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Developing Trends in Medical Practice Revenue and Operating Expenses

SURVEY RESULTS WITH KEY ISSUES FACING PHYSICIAN'S PRACTICES

Each year the Medical Group Management Association performs a cost survey to evaluate the financial performance of medical group practices in the United States. The 2008 report was just released, and not surprising to many physicians, operating costs are rising faster than revenue and physician practices. I am Dr. Larry Kaskel, host of The Business Of Medicine. Joining me today is Dr. William Jessee, President of the Medical Group Management Association and we are going to talk about this year's survey results and the key issues facing physician practices.

DR. LARRY KASKEL:

Dr. Jessee, welcome to the show.

DR. WILLIAM JESSEE:

Thank you very much. Good to be here.

DR. LARRY KASKEL:

Well, Bill, before we discuss the results of the survey, can you tell me how you actually do the survey?

DR. WILLIAM JESSEE:

Sure, every year we put out both a physician compensation survey and a cost survey and the one we are focussing on today of course is the cost survey. It's open to both MGMA members and nonmembers and this year we had practices respond representing about 30,000 physicians and mid-level practitioners, that's the largest survey of its kind in the country and it collects a wide variety of data. There are about 140 questions on the survey that allow us to report detailed information on practice operating cost, on revenues, on physician productivity, and a variety of staffing and resource requirement data from the practices.

DR. LARRY KASKEL:

So, Bill, what happened this year?

DR. WILLIAM JESSEE:

Well, I think the key is that what we found this year is a continuation of an unfortunate trend that's been going on for at least the last decade and that practice operating cost are going up faster than practice revenues. For multispecialty group practices, for example, revenues were up about 5-1/2% in 2007 and by comparison operating expenses were up about 6-1/2%. So when your expenses go up faster than your revenues that translates to less leftover for the owners and so it results in reduced compensation for the physicians of that practice.

DR. LARRY KASKEL:

So that's across the board, but were there any outliers, any physicians that actually saw an increase in revenue this year?

DR. WILLIAM JESSEE:

Everybody did see revenue growth. The average revenue growth was 5-1/2%. The only problem is the expense growth outstripped the revenue growth, so in terms of that, they didn't really see some substantial increases, in fact we actually some practices that saw declines in their revenues this year. For example, cardiology revenues were down about 0.6% and it's unusual to see revenues go in a negative direction. Just a normal inflationary increases in revenues and volume driven increases usually produce some increased revenues, but for cardiology I think the big item for them was clamping down on a lot of imaging studies and then the reimbursement rates for imaging studies in cardiology practices were cut way back, so that actually resulted in a decline in their gross revenues.

DR. LARRY KASKEL:

So what were you seeing as the major reasons that are increasing the overall cost. Is it just employee cost or is it you know what is it?

DR. WILLIAM JESSEE:

Obviously the biggest item in most practices budget is the salary line and it's just a fact of life that you typically have to increase salaries around 3 to 3-1/2% per year to keep your employees even with the inflation in the economy. If you don't do that, you risk loosing those employees to not necessarily other medical practices, but in some cases hospitals and other industries. So you have got to built in an annual escalator in your staff cost, but for many health professions, we are in shortage situation right now. There has been a nursing shortage for years, most of the allied health professions are in shortage situations and that tends to drive salaries up, so staff cost went up more than the rate of inflation in the economy at large where another big item was increase in drug cost. We saw a 17% increase in 2007 on top of an average increase for about 33% in 2006, and in fact in some pediatric practices, what they have to pay for drugs far exceeds what they receive in reimbursement for administering them primarily immunization <_____> pediatricians.

DR. LARRY KASKEL:

Right, that is not a good business to be in. You know I would like my staff to read the newspaper to know that the rest of the world

doesn't have jobs and they should be thankful that they are in the healthcare field, but you know, like you said they can always go elsewhere. Were you able to see anything that was the cause of affecting the primary care physician revenues not going up that much, and did you see an impact on retail health clinics, so are you not able to really tell what is causing it?

DR. WILLIAM JESSEE:

We have not really seen much impact from the very much hyped retial clinics. Anecdotal information we got indicates that about 60% of the patients who are showing up in those retail clinics do not have primary care physician, so it's not as if they are siphoning off the existing patients from primary care physicians. We didn't really see anything that would indicate a significant impact on primary care practices from the growth of the retail clinics. The one thing that did favorably impact primary care practices was the re-rating of evaluation and management codes that took place in 2007. In some cases, primary care physicians were seeing an income increase because of the fact that the rates were shifted away from procedures, i.e., taking money off of the surgical specialists and the interventional specialists to give more money to the ENM codes for primary care physicians. So this is the first time in a number of years that primary care physicians they actually did a little bit better than specialists by the most part.

DR. LARRY KASKEL:

Now, is there a way that you know physicians can actually combat the trend of operating cost increasing because we can't really increase our fees, we are kind of locked, so you know what can we do.

DR. WILLIAM JESSEE:

There are somethings you can do to help control the rate of rise of operating costs. One thing we find is that practices that are more successful financially do a better job of capturing charges. Unfortunately, a lot of physicians provide services that they never enter into their practices billing system, particularly if you provide in-hospital services, it's easy to forget to mention that you paid a call on the patient while you were in the hospital and that may never get billed, so increasing charge capture is one way to increase the revenues. Another factor that we found makes a lot of difference in practice profitability is how well you collect what you are owed by the payers. Practices that are more successful financially collect a greater percentage of what they are owed than those that are less successful and some of that is because they got aggressive people in their billing office that are out there hounding the insurance companies to collect every dollar that are due. One of the interesting conundrums we have seen over a number of years is that practices that have more FTE support staff per FTE physician are more profitable than practices that have a lower numbers of support staff and that's sort of counterintuitive. I think many physicians look at their practice expenses and say well I got to cut expenses, so the way to do that is to cut back on staff. Well, it turns out that's probably the wrong response because if you cut back on the staff, you probably are not going to be as effective in collecting what you are actually owed. So you have to look very carefully to make sure that you got the right number of staff and the right kinds of staff. You don't need to use an RN, for example, to pull charts, that's pretty high price labor for a task that can be better performed by somebody at lower pay scale. Another approach that many groups are using to combat this trend is to use more midlevels. In several specialties, we find that midlevels are generating a lot of additional revenue for the practice far in excess of what the midlevels are being paid as compensation, so that's the way of growing the top line and then another approach is being used is adding non-insured service. I think we sometimes think that the only source of revenue in the practice is being the insurance companies, but there are growing numbers of practices that are findings ways of creating revenue streams from non-insured services.

DR. LARRY KASKEL:

If you have just joined us, you are listening to the business of medicine on ReachMD XM 160, The Channel for Medical Professionals. I am Dr. Larry Kaskel and I am talking with Dr. William Jessee, President of the Medical Group Management Association and we are talking about the results from the 2008 cost surveys of physician practices.

Bill, how many docs out there are actually using EMRs or electronic billing services?

DR. WILLIAM JESSEE:

Well, I think the vast majority of practices now are doing most of their billing electronically, but with electronic records that's a different kettle of fish, it varies from specialty to specialty, it varies by size of the practice, the larger the practice the more likely they are to be using an EMR, but across the board, our data indicate that around 18% to 20% of the physicians currently are in a practice where they are using some form of electronic medical record. Now obviously if you got an EMR that allows you to capture information one time and seamlessly transfer a lot of that into your billing system, it helps you with things like charge capture. It helps with reducing some of your operating expenses in the practice once you get passed that early implementation learning curve, so it can be a real positive step, but it's still not the norm in medical practices around the country.

DR. LARRY KASKEL:

In your survey, did you talk to any practices that are dealing with what's called real time adjudication where the patient actually is paying their responsibility before they actually leave the office?

DR. WILLIAM JESSEE:

Yeah, we have got in some parts of the country, Florida for example, that's becoming increasingly common and some of the payers are trying to offer that as a service to practices, clearly there is some huge advantages there as the amount of patient responsibility has increased over the last several years with employers increasing co-pay, increasing deductibles, collecting those patient due amounts has become more and more important for practices. We have collected data from the cost survey for a number of years to show that practices that routinely collect co-pays and deductibles at the time of service are much more financially successful in those that do not. Sometimes it's just a matter of training your personnel to ask for it, but one of the problems we've had with the growth of the higher deductible health plans is that often you can't find out what the patient care is. There are a lot of insurers who say well just submit the claim and when the EOB comes back you will know how much the patient owes. Well that's easy for them to say, but once the patient has left the office then you have the expense of generating a bill, you have to wait for the patient to pay it, accounts receivable go up, bad debts go up, so if you can get that amount at the time of service through real-time claims adjudication that's a huge advantage and it's also more patient friendly. The patients want to know how much they are going to owe and the ability to get that information, get that answer for them at the time they are at the front desk is an important factor in increasing the patient's satisfaction as well.

DR. LARRY KASKEL:

Bill, if you take the data that you acquired from this year's survey and extrapolate it out to the future, when do you think that we will no longer be in business?

DR. WILLIAM JESSEE:

Well, let me put it this way. When the expenses exceed the revenues, it's clear that nobody will be in business, but we are going to see the crunch come long before it reaches a 1:1 ratio. The trend we have been seeing for the last several years of growing expenses outpacing growth and revenues results in the amount of available for physician compensation to become less and less that many

physicians feel like they are working harder than they ever have for the same or lower income, but what we are seeing right now is a fascinating trend to try to basically get out from under a lot of the economic pressures of operating a practice. Perhaps one of the fastest growing segments of MGMA's membership is practices that are now hospital owned or part of an integrated delivery system and we just recently looked at what the trend has been in hospital-owned practices in our surveys and it's clearly rising significantly over the last several years. If you project out the proportion of physicians who are hospital employees, we are estimating that within 10 years if the trend continues as it is, it will be up to around 60% of the physician population and I think that is purely and simply a response to the economic environment. Physicians are increasingly saying I am willing to sacrifice the professional autonomy of running my own practice to the economic security of being part of a larger organization where I will be assured that I am going to get paid at the end of the month and I don't have to worry about leaving the payroll for all those people that depend upon me.

DR. LARRY KASKEL:

Dr. William Jessee, thank you very much for talking with me today.

DR. WILLIAM JESSEE:

My pleasure, thanks very much for the opportunity.

DR. LARRY KASKEL:

My guest was Dr. William Jessee, President of the Medical Group Management Association and we were discussing this year's survey results with the key issues facing physician's practices.

I am Dr. Larry Kaskel and you have been listening to the business of medicine on ReachMD XM 160, The Channel for Medical Professionals. Please visit our website at reachmd.com, which now features our entire library of on-demand podcasts and thanks for listening.

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