police to prosecute the thief.

The physician in this article says he hopes his colleagues never experience what happened to him. He recommends physicians become educated about employee embezzlement by attending one of the programs offered by TMA Practice Consulting and taking steps to prevent theft in the office.

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Business Basics for Physicians restores the idea that a physician can move from a large organization or from a training program into solo or small group practice. This publication provides a comprehensive and comprehensible overview of the business side of medicine. It should also be read and studied by the providers who are secure in their current practice arrangement.

Susan K. Blue, MD

Fort Worth, TX

Your passion as a physician is caring for patients, but to realize your calling, you need solid business skills. For practices to remain viable in today's ever-changing payer and regulatory atmosphere, physicians need to have a grasp of fundamental business principles and how to control costs and increase revenue for their business.

Business skills like hiring and managing staff, developing and adhering to a budget, crafting administrative policies and procedures, monitoring expenses, and promoting the practice are vital but often elude physicians. Read this book to equip yourself with the knowledge and skills you need to ensure your practice's longevity.