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Bending the Cost Curve and Increasing Revenue

A Family Medicine Model that Works!

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KEYWORDS

• Revenue • Cost • Profitability • Contracting • Practice enhancements

KEY POINTS

- Family physicians looking to expand services need to consider their expertise and interest in the multiple opportunities in the community in which they practice.
- It is imperative that practices develop an organizational culture focused on rigorous financial management and set aside dollars for capital for investment. Furthermore, it is important to understand space allocation opportunities, for example using the day space for a nighttime sleep study center, and to develop stimulating and rewarding roles and responsibilities for all staff members as well as provide protected time to devote to developing new skills.
- Understanding the competitive landscape in the surrounding area is important. The development of a highly functional practice that is able to bend the cost curve and increase revenues is not a short-term, turnkey proposition, Moreover, it is not necessarily feasible to try all of the suggestions presented in this article at the same time; rather, the practice needs to determine what works best given the marketplace, and focus on those areas.

As family physicians face increasing economic pressures with changes in insurance reimbursement from government and nongovernment payers coupled to economic hardships that many patients face such as unemployment and higher out-of-pocket expenses, it is important that practices look critically at the financial impact of both building and sustaining a primary care Patient Centered Medical Home. This article highlights lessons learned and key strategies used by a successful California Family Medicine practice. By incorporating new models and revisiting time-tested methods for enhancing practice revenues, this article is not intended to serve as

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a comprehensive list of "to dos" but rather to serve as a potential checklist to ensure maximum revenues.

PAYER AGREEMENTS: READ THE CONTRACT

Most family physicians act as participating providers in a variety of insurance plans. Although Medicare and Medicaid reimbursements are set by the government and are not open for negotiation, family physicians may be able to negotiate with some preferred provider organizations (PPOs), health maintenance organizations (HMOs), and independent practice associations (IPAs). Typically physicians enter into individual contracts with PPO plans. These contracts are sometimes received unsolicited, while at other times being requested by the physician. Typical supply and demand economics often apply to payer contracting. A contract received unsolicited may indicate that the payer is looking to grow its' primary care physician workforce, which may allow physicians who are negotiating from themselves or a group some leverage in setting rates.

It goes without saying that physicians need to carefully read the payer agreement.

Unfortunately and all too often, physicians simply sign and return a contract without reading and understanding all of the provisions, especially the information regarding renewal agreements. While the reimbursement rate is an important part of the agreement, it is important that every section of the contract is carefully analyzed and understood. Before negotiating a new or existing payer agreement contract, family physicians need to analyze the current state of their practice and determine if there are specific items of importance that need to be fully discussed before signing a payer agreement, whether new or existing.

LIST SERVICES PROVIDED AND SCOPE OF PRACTICE

Create a table of the scope of services offered by the practice. This table does not need to be exhaustive but should include practice locations such as office, hospital, and skilled nursing facilities. Furthermore, make a list of the frequently billed Current Procedural Terminology (CPT) codes by location, including codes for all procedures performed in all practice locations. The breadth of procedures offered will depend on the marketplace but may include office-based procedures such as colposcopy, laceration repair, treadmill testing, electrocardiograms, and so forth. In addition, some offices may offer imaging, Clinical Laboratory Improvement Amendments (CLIA)-waived laboratory services as well as hospital and outpatient surgery center billable services. Finally, list as an added value of your practice extended office hours, urgent care services, or any other services not usually provided in a "typical" family medicine practice (**Table 1**).

Create a snapshot of the practice contract renewal dates by payer, and determine the amount of reimbursement by payer and what percentage each payer contributes to the practice income (**Table 2**). It is important to recognize when a particular agreement will renew, as old rates may continue to prevail if newer rates are not negotiated.

Using the list of services from **Table 1**, create a "market basket" of typical CPT codes with the current reimbursement rates for the top 5 or 10 payers for the practice (**Table 3**). In **Table 3**, 3 payers (A–C) with 2 common CPT codes billed are the outpatient new and established patient-visit codes. The reimbursements by payer would be compared, and it would be determined whether the reimbursement rates were acceptable or that a particular contract agreement should not be continued without significant changes in reimbursement.

Table 1
A list of services not usually provided in a "typical" family medicine practice

Scope of Practice	Outpatient	Hospital	Skilled Nursing Facility	Office-Based				Extended Hours or Urgent Care	Hospital or Surgery Center
List top 5–10 Payers	E&M codes	E&M codes	E&M codes	Procedures	Imaging	Point-of-Care Testing	Vaccines and other biological agents		Assistant surgeon colonoscopist
Payer A	Most frequent CPT codes								
Payer B	Most frequent CPT codes								
Payer C	Most frequent CPT codes								

Table 2
Periodic practice review of payer contracts and percent of business by payer

	Date Reviewed			
Payer	Original Contract Date	Renewal/ Termination Date	Reimbursement by Payer ($)	% of Income by Payer
A	1/1/2012	12/31/2013	800,000.00	33%
B	—	—	—	—
C	—	—	—	—
D	—	—	—	—
E	—	—	—	—

IDENTIFY SPECIFIC NUANCES FOR EACH CONTRACT

Analyzing current payer agreements will help identify specific nuances in particular contracts. Important areas to focus on include (but are in no way limited to) the following:

1. How much time is allowed to submit a claim? For some payers, they limit submission to within 90 days of the date of service and will not pay a claim received after 90 days from date of service.
2. If a claim is rejected, how much time is available to resubmit and challenge the denial?
3. Does the payer specifically bundle certain services and disallow additional payment? Keep a watchful eye, as some payers may try to bundle in-office CLIA-waived point-of-care testing as part of the office visit.
4. Will the payer reimburse the family physician for all services that (s)he is able to perform? For example, will office-based treadmill testing performed by the family physician be paid or does the payer require that the patient have the test performed by a cardiologist?

Table 3
CPT code reimbursement by payer and location/activity

	Payer A Reimbursement ($)	Payer B Reimbursement ($)	Payer C Reimbursement ($)
New Outpatient Visit			
99205			
99204			
99203			
99202			
99201			
Subtotal A			
Established Outpatient Visit			
99215			
99214			
99213			
99212			
99211			
Subtotal B			

5. Does the payer provide additional compensation for services not usually provided in the normal scope of practice such as extended hours, house calls, and telephone or electronic mail consults? Having a practice operate an urgent care or offering extended office hours is advantageous for many payers, as it reduces the number of emergency room visits that are ultimately more costly for the majority of payers. It is important to keep in mind that family medicine practice incurs additional costs by remaining open after usual business hours. Although CPT codes do exist for the provision of extended office hours-based care (99050 and 99051), it is important to ask:
   a. Will the payer agree to pay for extended office hours?
   b. Will the payer reimburse for these codes 99050 and 99051 and modifiers, or will they bundle the payment and disallow any additional payment?
6. When the payer requests copies of records for use review, quality assurance, or payment queries, who is responsible for making the copies?
   a. Will the payer reimburse the practice for copies? If so, at what rate?
   b. Has a rate been established for paper records versus electronic records?
7. If the contract agreement terminates, how will the physician be paid after termination? Many payer agreements require that physicians continue to care for patients in the middle of treatment, such as hospital inpatients until the patient is discharged, even if the agreement terminates. If the physician is capitated, will additional payments be made on a fee-for-service basis?
8. How much notice is required to terminate the agreement? Review whether the agreement contains an "evergreen" clause. This clause allows for the automatic renewal for subsequent terms unless the physician actively terminates it. If it does contain such a clause, then how much notice does the physician need to provide? Some payer agreements may have a notice provision requiring up to 1 year's notice for the physician to terminate, but the payer may terminate with just 30 days' notice.
9. What form of notice to terminate an agreement is required? Carefully read the notice provision language. A notice of termination may not be valid if not performed exactly as specified in the "notice section" of the agreement.
10. If the practice bills as a group entity, will the payer allow new physicians to join the practice if requested by the practice as long as the physician meets credentialing requirements?
11. Does the payer allow for the provision of services by mid-level practitioners such as nurse practitioners and physician assistants? If so, what services and will reimbursement be made that the same rate as a physician or at a reduced rate?
12. Does the physician have the ability to elect to "close panel" and limit the acceptance of new patients? Is the practice able to do this only with respect to that particular payer, or is it tied to the practice being closed to new patients from any payer source?
13. Does the agreement include the ability for other payers to "piggy back" onto the agreement without the practice's consent? For example, the practice may agree to a contract based on the assumption that the patients will be from a particular employer, regional location, and so forth, only to find that other employers are able to use the payer's negotiated provider network and thus expand the number of potential patients that the practice sees at these negotiated rates. If the rates are favorable the practice should be agreeable to this. However, if the contract was viewed as a "loss leader" then this "silent PPO" issue may result in the practice seeing more patients at a reimbursement rate that is not favorable to the bottom line.

14. Does the agreement contain any exclusivity language whereby the payer attempts to limit the ability of the physician to join or contract with another group or payer?
15. Does the agreement have any nonsolicitation language limiting the ability of the physician to notify patients if a decision is made not to renew a particular agreement?

Although a particular practice may find that it needs to continue to contract with a particular payer and that it has little negotiating leverage with the payer, the practice will at least be aware of the specifics of the agreement.

PRACTICE ENHANCEMENTS

In the previous section, the importance of understanding contract agreements from a selective and informed position was presented. Increasingly there will be opportunities to develop innovative patient-centered medical home (PCMH) models that effectively use health information technology to drive clinical and business decisions as well as leverage contract negotiations with strategic community partners. Discussed here are strategies used by a 21-physician member practice in West Los Angeles. Although all of the practice enhancements used by this physician group may not fit all practice groups, exploring practice enhancements need to be part of any PCMH checklist. This section discusses office-based imaging, certified laboratory services, sleep medicine, procedural service lines, and the use of telephone and e-visits.

Imaging

There are several ways to increase revenue through imaging procedures. The most common is to perform radiography within the office practice. The cost of digital radiograph packages for office use has decreased, making it feasible for physicians even in solo practice to provide this service, and it is certainly a revenue booster for a practice of 4 or more physicians. Any practice skewed toward urgent care will find radiography probably essential for patient care, but definitely a revenue booster. Offering radiographs in the office will require hiring certified x-ray technologists as well as the supervising physician obtaining an x-ray supervisor license to be able to assure radiation safety. Physicians trained in reading radiographs can bill a global fee to provide the service. An alternative is for the primary care physician office to perform the radiography and bill for the technical component, and arrange for a radiologist to provide the reading and also bill for the professional component. Either arrangement will increase revenue for the primary care office.

Another radiology service that can be provided in the primary care office is bone densitometry. Although there are several low-cost bone density devices, such as those that measure bone density at the ankle, these may function at less than optimal reliability and reproducibility. The preferred method for providing bone density analysis is by DEXA, dual-energy x-ray bone absorptiometry. Unlike regular x-ray rooms, the examination room that houses the DEXA unit does not require lead shielding, as the radiation emitted during an examination is very low. Similar to having radiography services, the office will need a technician certified in DEXA to perform the examination and the physician must be trained in interpretation of the study. A group practice of 2 to 4 doctors would find the addition of DEXA screening to be a solid boost to practice revenue.

In recent years the cost of ultrasound units has come down, now making it realistic for primary care doctors to provide ultrasonography and echocardiography in their offices. A certified ultrasonography technician must be hired to perform the diagnostic tests, which may include gall bladder, renal, and pelvic scans as well as screening for

aortic aneurysm and carotid artery stenosis. Many ultrasound units also can be configured for echocardiography. The physicians that choose to provide these imaging services must have special training to become proficient in the interpretation of these studies. Several organizations, including the National Procedures Institute, provide training in these modalities.

Beyond CLIA-Waived Point-of-Care Testing

Most offices provide CLIA-waived tests such as urinalysis. It is possible for group practices to provide more advanced laboratory testing, such as complete blood counts, chemistry panels, and some immunologic testing. Clinical laboratories such as this will require state licensing, periodic recredentialing, employment of certified laboratory technologists, enrollment in national proficiency testing programs, and rigorous oversight by the physician laboratory director, as there is significant liability associated with laboratory testing. However, a group practice of at least 6 busy physicians can support an in-office clinical laboratory, and the revenue from the laboratory will exceed the cost of the equipment, reagents, laboratory technicians, and regulatory oversight. For a busy group practice a laboratory can be an excellent revenue booster.

Sleep Medicine

For a group practice of at least 10 physicians, and one that includes a neurologist or pulmonologist interested in sleep medicine, an overnight sleep laboratory can be a good revenue booster. Ideally the sleep-study laboratory could be housed in the existing office space and converted to sleep-diagnostic beds at night. Obstructive sleep apnea is underdiagnosed and is often contributory or causative of other medical conditions diagnosed in the primary care office. In addition to the proper facility and equipment providing diagnostic sleep services, this service line will also require certified sleep technologists to administer the test and board-certified physicians to interpret the studies. However, revenue from the studies can be an excellent revenue booster for a practice, as these studies are periodically repeated to determine the appropriate settings for continuous positive airway pressure (CPAP) therapy. In some circumstances, the sale of durable medical equipment, such as the CPAP devices and masks, may add additional revenue to the practice.

Additional Service Lines

Cardiodiagnostics

Holter monitors and exercise treadmill testing require specialized equipment, but the equipment is not prohibitively expensive, even for a group practice of 2 to 4 physicians. The interpreting physicians must have training in these procedures, but once training is complete this will be a revenue booster, particularly if the practice is skewed toward older patients.

Endoscopy

A gastroenterology residency is not required to perform endoscopy and colonoscopy. However, additional training at special courses is required, and most endoscopy centers will require a primary care physician interested in performing these procedures to demonstrate training and to have a mentoring and supervision program in place before they become fully credentialed to perform the procedures independently. Although it is not an easy undertaking to accomplish the training and obtain credentialing privileges, these procedures are valuable to patients and can provide a significant revenue boost to the practice.

Telephone and e-visits

Traditional models of delivery of care are changing, and patients may request evaluation and management services outside of the traditional office setting. The practice should consider the use of telephone consults and e-visits to provide clinically appropriate services. Fees should be charged for providing these services, but it can be a challenge if insurers are bundling these services and consider them as part of the "primary care package." A secure network must be used to ensure the privacy and security of protected health information (PHI). Several commercially available software solutions exist for providing these services.

EVALUATE WORK FLOWS: WORK SMARTLY AND EFFICIENTLY

Personnel will typically be the largest variable expense in any primary care office. As office technology changes, such as implementing an electronic medical record or the office personnel becomes more experienced, it may be possible to make the office more efficient and reduce staff. Periodically a physician or group practice serious about keeping expenses down must perform a workflow analysis of the entire office. Several models exist that help the practice determine whether all of the steps in the process or flow are actually necessary or add any value to the operation, or might be possible to eliminate. For example, having a health team member screen calls to determine if an office visit is truly necessary may provide the physician with a sense of a protected schedule. However, if the practice recognizes that a patient's request for an appointment will most likely end up in an appointment being scheduled, at some point then it is better to just empower the front-office staff with scheduling an appointment when requested by a patient, without input from other unlicensed personnel. It is useful to ask members of the health care team how they think something could be done better or less expensively, and award bonuses to staff who offer successful ideas on expense reduction.

NEVER LOSE AN OPPORTUNITY WITH A PATIENT

Patients come to their family physician for advice and counseling. Tests are run and there is an obligation to notify patients of the results. While this can be done easily via telephone or mail, the best way is to schedule a visit with a patient to discuss the results in person, thus providing the family physician with adequate time to review the results, initiate changes in treatment if applicable, and discuss follow-up items that may be necessary. If results are completely normal then notifying the patient of the results may suffice and can be accomplished via mail, phone, or secure e-mail. However, many patients welcome the opportunity of scheduling a follow-up visit with their physician.

In addition, when patients are in the office, the workflow should ensure that the patient always stops at the checkout desk to not only make whatever payment may be owed for the visit but also to schedule a follow-up visit if suggested by the physician. Too many patients leave the office having been told to schedule a follow-up for medical reasons, only to never follow through on such an appointment. Patients will always have the opportunity to cancel the appointment if it is no longer necessary.

PHYSICIAN AND PATIENT TIME IS VALUABLE

Patients seek advice and medical consultation in a variety of ways. It is important that the physician's time is valued appropriately and that the physician and his or her team members also recognize that an hour lost can never be regained. Consider

implementing some basic charges that alone will not enhance revenue significantly but will help to highlight the value of physician time and set practice expectations, including charges for:

1. Late cancellations. Consider charging patients for appointments not canceled within 24 hours' notice. A patient "no show" for an appointment has used up a slot that could have been used by another patient and that cannot be regained.
2. Telephone consultations using standard coding guidelines.
3. E-mail consultations using standard coding guidelines.
4. After-hours telephone consultation. Although the physician may not actually choose to bill the patient, it may cut down on call or e-mails that are able to be addressed the following business day.

BILLING FOR PROFESSIONAL SERVICES: MAKE SURE YOU ARE PAID FOR WHAT YOU DO!

It is discouraging when a physician's hard work is not ultimately rewarded by appropriate reimbursement. The effective practice will regularly review the performance of the billing and collections office. The entire revenue cycle must periodically be reviewed and audited. The practice must assess and be confident that all:

1. Charges are captured
2. Charge documents are delivered to the billing office
3. Charges are posted by the billing office or vendor
4. Charges are submitted for insurance payment on a timely basis
5. Patient balances are billed to the patient on a timely basis after action by the insurance company
6. Receipts are correctly entered
7. Cash is collected properly

In addition, the practice must periodically review the collections activity to ensure that outstanding balances are actively pursued, including requesting payment of outstanding balances at the front desk at the time that patients present for appointments, and to seek the maximum possible collections after contractual adjustments are factored in.

As previously discussed, contractual adjustments made by the payer need to be reviewed at least annually. It is important to select a sample of reimbursements by each payer and compare it with the terms contractually allowed and agreed on. The practice must seek accurate payments from insurance companies, and consider termination of contracts for those payers that fall to the bottom of the reimbursement list or fail to honor their contracts.

COLLECTING COPAYMENTS, PROMPT-PAY DISCOUNTS, AND INCENTIVE AWARDS

Encourage staff to collect copayment at the time of service and offer prompt-pay discounts. In addition, collect outstanding balances at the time of the visit. Often this requires that the clinical staff turn in the charge documents promptly and completely at the end of the visit. However, it is worth the time and effort it takes to do this so that the staff can assist with collections. In addition to collecting for any amounts due at the time of service, consider the following:

1. Charging for copayments not paid at the time of service. There is an expense incurred by the practice for balance billing, therefore it is reasonable to pass on a "billing fee" for copayments not paid at the time of service.

2. Providing a prompt-pay discount to uninsured patients who pay their discounted bill in full at the time of service. Billing fees are not incurred when full payment is made at the time of service, and the practice is more likely to be paid if payment is obtained at the time of service.
3. Providing a financial incentive to front-office staff to collect on old accounts. In some practices, it may be possible to share a portion of outstanding balances collected on old accounts. Consider providing incentive awards to the practice unit responsible for collecting on old accounts.

EXPENSE REDUCTION

In addition to reviewing the revenue received for services, it is important to also to analyze the expenses of the practice on a regular basis. Two significant expenses for the practice are the cost of labor and medical supplies.

Employee Costs

As previously noted, employee expenses are typically the most expensive variable expense in a family medicine practice. Periodic review of salaries in comparison with the marketplace is important. If the practice has regular staff turnover, any savings in lower salary expense will be offset in time spent training new employees and the adverse effect that this has on physician and practice productivity. Also, be sure that each member of the team is providing care in the most efficient way possible to ensure that physician time is not being spent on tasks that can be handled efficiently by other health care team members.

Supplies and Vendor Relationships

Medical supplies are typically the next most expensive variable expense. Family medicine practices frequently procure both biological and nonbiological medical supplies, frequently from the same vendor. The practice should set up regular meetings with the vendor to review purchasing patterns, products chosen, and potential discounts. Comparable products may be available at lower costs. For example, one practice delegated supply purchasing to a medical assistant who decided to always order latex-free examination gloves. These gloves are significantly more expensive than the regular "house-brand" gloves offered by the medical supplier. Changing to the regular house-brand gloves with a few boxes of latex-free gloves available for those patients with latex allergy resulted in a significant savings to the practice.

Some vendors may be willing to offer a discount either for volume or for a period of exclusivity. These agreements should be reviewed at least annually, to assure that the negotiated rates are being honored.

Biological medical supplies constitute a significant cost to family medicine practices. Use of generic agents may substantially reduce costs. In addition, meet with representatives of vaccine manufacturers and determine if savings can be obtained by using a particular vendor for most vaccines.

Group-Purchasing Organizations

Group-purchasing organizations (GPOs) may be available to a practice. These GPOs allow practices access to discounted rates for medical supplies, negotiated by the GPO with specific vendors. Sometimes GPOs are available through specialty societies or local physician organizations, whereas some are private companies. In some instances, a membership fee is required and many GPOs rebate savings to their members at the end of the year. The GPOs are positioned to negotiate markedly

reduced rates, based on providing some exclusivity and volume purchasing to the manufacturer.

SUMMARY

As family physicians and other primary care physicians face the challenge of rising overheads and lower reimbursement rates, it is important to review opportunities to enhance revenue and streamline operations. Family physicians looking to expand services need to consider their expertise and interest in the multiple opportunities in the community where they practice.

It is imperative that practices develop an organizational culture focused on rigorous financial management and set aside dollars for capital for investment. Furthermore, it is important to understand space-allocation opportunities, for example using the day space for a nighttime sleep-study center, develop stimulating and rewarding roles and responsibilities for all staff members, and provide protected time to devote to developing new skills. Understanding the competitive landscape in the surrounding area is important. The development of a highly functional practice that is able to bend the cost curve and increase revenues is not a short-term, turnkey proposition, Moreover, it is not necessarily feasible to try all of the suggestions presented in this article at the same time; rather, the practice needs to determine what works best given the marketplace, and focus on those areas.