

## PRACTICE OPTIMIZATION: AN ARGUMENT FOR SPENDING MORE

By Jeff Gorke, Senior Vice President | Coker Group

The title of this article is a bit misleading in that the argument is more toward *investing* in the practice than spending more. Ultimately, the investment *is* spending. As operators, we occasionally take the short view on profitability vs. the longer, big-picture view of a dollar investment and the subsequent return on investment (ROI).

This spend-thrift mindset is ingrained in management’s mantra. Managers are constantly under pressure to manage and reduce costs and increase revenue. Managers carefully babysit overhead by watching employee costs, monitoring the IT spend, measuring the capital expenditure, etc. Our objective is to increase profitability, whether we are in the private practice setting or the employed physician network model (e.g., hospital employment).

Efficient deployment of resources and, in some cases, *increased spending* may hold the key to enhanced profitability.

Figure 1 represents a private practice (cash accounting vs. health system accrual accounting) and displays the general profitability rubric under which administrators labor.

**Figure 1**

**Drs. X & Y Practice Projections**  
**Static revenue, reduced expenses**

	2016	2017*	
<b>Revenue</b>			
Private payors	\$ 70	\$ 70	
Medicare	\$ 30	\$ 30	% change
<b>Total revenues:</b>	<b>\$ 100</b>	<b>\$ 100</b>	<b>0%</b>
<b>Expenses</b>			
Equipment	\$ (10)	\$ (9)	
Salaries & benefits	\$ (25)	\$ (24)	
Rent	\$ (8)	\$ (7)	
Med/mal	\$ (4)	\$ (3)	
Drugs	\$ (10)	\$ (9)	
Other (misc)	\$ (5)	\$ (4)	
<b>Total expenses:</b>	<b>\$ (62)</b>	<b>\$ (56)</b>	<b>-10%</b>
<b>Profit</b>	<b>\$ 38</b>	<b>\$ 44</b>	<b>16%</b>
Partner share	\$ 19	\$ 22	

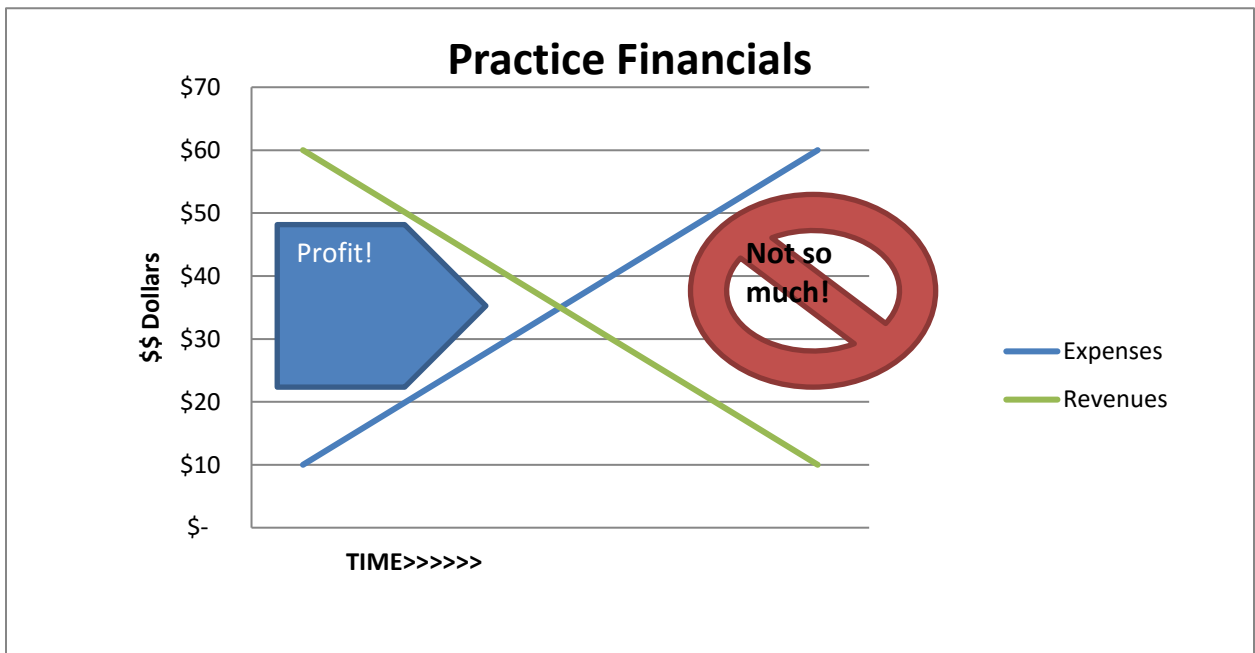
\* Projected

As Figure 1 illustrates, the practice surmises it will head toward higher profitability in 2017 than in 2016. There is no expectation of additional revenue. Instead, the practice contemplates an expense reduction of nearly 10% across the board. For instance, salaries drop from \$25 to \$24, and drug costs dip from \$10 to \$9. The practice’s overhead percent (a function of revenue/expense ratio) improves from 62% to 56%, and profitability increases 16%. In this example, the two partners in the private practice split the profits equally. Thus, their compensation increases from \$19 to \$22 each.

In Figure 1, our administrator is able to manage expenses to increase profitability. She was able to carve out 10% in costs while revenues remained static. Those savings passed straight to the bottom line. However, as the old saw theorizes, “You can’t cut your way to profitability.” To put a finer point on it, you can’t continue to reduce costs expecting that business operations won’t suffer. At some point, there are no more expenses to cut, revenues must increase, or the business must shutter.

In Figure 2, we notice the calculus of Practice Financials. On the far left side of the graphic, \$60 in revenue is riven from \$10 in costs, an astounding (and unheard of) 17% overhead. As illustrated, over time, if the revenue drops and expenses increase, the practice reaches the point of financial unsustainability (e.g., the “Not-so-Much” zone).

Figure 2



While Figure 2 is logical, it graphically drives home the point that the larger the quotient percentage of expenses to revenue, the worse the practice is performing, financially. Therefore,

Figure 2 indicates the practice begins losing money somewhere near \$35 in revenue and expenses.

However, what about the logic of *spending* your way to profitability? This theorem is the antithesis to the traditional thinking managers generally live and breathe in the day to day; it's counter to our very being.

However, what if spending (e.g., investing) in additional staff made financial sense and kept the practice in the "Profit" section in Figure 2? Data in Figure 3 was compiled from the Medical Group Management Association (MGMA). The MGMA contemplated the revenue, cost, productivity, and infrastructure of the "most profitable" multi-specialty groups with primary and specialty care.

**Figure 3**

Revenue, cost, productivity, and infrastructure for the most profitable and all MS groups w/primary and specialty care	Most Profitable	All multi-spec
Median total medical revenue per FTE physician	\$ 1,169,542	\$ 700,576
Median total operating cost per FTE physician	\$ 630,680	\$ 428,766
Median total medical revenue after operating cost per FTE physician	\$ 538,320	\$ 280,142
Median total physician compensation and benefit cost per FTE physician	\$ 462,722	\$ 373,846
Median total operating cost as a % of median total medical revenue	54.1%	60.2%
Median work RVUs per FTE physician	7,726	6,906
Median square footage per FTE physician	2,784	2,378
Median total support staff per FTE physician	5.12	3.96

Source: The Enterprise version of the *MGMA DataDive Cost and Revenue 2016*.

Survey respondents realized an increase in both median revenues and total operating costs. However, Total Physician Compensation was 23% higher for the "Most Profitable" groups than the cohorts. Interestingly, "Median total support staff" of 5.12 for "Most Profitable" clinics was 29% more in staffing per physician than their cohorts.

Perhaps most importantly, though, is that while expenses increased, the overhead percent of "Most Profitable" practices was more than 6% *lower* than "All multi-spec" groups.

The devil, of course, is in the details. Spending cannot occur for spending's sake. Instead, proper analysis, contemplation, and thoughtful alignment and optimization of current resources may improve profitability. For instance, deploying medical assistants (MAs) to the full scope of their licenses may save on nursing costs. Investing in a cloud-based solution might cost a little more on the front end but may mitigate future hardware and assorted IT costs in the longer term.

Let's look at a hypothetical practice (Figure 4). Practice X sees 600 and 800 new patients and established patients, respectively, per year. Practice X generates \$174K in new/established patient revenue.

**Figure 4**

New Patients	Allowable	Current Annual Volume	Current Annual \$\$\$
99203	\$ 100	100	\$ 10,000
99204	\$ 140	300	\$ 42,000
99205	\$ 200	200	\$ 40,000
Sub Total:			\$ 92,000

Estab Patients	Allowable	Current Annual Volume	Current Annual \$\$\$
99213	\$ 75	200	\$ 15,000
99214	\$ 105	400	\$ 42,000
99215	\$ 125	200	\$ 25,000
Sub Total:			\$ 82,000
Grand Total:			\$ 174,000

Suzy Q, the venerable administrator, noted that by adding a qualified staff member at a salary cost of \$5,000, the practice could increase new and established patients by 10%.

**Figure 5**

New Patients	Allowable	New Annual Volume	New Annual \$\$\$
99203	\$ 100	110	\$ 11,000
99204	\$ 140	330	\$ 46,200
99205	\$ 200	220	\$ 44,000
Sub Total:			\$ 101,200

Estab Patients	Allowable	New Annual Volume	New Annual \$\$\$
99213	\$ 75	220	\$ 16,500
99214	\$ 105	440	\$ 46,200
99215	\$ 125	220	\$ 27,500
Sub Total:			\$ 90,200
Grand Total:			\$ 191,400

After adding the staff member, all things being equal, the patient volumes and revenue increased 10% or \$17,400. (In our example, we assume no other cost increases and note increased profitability of \$12,400 [\$17,400 in gross revenue--\$5,000 cost of employee]). So, in the instant (and overly simplistic) case, we spent more money to make more money.

Let's examine another overly-simplistic case but one that solidifies the logic behind care process redesign and efficient use of resources. Figure 6 details a practice attempting to measure its outcomes and profitability.

**Figure 6**

RN heavy, no process, per visit Procedure X Scenario 1	
Staffing	\$38
Supplies	\$25
IT & Other	\$50
Time to perform	45
Reimbursement	\$150
Max Patient Load	9.33
Max Reimbursement	\$1,400
Cost per Visit	\$113
Margin	25%

The practice provides Procedure X. The procedure costs the practice \$113 per visit including supplies, staffing, etc. Procedure X currently takes 45 minutes to perform. With these variables, Figure 6 displays that the practice can only perform 9.33 Procedure Xs per day with maximum revenue generation of \$1,400 and a 25% margin.

After careful system review and time-driven activity-based cost accounting, Suzy Q obtained the results delineated in Figure 7.

**Figure 7**

Shifting of staff, measure, monitor, manage process Procedure X Scenario 2	
Staffing	\$30
Supplies	\$22
IT & Other	\$48
Time	30
Reimbursement	\$150
Max Patient Load	14
Max Reimbursement	\$2,100
Cost per Visit	\$100
Margin	33%

The practice realized for Procedure X:

- repeatable outcomes, higher quality delivery of care
- staff utilized more effectively and to the full scope of their respective clinical job functions and licenses,
- better managed IT systems
- improved utilization and purchasing of supplies, and
- reduced time for Procedure X *and* increased maximum patient load

As can be seen, Suzy Q utilized the staff (right person, right job) driving savings, ultimately, enhancing profitability.

The results displayed in Figure 8 delineate a reduced cost per visit of \$13, higher patient volumes, and increased profitability.

**Figure 8**

<b>CHANGES</b>	<b>Old</b>	<b>New</b>	<b>Difference</b>
<b>Cost per visit</b>	\$113	\$100	\$13
<b>Margin per visit</b>	25%	33%	8%
<b>Patient visit volume</b>	9.33	14	4.67
<b>Revenue</b>	\$1,400	\$2,100	\$700

**CONCLUSION**

Do the points made in this argument this suggest that health systems and medical practices should begin spending money on staff and equipment? Not necessarily. However, thoughtful investment may prove financially beneficial to managers and physician-leaders who properly value the delivery of care and work toward its efficient deployment. All options should be considered in the prickly balance between revenue and expenses in the brave new world of MACRA/MIPS.

Coker Group would be delighted to help you optimize your practice revenue. If you are interested in discussing how this could be done call 678-832-2021 to speak with Jeff Gorke, Senior Vice President.