

### **Medical Amelioration**

The fiscal environment of Medicine today permits little optimism for the future. Diminishing revenues from governmental sources and third party payers coupled with rapidly increasing practice costs are continuing to reduce profit in physicians' practices.

The sum of available tax dollars and premium dollars are far from sufficient to pay for the increasing demand for healthcare. According to a survey by the American Medical Group Association, the average medical group had a loss of over ten thousand dollars per physician in 2001. In all areas of the United States, physician practice profits are declining.

The reasons are multivaried. On the revenue side, increases in payments - on the average - have been at or below the already low national inflation rate. The true impact on profit, however, comes from the expense side of a practice.

For many practices, Medicare and HIPAA regulations have necessitated the addition of staff and purchases of outside services (e.g. HIPAA training) in order to comply with these mandates. There is no doubt that HIPAA-associated expenses will rise in 2003 as many practices are just beginning to come into compliance. The national shortage of nurses and other paramedical staff has driven labor costs to new highs. Benefit costs for practice staff, especially health insurance premiums, are rising.

Billing and coding expenses continue to rise as payers deny claims and carry out audits. More documentation is constantly demanded.

Medical malpractice insurance premiums have increased nation-wide. Certain areas of the country are in crisis situations with respect to the cost of medical malpractice insurance. In those areas, some physicians are leaving for less expensive areas, or are leaving the practice of medicine altogether. We, in Arizona, are fortunate in having MICA who has managed to keep premium cost increases low, especially when compared to states such as Pennsylvania, West Virginia, and Florida. In addition to excellent management, MICA's local roots and its single product orientation have contributed to its success.

Medicare cutbacks have resulted in similar action by commercial carriers. As many third party payers have tied their payment rates to a percentage of Medicare's, when Medicare lowers its reimbursements, so do those other payers. A lack of financial sophistication on the part of some practices has occasionally resulted in substantial underpayment by some payers.

While Congress eliminated the 4.4% reduction in Medicare reimbursement that was scheduled for March 1 of this year, it did not take any steps to correct the admittedly incorrect formula on a permanent basis. The reason: budget concerns. This means, of course, that further cuts in Medicare payments for 2004 and perhaps beyond are likely to occur.

Now that we have defined the problem, are there any solutions, and, if so, what are they?

There are no good solutions that lie within the realm of the achievable; however, some actions on the part of physicians can ameliorate the situation.

First and foremost, we must review how we practice and eliminate any practice expenses that are non-productive. In an environment of declining revenues and rising costs, maintaining or increasing profit requires an increase in productivity.

Streamlining one's practice methods and patterns frequently leads to higher productivity. It also tends to increase patient satisfaction and retention. As the sophistication of our patient population increases, long waiting times and less than caring staff members contribute to patients' decision to go elsewhere for their care.

In a busy practice, a review of existing health plan contracts should lead to the elimination of plans with few members and low payments. As health plans increase co-payments and deductibles in order to shift more of the healthcare cost burden to the consumer, timely collection of such co-payments becomes even more important because co-payments not collected at the time of service will lead to higher bad debts and increase the cost of collection. Higher co-payments and a stagnant economy may also lead to lower use of physician services and further contribute to the decline in revenues.

The current revenue/cost squeeze has caused many specialty group practices to review their physician compensation patterns and recruiting offers. Various medical practice consultants report a shift from shared income to production-based schemes as high-production physicians seek to protect their income streams. Among groups whose physicians are compensated on a production basis there appears to be a shift from equally shared overhead to a production-based overhead sharing. This method assists those members of the group who are – for a variety of reasons – lower producers. Some groups- especially groups who have semi-retired members – are moving in the opposite direction, from production-based overhead sharing to equal overhead sharing in order to entice their semi-retired colleagues to retire.

Similar changes are occurring with respect to recruiting offers. Many group practices have established slightly lower base salaries for new physicians who can earn additional income through a production bonus which kicks in when the full costs associated with the employed physician (salary plus benefits plus practice expense attributable to the employed physician) have been recovered.

Congress has the opportunity to ameliorate the current, ultimately untenable situation by taking at least two steps. A federal law limiting non-economic awards in medical malpractice suits will go a long way toward stabilization of the liability insurance situation. A permanent correction of the flawed formula used to calculate Medicare fees would bring Medicare reimbursement more in line with reality.

Contact your senators and representatives to let them know your thoughts in these matters!

Any thoughts, comments or views with respect to this topic are welcome.

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