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Physicians have many challenges they must tackle to keep their practice successful, their patients healthy and their career moving forward.

Underlying all of these challenges is a vital one: maintaining your financial security and success, both for your practice and your family. Medical Economics® is renewing its focus on finance, and we’re excited to announce some big changes to our print magazine and website.

Medical Economics® has always had a strong practice finance and management focus, and in the past, we offered robust personal finance content as well. Now, starting with the issue in your hand and on MedicalEconomics.com, Medical Economics® is joining forces with two legacy MJH Life Sciences brands to bring you the full spectrum of financial content you need.

Here’s a brief explainer of these historic brands, and how they will provide the content you need to find financial success:

Physician’s Money Digest® will be a source of practical, forward-looking and insightful personal finance content. We will offer in-depth reported features, columns authored by physicians and financial experts, exclusive data, quick tips, and more. PMD, as we call it, will have a strong focus on the financial decisions within each physician’s control, including retirement and estate planning, investing advice, navigating student debt, real estate, and much more.

Physicians Financial News® focuses on all of the larger factors at play that can impact a physician’s finances. Here we will delve into — in an intelligent and analytical way — health care reimbursement trends, government policy, business mergers, stock market and economic trends, and more.

We are very excited about this new direction, and strongly believe that the combined power of these three brands will provide all physicians with excellent and timely financial top-ics, relevant to you regardless of your specialty, practice type or career stage.

We want to know what you think of our new approach, and are excited to engage you, our physician audience, on what kinds of financial content you need. If you have story ideas our content team should pursue or financial tips and ideas you want to share with your peers, please reach out to medec@mjhlifesciences.com.

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Physicians Financial News®

4 The latest data revealed on medical practice ownership
Is there a future for independent practices?

5 Investing Intelligence
Dave S. Gilreath, CFP, discusses how rising interest rates and inflation affects stocks.

Legal

9 Reducing crypto currency risks
Why your asset protection plan must include your crypto portfolio too.

Practice Management

10 The 5 secrets of financially successful practices
How you can apply these tips at your business.

13 Common patient experience mistakes
When a patient has a bad time, these practices are usually to blame.

Careers

14 The 92nd Physician Report
Our exclusive data on physician salaries, productivity, malpractice costs and more.

Technology

23 Revenue cycle management 101
How to find the right vendor partner for you.
Physician’s Money Digest®

26 Estate planning
Assembling an ironclad estate plan is crucial to safeguard your assets for the next generation.

31 Finding a great financial adviser
Why going it alone is not the best option for most physician investors.

32 Selling your practice
The financial and tax implications physicians need to know before the strike a deal.

Chronic Conditions

36 Diabetes management and reimbursement
Reach your patients and get paid for improved outcomes.

39 Coding scenario:
Type 2 diabetes
Can you code it correctly?
OUR ADVISERS

Allen Dobson M.D.
Editor-in-Chief
Family Medicine
Mt. Pleasant, North Carolina

Maria Young Chandler, M.D., MBA
Business of Medicine / Pediatrics
Irvine, California

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Austin, Texas

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Family Medicine
La Quinta, California

Salvatore Volpe, M.D.
Pediatrics/Internal Medicine / Pediatrics
Staten Island, New York

Have a question for our advisers?
medec@mmhgroup.com

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- Tips for physicians to extend the life of N95 respirators.
- Mental health tips for doctors and other providers.
- How physicians can protect themselves from COVID-19.
- Strategies for using telehealth.

To read all of our ongoing coverage, go to MedicalEconomics.com

Perfect your telehealth program

Tabassum Salam, M.D., the ACP’s vice president of medical education, discusses what physicians need to know to get started with telehealth right away.

Watch this video and others at: bit.ly/MedEcVideo

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Number of physician-owned private practices saw major decline since 2018

By Keith A. Reynolds
Associate Editor

Most physicians worked outside physician-owned practices in 2020.

A biennial American Medical Association (AMA) analysis found that the share of physicians in private practice fell below 50% for the first time since the association began the analysis in 2012.

While data collected by the AMA from 3,500 U.S. physicians last year show that the shift to larger medical practices away from those owned by physicians continues, the rate of the shift seems to have accelerated. It is worth noting, though, that the data were collected from September to October and may not reflect the full impact of the COVID-19 pandemic, a release from AMA says.

Only 49.1% of physicians reported working in a physician-owned practices, a drop from 54% in the 2018 survey, the largest two-year decline measured by the AMA. Meanwhile, the percentage of physicians working at practices with more than 50 doctors rose from 14.7% percent in 2018 to 17.2%, according to the release.

“There are several contributing factors to the ongoing shifts in practice size and ownership that include mergers and acquisitions, practice closures, physician job changes and the different practice settings chosen by younger physicians compared to those of retiring physicians,” says AMA President Susan R. Bailey, MD. “To what extent the COVID-19 pandemic was a contributing factor in the larger-than-usual changes between 2018 and 2020 is not clear. Physician practices were hit hard by the economic impact of the early pandemic as patient volume and revenues shrank while medical supply expenses spiked.”

“The impact of these economic forces on physician practice arrangements is ongoing and may not be fully realized for some time,” Bailey says.

Other findings of the survey include the following:

• Employed physicians make up 50.2% of all doctors, a 2.8% percent drop from 2018; while self-employed physicians account for 44%, a 1.9% drop from 2018.
• Nearly 40% of physicians work either for a hospital or at a practice at least partially owned by a hospital.
• In a first for the survey, 4% of respondents reported working at a practice owned by a private equity firm.
• 53.7% of physicians work in a practice with 10 or fewer doctors.
• Most respondents work in practices structured as limited liability companies, 27.8%, and S corporations, 24.7%.”
ADVICE YOU CAN INVEST IN

INVESTING INTELLIGENCE  with Dave S. Gilreath, CFP

Inflation is everywhere: What it means for investing

The financial media’s obsession with the assumption that rising interest rates and inflation are bad for stocks is remarkable — for being so flat-out wrong.

And flat-out illogical. Rising rates and moderate inflation naturally benefit stocks because they reflect economic growth that usually helps corporate earnings and pushes up share prices.

But this economic reality hasn’t eased the current paranoia surrounding any transitory, minuscule uptick. Any increases are viewed as being on a seesaw, with equity returns on the opposite end. If rates rise, goes the logic, equity returns will probably go down.

Never mind that stocks have historically done quite well in months following interest rate increases, and that most stocks do pretty well amid moderate inflation.

But talking heads and columnists habitually obsess over any wisp of potential for interest rates or inflation to rise. They burn many hours of airtime and countless electrons online fussing over the slightest upward blip, stirring investor fears that equities might plunge, with foreboding on a level close to medieval fear of satanic forces. From the way they act when the yield on the 10-year Treasury bond goes up a couple tenths of 1%, you’d think someone’s head were rotating 360 degrees from demonic possession.

Picking up on this cue, some investors sell stocks, sometimes missing out on near-term gains. You could say the devil makes them do it — devilishly uninform ed motivation, that is. Over the longer term, the impact of this behavioral investing on the market is muted by real factors affecting actual value, but these investors have misguided their portfolios.

Those possessed by these demons need the kind of exorcism that only a clear look at market history can bring. This might lead to some much-needed investor epiphanies about the actual effects of interest rates and inflation on equities.

Some pertinent points:

1. Research by Strategas looked at seven periods of rising interest rates over the last 30 years. The average annual return for the S&P 500 in ensuing 12-month periods was 20%. The sectors with the highest annual returns were financials (27.5%), technology (26.5%) and health care (23.6%). Further, one well-known researcher looked at this question 150 years back, examining periods of stock market performance one, five and 10 years out from interest-rate increases. He found no discernible impact on returns when adjusted for inflation and dividends. So the idea that interest rate increases, as reflected in bond yield rises, negatively affect equities has no basis in historical fact — it’s a myth kept alive by repetition.

2. Normal inflation isn’t bad for equities. Contrary to popular belief, stocks can actually benefit from it, particularly in industries where earnings and revenues tend to rise with inflation-driven price increases. According to an analysis performed by the U.S. Bank Asset Management Group, over the past 30 years, U.S. stocks in a variety of sectors have tended to rise amid moderate inflation. Historical data show that an inflationary environment is a neutral condition to stocks.

3. The financial media’s obsession with the assumption that rising interest rates and inflation are bad for stocks is remarkable — for being so flat-out wrong.

Despite the COVID-19 pandemic, insurance companies in most markets appeared to become more profitable in 2020.

According to an analysis from the Kaiser Family Foundation, insurers across four markets saw an increase in gross margins, which seems to indicate an increase in profitability. The four markets are Medicare Advantage, Medicaid managed care, individual (non-group), and fully insured group (employer).

While gross margins do not directly translate to increased profitability, without a commensurate increase in administrative costs it could indicate that these markets have become more profitable during the pandemic.

A separate Kaiser Family Foundation analysis found that commercial insurers will owe substantial rebates of about $2.1 billion, to beneficiaries this year under the Affordable Care Act’s Medical Loss Ratio provision.

“The pandemic’s effect on health spending and insurer financial performance in 2021 remains uncertain,” the analysis reads. “Health care utilization has mostly rebounded to pre-pandemic levels and there could be additional pent-up demand for care that had been missed or delayed last year.”

Medical Economics.com

INFLATION continued on page 7

By Keith A. Reynolds
Associate Editor

Despite pandemic, payers saw profits surge

INFLATION continued on page 7

INFLATION continued on page 7
Treatment of Hepatic Encephalopathy in Primary Care

In this Medical Economics® Clinical Consult series, experts Dr. Nancy Reau and Dr. Arun B. Jesudian discuss hepatic encephalopathy and strategies to address its challenges, including current guidelines for diagnosis and treatment, co-management in the absence of a unique ICD-10 code, and outpatient care adaptation. They also review therapeutic developments showing the most promise.

Watch the series now: medicaleconomics.com/he-primary

Sponsored by: Salix
INFLATION continued from page 5

ideal annual inflation rate for many stocks is about 3%, just a bit higher than the 2.6% posted by the U.S. Department of Labor for the 12 months ended March 2021. (This is quite low historically, and some recent monthly inflation estimates are even lower.) Though a little inflation is not at all bad for the market overall, larger companies tend to be more sensitive to it.

Rampant inflation can pummel equities. People who were around in the 1970s can remember the market damage that occurred when the annual inflation rate rocketed from 6.22% in 1973 to a whopping 13.3% in 1979. To witness all the hair-pulling these days from slight upticks in inflation (and, notably, no emotional relief from recent monthly downturns), you'd think we were all wearing bell-bottom pants.

If there's no evidence that rising interest rates hurt stocks, why do so many people think they do?

For one thing, there's the notion that price-earnings ratios are inversely related to interest rates, that these ratios are higher when rates are low and vice versa. Yet market history clearly shows this isn't the case.

Then there's the competing-assets argument: When rates rise, this makes bonds more attractive relative to stocks because bond yields go up. But given the superior long-term returns of the stock market versus those of bonds, this argument has always been weak. And it has become ludicrous now that bond yields are scraping rock bottom during a galloping bull stock market. Portfolio diversification has traditionally been a reason to buy bonds, but a growing correlation between stocks and bonds is chipping away at this allure.

Also, many stock valuations are heavily influenced by analysts' use of the capital asset pricing model, a formula that uses interest rate data to discount future equity earnings. Yet this valuation method is theoretical rather than market-based. It assumes that cash flows can be accurately projected far into the future, but they can't. Yet the capital asset pricing model nonetheless influences many analysts' buy-sell-hold ratings and has an impact on prices of growth stocks.

Regarding inflation, the current contagion of inflation is being fueled by changes in the way the money supply is measured and a limited understanding of what makes the dollar inflate.

Rising inflation is often laid at the doorstep of a growing money supply. Inflation hawks routinely inveigh against the Treasury's printing more money because they believe money supply is already too high and that this alone causes inflation. The money supply has substantially increased, but not so much from printing money as from the Federal Reserve's move this year to reclassify savings deposits as transaction accounts, which caused a retroactive tripling of the money supply.

Increased money supply alone doesn't cause inflation. Another key element is velocity of money — the rate at which a dollar is used to buy stuff. And velocity has been declining since 1997 and fell during the pandemic.

Those worried about interest rates and inflation and their impact on equity performance should examine market history and relax, rather than twitching with every uptick — or, worse, selling stocks in reaction.

Dave S. Gilreath, CFP, is a 40-year veteran of the financial services industry. He co-established Sheaff Brock Investment Advisors, LLC in 2001. The firm manages over $1 billion in assets nationwide.

Private equity firms show growing interest in hospitals, new analysis finds

The journal Health Affairs examined private equity-backed hospital acquisitions from 2003 to 2017 and what effects they have had on the financial and operational aspects compared with those not acquired.

In 2000, the total valuation of private equity deals in the health care sector was less than $5 billion, but by 2018, that had increased to more than $100 billion. Acquisitions ranged from physician practices to mobile application companies. This increased interest by private equity was likely fueled by a perception that health care is recession-proof, a projected increase in demand because of an aging population, or the operational inefficiencies of health care organizations, according to the authors.

In 2017, private equity-acquired hospitals accounted for almost 7.5% of all nongovernmental acute care hospitals and 11% of all patient discharges. Private equity-targeted hospitals were predominately in the mid-Atlantic and southern United States between 2003 and 2017, with the hospitals more likely to be for-profit and in urban areas.

During this same period, private equity-backed hospitals had better operating margins than nonacquired hospitals on average, and the magnitude of difference in the margins rose 3 percentage points.

In this period, operating expenses per adjusted discharge from private equity-acquired hospitals declined relative to those of nonacquired hospitals. Facilities that were acquired by private equity during the study period had higher charge-to-cost ratios in 2003 relative to nonacquired hospitals, and this differential widened in 2017. Hospitals with higher charge-to-cost ratios can induce higher payments from patients and insurers.

HOSPITALS continued on page 8
Walmart, Verizon push into the telehealth market

By Keith A. Reynolds
Associate Editor

Two corporate giants are pushing their way into the hot telehealth market.

Walmart Health announced in May it will acquire multispecialty telehealth provider MeMD as part of the company’s push to leverage data and technology to improve health engagement, equity and outcomes. Meanwhile, Verizon announced its own physician-focused telehealth venture in April, and it’s already available.

According to a Walmart news release, over the coming months the acquisition will allow Walmart Health to provide virtual urgent, behavioral and primary care nationwide, complementing the company’s in-person health centers. Walmart’s focus is on consumer engagement, improved health outcomes and equitable access to care seeking to lower overall health care costs across all populations.

“The pandemic has accelerated telehealth adoption and changed the conversation around what patient care will look like moving forward.”

Telehealth offers a great opportunity to expand access and reach consumers where they are and complements our brick-and-mortar Walmart Health locations. Today people expect omnichannel access to care and adding telehealth to our Walmart Health care strategies allows us to provide in-person and digital care across our multiple assets and solutions,” Cheryl Pegus, MD, executive vice president of health and wellness, says in the release. “Our Health & Wellness mission is to focus on the consumer’s seamless experience and improved health. We are excited to welcome MeMD employees to the Walmart family, and we are looking forward to together, accelerating health care access across the country.”

The acquisition is expected to close in the coming months pending regulatory approval, the release says.

The Verizon effort is physician focused. According to a news release, Verizon Business launched the new venture as a purpose-built solution for doctors to streamline telemedicine experiences as they seek to expand their telehealth practices after the COVID-19 pandemic.

BlueJeans Telehealth looks to connect physicians to their patients simply and securely.

“While the use of telemedicine has been steadily growing for some time now, the pandemic has accelerated telehealth adoption and changed the conversation around what patient care will look like moving forward,” Tami Erwin, CEO of Verizon Business, says in the release. “We worked closely with an advisory board of health system clinicians and health care decision-makers to build BlueJeans Telehealth specifically to address the most pressing needs for a virtual-first telehealth offering — from ease of experience to enhanced security.

BlueJeans Telehealth seeks to address technological literacy by presenting one-click, download-free access through a mobile device or desktop, and to increase visit efficiency by expediting information sharing through landing pages that include patient onboarding and education materials.”

HOSPITALS continued from page 7

Registered nursing staff ratios were comparable between acquired and nonacquired hospitals in 2003. While in both types of hospitals registered nursing staff ratios increased moderately, all-personnel staffing ratios decreased in acquired hospitals and increased in non-acquired ones.

Previous research demonstrated that private equity acquisition was associated with moderate increases in income and charge-to-cost ratios, and these findings suggest how investors may affect operational decisions. The Health Affairs analysis of detailed financial measures suggests that private equity investors acquired larger hospitals with healthier operating margins. Post-acquisition, these hospitals appeared to continue to boost profits by restraining growth in cost per patient, in part by limiting staffing growth.

Despite the massive shocks to credit markets worldwide in 2008, private equity-backed deals in health care have continued to rise and amounted to $79 billion in 2019, or 18% of private equity deals worldwide, even excluding add-ons.

3 largest private equity hospital deals, 2003-2017

No. 1: Bain Capital’s $33 billion buyout of 162 hospitals from HCA for $33 billion, 2006-07

No. 2: GTCR LLC’s $4.6 billion buyout of 19 hospitals from HCA in 2005, 2007 and 2015


Source: Health Affairs
Asset protection for physician crypto currency investors

by Ike Devji, JD

Crypto currency is all the rage. It continues to make some physician coin investors small fortunes even as prices swing widely. These are some basic measures to keep your digital wallet safe.

Fact vs. fiction
One common bundle of myths about cryptocurrency is, “My coin is creditor proof because it’s secret and no one can find it and only I have the key.” Here’s why that’s false and why you shouldn’t hold crypto in your own name:

- Any strategy that relies on “secrecy” also relies on your willingness to commit “perjury” and lie about the existence or value of your holdings in a debtor’s exam, deposition, or similar sworn testimony.
- Any U.S. court that has jurisdiction over you and your assets can order you to tender the assets to satisfy a judgment, this includes access to your crypto wallet.
- Your crypto assets are discoverable through a variety of methods including your tax returns, where you have a legal duty to report crypto profits to the IRS.
- Failure to report crypto gains is criminal tax evasion and that includes holdings you may be holding through an offshore trust, LLC or similar device.

How do you hold title?
Crypto assets held in your own name are subject to all your personal and professional liabilities, just like all your other liquid assets. As such, holding your coin through a properly structured legal entity that is legally distinct from your unrelated risks is best practice. Some commonly used holding structures include LLCs, limited partnerships, and irrevocable trust structures. Long term investors can also consider making their crypto holdings an exempt asset by investing in them through qualified, and legally protected retirement plans including self-directed IRAs.

Crypto & your estate plan
Your estate plan should include your valuable digital assets including your crypto holdings. At a minimum, it should allow the trustee of your estate to identify, take control of, and manage those assets. Some of the basics of your crypto estate plan should include are:

- Access to your key/passwords. If you die without providing access, it dies with you.
- What coin you bought, when you bought it, and the price.
- How you are holding it, (i.e., in your own name, in an LLC, etc.)

Physical & digital security
You may have seen horror stories about wallets ranging from thousands to millions of dollars in value being lost when a password is lost or physical device is lost, stolen or destroyed. If you are using a physical device, it should be stored in a water and fire-resistant document safe to protect it from basic, recurring risks like flood, fire, hurricane or burglary.

Make sure you understand the security differences in the basic ways you can hold coin. Bitcoin itself advises that you maintain two separate wallets, one with limited funds for trading and daily access and a secure, physical, offline wallet that’s stored in a safe and holds the bulk of your coin. The digital nature of purely online wallets means they are always vulnerable to online hacking and malware, so spreading your risk between several holding methods, including keeping the bulk of your holdings offline on a hardware device, is highly recommended.

Ike Devji, JD, has practiced law exclusively in the areas of asset protection, risk management and wealth preservation for the last 16 years. Send your legal questions to medec@mjhlifesciences.com.
5 winning financial strategies for medical practices

What’s the difference between a highly successful practice and one that just gets by? Often times, it comes down to focusing on a handful of key financial details. Physicians who institute best practices bring in more revenue and profit than those who do not, and this can be the difference between being successful and being out of business.

According to the Medical Economics® 2021 Physician Report, only 11% of practice owners said they did better in 2020 than in 2019, while 46% said they were doing worse. The top reason listed was lost revenue and increased expenses due to COVID-19.

With patient volumes still below normal because of the pandemic, growing competition from urgent care centers and retail clinics and rising operating costs, experts say every dollar counts. Here are the five best financial strategies to boost a practice’s bottom line.

Benchmark performance

Practice leaders who want to succeed must track key performance indicators so they can identify opportunities for improvement, says Andrew Hajde, assistant director, association content, Medical Group Management Association. These indicators include physician productivity, accounts receivable, insurance claims, reimbursement, and denials. Other measurable might include compensation to staffing ratios, expense management, performance to budget, and patient satisfaction.

With that data, Hajde says practices can not only track their own performance over time, but also benchmark themselves against data from similar providers. (National data is available from MGMA and other sources.) “It gives them a bar to see if they’re doing well or if they have some opportunities for improvement in any of those areas,” Hajde says.

Practices need to take action to find the formula for success. “What are the other practices actually doing to get that patient engagement and quality rating and everything else?” asks Hajde. “I think that’s where it is critical to work with your peers across the country that are achieving those best practices via conferences, member communities with associations, and in researching, reading articles, podcasts or any way you can get in front of how people are achieving those things to bring to your practice.”

Naresh Rao, D.O., FAOASM, a private practice physician who is also the founder and CEO of MAX Sports Health Inc., says he and his private practice partners get a lot of useful information from talking to peers at conferences. He seeks out those who are also in private practice so they can compare strategies for tackling different challenges.

Analyze denials and accounts receivable

The most successful practices analyze their claims denials and take action to reduce them. “It’s really important to go and look at what denials are actually coming through from which payers, whether it is commercial payers or Medicare or Medicaid, and then look to see why they are happening,” says Hajde.
Likewise, look at your accounts receivable and analyze those that fall into different aging groups, such as 30 days and 60 days old and determine the cause. “Is it because you are not getting paid in a timely manner, or that a lot of claims are being denied?” asks Hajde. “Determine the causation and, going back through those based on high volume or high dollar amounts, go back to your physicians or front-office employees. Make sure they are entering the information correctly so that if you get it straight on the front end, you’re going to reduce those denials.”

In addition, practices need to make sure all claims are filed in a timely manner, and that all denials that are deemed inappropriate are appealed within the established deadlines from those payers.

“Sometimes you only have 30 or 60 days, so make sure you are on top of that,” says Hajde. “Prevention of denials is key to being a high-performing practice.”

Rao says the billing department is the most important aspect of the business. “If you did a service, and you don’t get paid for it, your payment for your time is zero,” says Rao. “You need the ability to be savvy when it comes to charging what’s appropriate, but also to know that insurance companies may put up roadblocks, so you need to have a really, really good billing system to deal with that.”

**TOP TIPS**

- Benchmark performance
- Analyze denials and accounts receivable
- Understand payer contracts and patient demands
- Communicate expectations
- Create a positive culture

Another aspect to understand is what the reimbursement rates are for physician extenders and how they might be able to help—or hinder—the overall profit of a practice, says Ross Nelson, MD, health care strategy leader for consulting firm KPMG. Having all providers work at the top of their license is the best formula, but reimbursement has to be taken into account to determine who should provide each service.

Practices also need to understand the services patients want. “You should make sure that you have the whole complement of services to the best extent that you are able to offer so you can best serve them and not lose them if they have to go somewhere else for those services,” says Nelson. “Practices should have a good sense either anecdotally or qualitatively of what services are required by their patients and whether those are being outsourced or not. They need to figure out if there is sufficient demand, the level of competition and whether they have a right in their patient’s mind to deliver that service.”

**Communicate expectations**

Patient communication ties directly to a practice’s finances. Patients need to know what they’re going to be responsible for when they first come into the office, says Hajde. They should be informed what part of the payment they will be responsible for and if they can’t pay, how payments will be handled.

“Patients want to know what they owe, as soon as possible,” says Rick Gundling, FHFA, senior vice president professional practice, HealthCare Financial Management Association. “Also, make sure that you’re able to talk through any payment plans or all other alternatives so that if a patient can’t pay, then they know what’s available.”

All payment policies and procedures need to be clearly communicated to staff as well. “Establishing with your staff how to work with patients is a great recipe for having good outcomes for collecting from patients and for people knowing exactly what they are going to be into upfront,” says Hajde. He recommends training staffers so they align with the best practices in the hospitality industry where service is paramount. The more communication a practice has, the more cooperation it will get from patients because they understand in advance what is going to happen and feel like they are getting exceptional service.

Gundling says to survey patients on how they wish to be contacted: text, phone, portal or app. Different patient populations have different
expectations, but knowing their preferred communication type can help with billing- and care-related messages. Gundling says an online payment portal is vital because patients expect the convenience and it can speed up payment.

Remember that communication goes both ways. Post-pandemic, patients may have new expectations for practices. “The whole flow of patients’ needs to be looked at because people do not want to be sitting around in waiting rooms anymore,” says Gundling. “You could reconfigure your space, and you may not need a large waiting room, or you may need less leased space, which could save money. The other thing to look at is how are you going to use telehealth going forward as part of your practice and how do you coordinate that into your care process?”

If new services are being added, or a practice needs to boost visits, communicate with the existing patient panel first, says Rao. “We already have their information, they’re already signed everything, so we just push out the ‘Hey, you are due for your physical’ notices. If you take care of a lot of diabetics, you may be able to point them to a webinar on diabetes, for example. Marketing to your existing patients is more powerful because they already know you.”

Create a positive culture

Management consultant Peter Drucker once said that culture eats strategy for breakfast. A practice can have the best strategy, but if the culture doesn’t align, retaining key employees will be difficult.

“You really need to demonstrate and have a high-quality mission, vision and values statement for your organization and commit to customer service training to really create a high morale and great patient experience,” says Hajde. “Patients really pick up on it and anyone who’s been in a medical practice or other health care facility, they can just tell when employees are dissatisfied, and it doesn’t lead to a great experience. It won’t make patients want to tell their friends and family to go to this practice or organization.”

When a practice starts tracking productivity and patient satisfaction levels, it might reveal some harsh truths about the existing staff. Some employees — including those who may have been with the practice for many years — may not be contributing as much as they should.

“Maybe the physicians were just looking the other way when the person was reading a book in the afternoon or whatever was happening, where they maybe weren’t doing what they should have been or could have been doing,” says Hajde. “I think it’s really important to kind of set expectations that apply to absolutely everyone, and that ties back into having that culture.”

Everyone should know the goals of the organization and the practice should work with them to make sure they are equipped to meet those expectations. Sometimes, people fail because they don’t understand how to do their job as well as they should, so it can truly be a training issue.

“In some cases, a process has been made so complex that they can’t possibly do it right,” says Hajde. “For example, if you look at the number of steps to check in a patient, there might be 75 steps. People are going to make a lot of mistakes. If you can apply some lean principles and get 75 down to 10, all of a sudden, the person making errors every single day can do those 10 things correctly. Sometimes the process is broken, not necessarily the individual.”

Employees become disengaged when they don’t really understand what their goals are, and they don’t understand how they are contributing to the success or the organization. Disengagement can also occur when there is a poor relationship with the supervisor.

Hajde says by making sure both employees and supervisors are properly trained, and everyone understands how they contribute to the organization, a positive culture can take root, boosting patient satisfaction and profits. “If you do those two things in parallel, it can really create a great culture for a practice,” he says.

Rao notes that employee retention is the biggest benefit of putting effort into creating a great culture. “The most costly thing you can do is to take a high performer and not have them feel valued,” he says.

Take action now

Even the best practices aren’t necessarily doing all of these things exceptionally well, so there’s always room for improvement. Focus on the areas with the biggest financial return first, such as productivity, accounts receivable or expenses, and benchmark those areas and track the budget for them. Once the habits of tracking and analyzing data on regular basis happen, it becomes part of the daily routine. Hajde says a practice of any size can accomplish this and it doesn’t necessarily require consultants or outside help.

For struggling practices, start by focusing on one or two items. “Benchmark those key performance indicators—that’s where you really want to begin,” he says.

Rao says successful practice leaders dedicate time to paying attention to the numbers. “You have to make sure you have a good pulse on what the finances are, because sooner or later, a crisis will come up, and that’s when you’ll realize you are in big trouble.”
Is your patient experience on the rocks? These practices might be to blame.

Think about going to the doctor for your annual checkup, and he or she pulls out files for a different patient, references medications you’re not taking and starts discussing tests you’ve never had. A mix-up like that would hurt your confidence in your physician and prompt you to find a new one.

Like the clinical experience, it takes just one problem or inconvenience to affect the patient financial experience. Frustrated patients often feel that any issue is their provider’s fault — even if it’s not. From a patient’s perspective, every part of the health care experience, from payments to scheduling to billing, is run by the provider. The behind-the-scenes reality of external partners and third-party technology stays behind the scenes, and patients base their experience on what they can see.

Further complicating things is the fact that outdated routines and procedures can hinder efforts to streamline the patient experience, resulting in more frustrations, lower quality of care and potentially a loss of patient loyalty. Because of this, cultivating the patient experience is a commitment. Health care providers have to ensure the process is as seamless, accurate and pleasant as possible — as consistently as possible.

**Problem: Relying on separate back-office systems**

Many health care providers still use separate systems for most components of the patient experience. Unfortunately, those technology systems don't always “talk” to each other. If there’s a glitch in one, it can cause undetected problems throughout the operation. Patients tend to see all of these separate components as one overall experience, so using a single integrated system will help create a seamless solution for both patients and providers.

Providers that prefer not to completely centralize their systems should take the time to research systems and providers that sync up well with native integrations and built-in data-transferring capabilities. This can help them mitigate the risk of technological mix-ups that could detract from the patient experience.

It takes time to garner customer loyalty, and it can all vanish based on one bad patient experience. Conversely, an excellent experience can reengage patients and increase their overall satisfaction levels. For this reason, it’s vital to carefully vet any third-party platforms you might use.

**Problem: Replacing human interaction**

In general, the impact of technology in health care has been positive. With automation, machine learning and cutting-edge technologies, many providers have made tremendous advancements in the level of service they’re able to provide patients. But that dependence on technology can also cause providers to rely too heavily on machines at the expense of human connection.

A successful patient interaction must have a healthy balance of both. Take advantage of automation, but make sure patients can also communicate with a member of the patient bill care team when they need help.

**Problem: Convoluted pricing**

As health care bills become increasingly difficult to understand, patients progressively demand price transparency. More patients are using high-deductible health plans, which means they’re the payers, rather than their insurance companies.

Because they are now responsible for payment, patients need to know before their appointments how much services will cost. This enables them to be better informed when making important decisions. Price transparency creates trust, and we all know trust creates a great experience and increased patient loyalty in health care.

**Cultivation is key**

While negative experiences can drive patients away, positive experiences can engage lifelong patients who refer their friends, family members and neighbors. For health care providers, that means communicating with patients even when they’re not in the office for an issue or checkup.

According to SDL, it takes up to two years to build customer loyalty — that’s two years of positive, strong experiences. You have to find ways to proactively provide best-in-class experiences that keep patients coming back.

Start by identifying outdated routines and procedures that could be detracting from the patient experience. Here are common problems that can be proactively addressed.

T. Scott Law Sr., CPA, is the founder and CEO of Zotec Partners. Send your business questions to medec@mjlifesciences.com.
CAREERS

THE 92ND

PHYSICIAN

REPORT

by Medical Economics® Staff

Medical Economics® is proud to present the 92nd Physician Report. Our in-depth survey presents exclusive data collected from our physician audience on salaries, productivity, malpractice rates, the state of the profession, and much more. The survey was conducted by HRA®, a full-service health care market research agency and a brand of MJH Life Sciences™. Data were collected from physicians who responded to email invitations during the first quarter of 2021.

What’s inside

16 Salary
17 COVID-19 impact
18 Malpractice rates
19 Student debt
19 Productivity
20 Secondary income
20 Medical lifestyle
21 Prior authorizations
21 Ancillary services
22 Who took the survey
Financial state of progress (compared to one year ago)

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Better than a year ago</td>
<td>22%</td>
<td>21%</td>
<td>21%</td>
<td>22%</td>
<td>23%</td>
<td>11%</td>
</tr>
<tr>
<td>About the same</td>
<td>46%</td>
<td>46%</td>
<td>48%</td>
<td>52%</td>
<td>55%</td>
<td>43%</td>
</tr>
<tr>
<td>Worse than a year ago</td>
<td>30%</td>
<td>32%</td>
<td>30%</td>
<td>26%</td>
<td>22%</td>
<td>46%</td>
</tr>
<tr>
<td>No answer</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Why finances improved or worsened in 2020:

**Top reasons for improvement**
1. Seeing more patients
2. Increased revenue from telehealth
3. Change in practice model
4. Renegotiated payer contracts
5. Addition of ancillary services

**Top reasons things got worse**
1. Lost revenue/increased expenses due to COVID-19
2. More time spent on uncompensated tasks
3. Lower reimbursement
4. Higher overhead
5. Greater technology costs

The top 8 issues facing physicians in 2020:

1. Burden of paperwork/quality metrics
2. Inadequate reimbursement
3. Third-party interference (e.g., prior authorizations)
4. EHRs don’t work as well as they need to
5. Growth and competition from convenient care/retail clinics
6. Malpractice/need for tort reform
7. Recruiting young physicians
8. Patients getting health information online
9. Of practices said COVID-19 was the reason their practice finances worsened in 2020.
CAREERS / 92ND PHYSICIAN REPORT

Salary

Average income by primary care specialty
Average pretax income comparison for both employed physicians and practice owners
2020 physician average pre-tax income = $270,500

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal medicine</td>
<td>$212,000</td>
<td>$230,000</td>
<td>$262,000</td>
<td>$243,000</td>
<td>$234,000</td>
<td>-$9,000</td>
</tr>
<tr>
<td>Family medicine</td>
<td>$187,000</td>
<td>$205,000</td>
<td>$242,000</td>
<td>$241,000</td>
<td>$232,000</td>
<td>-$9,000</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>$187,000</td>
<td>$205,000</td>
<td>$233,000</td>
<td>$231,000</td>
<td>196,000</td>
<td>-$35,000</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>$237,000</td>
<td>$271,000</td>
<td>$288,000</td>
<td>$298,000</td>
<td>$285,000</td>
<td>-$14,000</td>
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</tbody>
</table>

Average income by gender

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>$266,000</td>
<td>$270,000</td>
<td>$268,000</td>
<td>$306,000</td>
<td>$300,000</td>
<td>$292,000</td>
</tr>
<tr>
<td>Women</td>
<td>$191,000</td>
<td>$204,000</td>
<td>$207,000</td>
<td>$232,000</td>
<td>$226,000</td>
<td>$222,000</td>
</tr>
<tr>
<td>Difference</td>
<td>$75,000</td>
<td>$66,000</td>
<td>$61,000</td>
<td>$74,000</td>
<td>$74,000</td>
<td>$70,000</td>
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</table>

Average income by region

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>$228,000</td>
<td>$262,000</td>
<td>$245,000</td>
<td>$280,000</td>
<td>$263,000</td>
<td>$254,000</td>
</tr>
<tr>
<td>Midwest</td>
<td>$238,000</td>
<td>$239,000</td>
<td>$249,000</td>
<td>$278,000</td>
<td>$280,000</td>
<td>$278,000</td>
</tr>
<tr>
<td>South</td>
<td>$252,000</td>
<td>$256,000</td>
<td>$245,000</td>
<td>$285,000</td>
<td>$280,000</td>
<td>$267,000</td>
</tr>
<tr>
<td>West</td>
<td>$237,000</td>
<td>$237,000</td>
<td>$252,000</td>
<td>$284,000</td>
<td>$269,000</td>
<td>$290,000</td>
</tr>
</tbody>
</table>

Average income by community

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inner city</td>
<td>$232,000</td>
<td>$231,000</td>
<td>$247,000</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Urban</td>
<td>$236,000</td>
<td>$254,000</td>
<td>$253,000</td>
<td>$283,000</td>
<td>$260,000</td>
<td>$276,000</td>
</tr>
<tr>
<td>Suburban</td>
<td>$248,000</td>
<td>$257,000</td>
<td>$249,000</td>
<td>$285,000</td>
<td>$280,000</td>
<td>$268,000</td>
</tr>
<tr>
<td>Rural</td>
<td>$232,000</td>
<td>$230,000</td>
<td>$230,000</td>
<td>$274,000</td>
<td>$281,000</td>
<td>$265,000</td>
</tr>
</tbody>
</table>

*In 2018, the survey was amended and inner city was removed as a choice.

Average income by practice ownership

<table>
<thead>
<tr>
<th>Ownership</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owner</td>
<td>$252,000</td>
<td>$315,000</td>
<td>$289,000</td>
<td>$276,000</td>
</tr>
<tr>
<td>Non-owner</td>
<td>$241,000</td>
<td>$248,000</td>
<td>$258,000</td>
<td>$265,000</td>
</tr>
</tbody>
</table>
Average income by practice type/employer

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private practice</td>
<td>$301,000</td>
<td>$282,000</td>
<td>$268,000</td>
</tr>
<tr>
<td>Hospital-owned practice</td>
<td>$288,000</td>
<td>$290,000</td>
<td>$297,000</td>
</tr>
<tr>
<td>In-patient hospital</td>
<td>$278,000</td>
<td>$276,000</td>
<td>$274,000</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>$228,000</td>
<td>$248,000</td>
<td>$254,000</td>
</tr>
<tr>
<td>Government</td>
<td>$206,000</td>
<td>$214,000</td>
<td>$224,000</td>
</tr>
</tbody>
</table>

COVID-19 Impact

How has the COVID-19 pandemic affected your practice financially?

- 72% Our revenues decreased
- 20% No significant financial impact
- 7% Our revenues increased

Did your practice receive any funds from a federal relief program (CARES Act, Paycheck Protection Program, etc.)?

- Yes
- No changes to telehealth use
- Yes, we increased our use of telehealth
- Yes, we used telehealth for the first time

Did your practice begin or increase its use of virtual visits (telehealth) because of the pandemic?

- Yes
- No changes to telehealth use
- Yes, we increased our use of telehealth
- Yes, we used telehealth for the first time

Medical Economics.com
Malpractice rates

Change in malpractice premiums for 2020, compared with 2019

<table>
<thead>
<tr>
<th></th>
<th>2020</th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median annual premiums for primary care physicians, 2020</td>
<td>$283,000</td>
<td>$277,000</td>
<td>$283,000</td>
</tr>
<tr>
<td>Family medicine</td>
<td>$11,000</td>
<td>$11,000</td>
<td>$11,000</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>$10,300</td>
<td>$10,300</td>
<td>$10,300</td>
</tr>
</tbody>
</table>

Median annual premiums by gender, 2020

<table>
<thead>
<tr>
<th></th>
<th>2020</th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>$11,000</td>
<td>$11,000</td>
<td>$11,000</td>
</tr>
<tr>
<td>Women</td>
<td>$8,300</td>
<td>$8,300</td>
<td>$8,300</td>
</tr>
</tbody>
</table>

Median annual premiums by geographic region, 2020

<table>
<thead>
<tr>
<th>Region</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>$12,400</td>
</tr>
<tr>
<td>South</td>
<td>$9,000</td>
</tr>
<tr>
<td>Midwest</td>
<td>$11,400</td>
</tr>
<tr>
<td>West</td>
<td>$10,200</td>
</tr>
</tbody>
</table>

Median annual premiums by years in practice, 2020

<table>
<thead>
<tr>
<th>Years in Practice</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 or less</td>
<td>$11,600</td>
</tr>
<tr>
<td>11-20</td>
<td>$11,300</td>
</tr>
<tr>
<td>21-30</td>
<td>$11,700</td>
</tr>
<tr>
<td>31-40</td>
<td>$10,000</td>
</tr>
<tr>
<td>41 or more</td>
<td>$8,700</td>
</tr>
</tbody>
</table>

Median annual premiums by practice ownership, 2020

<table>
<thead>
<tr>
<th>Ownership</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice owners</td>
<td>$10,500</td>
</tr>
<tr>
<td>Non-owners</td>
<td>$10,300</td>
</tr>
</tbody>
</table>
Productivity

Average number of hours worked per week, by specialty

Average number of hours for all physicians = 49

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Family medicine</td>
<td>51</td>
<td>52</td>
<td>52</td>
<td>52</td>
<td>48</td>
<td>50</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>53</td>
<td>54</td>
<td>54</td>
<td>53</td>
<td>51</td>
<td>52</td>
</tr>
</tbody>
</table>

Average number of hours worked per week in 2020, by gender

- Men: 49
- Women: 48

Average number of hours worked per week in 2020, by practice ownership

- Practice owners: 50
- Non-owners: 48

Average number of hours worked per week in 2020, by years in practice

- 0 to 10 years: 48
- 10-20: 51
- 21-30: 51
- 31-40: 47
- 41 and more years: 45

Student debt Average amount of medical school debt, by physician years in practice, in 2020

- 0 to 10 years: $163,000
- 11 to 20 years: $106,000
- 21 to 30 years: $116,000
- 31 to 40 years: $50,000
- 41 years and more: $0
Secondary income

Did you earn income from an employment source outside of your practice?

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>33%</td>
<td>30%</td>
<td>32%</td>
<td>30%</td>
<td>33%</td>
</tr>
<tr>
<td>No</td>
<td>66%</td>
<td>69%</td>
<td>68%</td>
<td>70%</td>
<td>67%</td>
</tr>
<tr>
<td>No answer</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Top 10 sources of secondary income in 2020

1. Consulting
2. Non-medical work
3. Expert witness
4. Clinic work
5. Medical administrator
6. Speaking
7. Clinical trials/research
8. Emergency department/urgent care
9. Hospital (not ED)
10. Hospice

*Arrow indicates change from 2019

Medical lifestyle

Q: If you could go back in time and choose your career again, you would choose:

<table>
<thead>
<tr>
<th>Choice</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>The same specialty</td>
<td>59%</td>
</tr>
<tr>
<td>A different specialty</td>
<td>21%</td>
</tr>
<tr>
<td>A different career altogether</td>
<td>16%</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>4%</td>
</tr>
</tbody>
</table>
Ancillary services

Most popular ancillary services in internal medicine/family medicine in 2020

1. Lab services
2. ECG
3. Radiology/imaging services
4. Spirometry
5. Nutritional counseling/weight loss
6. Pharmacy services
7. Pain management
8. Holter monitoring
9. Implantable contraceptives
10. Cosmetic/aesthetic services

*Arrow indicates change from 2019

Prior authorizations

Time spent weekly on prior authorizations in 2020

<table>
<thead>
<tr>
<th>Time spent weekly</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 20 hours</td>
<td>15%</td>
</tr>
<tr>
<td>16 to 20 hours</td>
<td>10%</td>
</tr>
<tr>
<td>10 to 15 hours</td>
<td>23%</td>
</tr>
<tr>
<td>1 to 9 hours</td>
<td>43%</td>
</tr>
<tr>
<td>0 hours</td>
<td>9%</td>
</tr>
</tbody>
</table>

Percentage of revenue for primary care from ancillary services in 2020 (average)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal medicine</td>
<td>11%</td>
</tr>
<tr>
<td>Family medicine</td>
<td>11%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>8%</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>13%</td>
</tr>
</tbody>
</table>

Q: Would you recommend that your child or a friend’s child pursue a career in medicine?

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>45%</td>
</tr>
<tr>
<td>No</td>
<td>30%</td>
</tr>
<tr>
<td>Not sure</td>
<td>23%</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>1%</td>
</tr>
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</table>
### Who took the survey

#### Primary field of practice

<table>
<thead>
<tr>
<th>Field</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Family medicine</td>
<td>19%</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>13%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>12%</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>10%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>7%</td>
</tr>
<tr>
<td>Urology</td>
<td>4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>4%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>3%</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>3%</td>
</tr>
<tr>
<td>Oncology</td>
<td>3%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>2%</td>
</tr>
<tr>
<td>Surgical specialty</td>
<td>2%</td>
</tr>
<tr>
<td>Other specialties</td>
<td>9%</td>
</tr>
</tbody>
</table>

#### Years in practice

<table>
<thead>
<tr>
<th>Years</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 5 years</td>
<td>1%</td>
</tr>
<tr>
<td>6-10</td>
<td>4%</td>
</tr>
<tr>
<td>11-20</td>
<td>19%</td>
</tr>
<tr>
<td>21-30</td>
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<tr>
<td>More than 40</td>
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#### Practice ownership

**Do you have an ownership interest in your practice?**

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<th>Percentage</th>
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#### Practice type

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<tr>
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<td>Hospital</td>
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<tr>
<td>Government</td>
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<tr>
<td>Urgent care</td>
<td>1%</td>
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<tr>
<td>Other</td>
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#### Practice size

<table>
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<tr>
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<tr>
<td>3-10 physicians</td>
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<td>11%</td>
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<tr>
<td>26-50 physicians</td>
<td>5%</td>
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<tr>
<td>More than 50 physicians</td>
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#### Physician's age

<table>
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<td>35-44</td>
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<td>55-64</td>
<td>35%</td>
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<tr>
<td>65 and older</td>
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#### Physician's gender

<table>
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<td>68%</td>
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<tr>
<td>Female</td>
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How to find the right revenue cycle partner

by Jordan Rosenfeld  Contributing Author

Physicians enter into health care because they want to help care for patients, not to become business people. This can make revenue cycle management (RCM) seem like an overwhelming or complex set of steps, yet, at its essence, “it is basically about obtaining payment for services rendered to a patient,” says Kelly Dingwell, principal attorney and CEO of Dingwell Law in Long Beach, California. Her firm specializes in representing health care providers. “There are a number of pieces to the puzzle that go into how you get from a patient contacting your office to collecting reimbursement for the services you provide, but that cycle is pretty similar, regardless of provider type,” she says.

Sometimes physicians have problems with the revenue cycle because “most physicians receive little to no business training,” says Monte Sandler, CPA, executive vice president of revenue cycle management at Experity, an electronic medical record practice management and RCM solution in urgent care, based in Rockford, Illinois. “Their time is better spent seeing patients than something that is not their core competency.”

Dingwell says many physicians can feel overwhelmed at how to improve their RCM and find a new or right partner to help them achieve their goals. “I think it’s important for physicians to know what their strengths are and what their knowledge gaps are,” she says.

When physicians should seek a new RCM partner

With the exception of brand new practices, most physicians, whether individual or group practices, likely already have a revenue cycle process, if not a partner, and may be doing everything in-house. So when should physicians seek a new partner? Sandler says it’s often a “trigger event” that leads physicians to seek to improve their RCM in one way or another. The COVID-19 pandemic is one such example, as many physician practices have taken a hit in cash flow and had to change how they practice. It might also be driven by swiftly changing payer rules, issues with contracting and credentialing and other tasks that impact cash flow. These are the moments when a physician might want to change things up.

Additionally, Sandler points out that physicians may be leaving money on the table by not optimizing their coding and billing. “Exceptions, meaning errors, come in the form of rejections and denials,” she says. “And those tend to range in the 10 to 15% range. That doesn’t even account for just claims that insurance companies don’t pay for whatever reason. So if a practice is failing at rejections, denials and accounts receivable management, they could be leaving 20% to 30% on the table.”

Improving revenue cycle starts with the physician having some sort of vision for their practice into the future, says Heather Richards, senior vice president of value-based initiatives for Texas-based MPowerHealth, which helps physicians improve quality, efficiency and outcomes.

“What is the goal of the practice? Is the practice looking at growth opportunities? That is the optimal time to (review the revenue cycle),” Richards says. “An optimal revenue cycle partner is going to have a road map in mind to continuous improvement.”

Rather than trying to overhaul the entire revenue cycle process at once, Dingwell encourages...
physicians to think step by step, starting at the beginning. “You can’t really move on to the next step in the cycle before you complete the step you’re on. If you do move on prematurely, that’s where challenges in your revenue cycle arise.”

The first step, Dingwell says, starts at the point of patient registration, in verification of eligibility, authorization and method of payment.

Sandler says this is an area where many physician groups struggle to get correct information. “Front desk people are the lowest-paid people in the organization with the highest turnover, yet they arguably have one of the most important jobs in the cycle. If you don’t get the right insurance information, anything an RCM company does is for naught.”

A strong RCM partner, he says, can teach a practice how to solve registration problems before they happen.

**In-house or outsourced**

Most experts agree that outsourcing the biggest pieces of the revenue cycle such as coding, billing and credentialing makes the most sense, though early in a physician practice, costs to outsource may be prohibitive.

“By working with RCM organizations, providers get access to a lot of resources they otherwise wouldn’t have, or would have to pay a lot for,” Sandler explains.

Many RCM partners offer CPAs, contracting credentialing specialists, certified coders, compliance specialists and other legal resources within one organization.

Outsourcing may be ideal when a practice is trying to scale and grow wealth, Richards says. “I would look at outsourcing as optimal when I have scalability concerns, when I have the opportunity to focus on patient care and leave what revenue cycle experts do best in their hands.”

**Considerations for your RCM Partner**

So how can physicians determine if they’ve found the right partner for them? Saiera Ahmed, MD, an internal medicine doctor and sleep specialist with Mediversity Health, a multispeciality practice in New Jersey, says physicians need to decide what type of RCM partner they want and offers some key considerations:

- **Certified coders/billers**: Ahmed emphasizes the importance of legitimate and certified professionals who are keeping up on the latest coding changes, which can make the difference between a successful claim and a rejected one.

- **Familiarity with your specialty**: A good RCM partner doesn’t just support physicians in general, but also understands your specialty in specifics, she says. Ahmed is a sleep specialist, for example, which comes with unique codes for treatment and specific equipment needs.

- **Familiarity with your EHR**: Your EHR is a key piece of the revenue cycle, and an RCM partner needs to be able to understand how to work with yours. Additionally, you want one who is up to speed on the most cutting-edge technology, as EHR programs adapt and change.

- **Reporting capabilities**: Reports enable physicians to see problems, such as denials or outstanding accounts receivable, Ahmed says. Strong reporting is important to improving the revenue cycle.

- **Billing frequency**: Billing has to be done every day without delays, she says. Accounts receivable that are older than 90 days reflect a problem.

- **Denials**: Lastly, Ahmed says, you want to know how they handle denials, whether you’ll be paying extra for them to correct and rebill for these or whether they leave that up to you.

Physicians should consider their RCM partner “an extension” of the practice, not so much a separate entity, according to Karen Schechter, MBA, director and assistant professor of health care administrative programs at Maryville University in St. Louis. “If that extension of you doesn’t have the same values, and you’re not comfortable with them, it will be hard to trust the relationship,” she says.

Even if you are outsourcing, she adds, the physician is responsible for any problems that arise, so working with an RCM partner should not be for the purpose of putting the subject out of mind.

Schechter also recommends choosing an RCM partner that is willing to have regular meetings, whether monthly or quarterly, but more often than once a year, and who is willing to answer questions as they arise. “You want a partner to be transparent, to disclose information. What kind of specialties do they work with, what size is their staff and how are they organized?”

Ahmed agrees that availability of an RCM partner is crucial. Her practice needed an RCM partner they could get a hold of at any time, not
just during the week. “I can call the owner of my vendor at 10 o’clock at night or on a Sunday evening and he’s going to get back to me. Because this is your livelihood and communication is super important.”

**What is the cost?**

If you’ve checked all the boxes and found a partner you feel good about working with, who can manage all the key pieces of your revenue cycle, the last piece of the puzzle is cost. How much can you expect to pay?

The two most common ways of paying, according to Ahmed and Sandler, are a flat monthly fee or a contingency plan where they charge a percentage of your receivables, typically between 5% and 7%.

For Ahmed’s practice, the flat rate makes the most sense. Sandler, on the other hand, thinks the contingency plan is a good option particularly when receivables vary. “(Cost is) variable based on volume,” he explains. That became an important point when COVID-19 hit, he says, because as receivables volumes went down dramatically, physicians’ payments to their RCM partners also went down. “They’re only paying for what we actually collect,” he says.

Richards also warns that being too focused on price can mean losing sight of key areas, primarily “expertise, gathering insights and the engagement the third party will have with the practice.” She finds that physicians don’t always understand the difference between a billing vendor and an RCM partner. “Managing the full-cycle journey for a patient from appointment to zero balance is really a data-driven collaborative engagement.” And that is worth paying for.

Sandler agrees that understanding the scope of the RCM partner’s service is key to determining if it is worth the cost. “Finding the right partner that you can trust and that is going to work with you to optimize your business, collections and cash flow is really paramount,” Sandler says.

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Protecting what’s yours:
Estate planning for physicians

Proper estate planning can keep a physician’s assets safe and private after death.

by Keith A. Reynolds Associate Editor

Physicians are used to having control, especially in matters of life and death, but with the COVID-19 pandemic causing more than 500,000 deaths in the U.S. in less than a year, the time has never been riper for physicians to consider what will happen when they die.

A proper estate plan can continue a physician’s sense of control beyond their death by protecting assets, providing privacy for the bereaved and ensuring the deceased’s wishes are honored.

Necessary steps
Julianne Andrews is principal at Atlanta Financial Associates, LLC, and she has helped physicians across the country handle their finances. She says she is often surprised at the number of new physicians she has interacted with who do not have wills.

“If you die intestate, which means you die without a will, you’re just...
making it very difficult for those left behind because they have to go to probate (court), they have to prove who they are and there's a whole process they have to go through,” she says. “The other problem that happens when you die intestate is that each state has its own laws about how assets are going to be distributed, which may or may not be what you had intended.”

According to Andrews, in her home state of Georgia, the law specifies that if a person dies intestate, their estate is divided equally among the spouse and the children with the proviso that the spouse receives no less than one-third of the total.

“Typically, people leave everything to their spouse,” she says. “So they want to make sure that they have legal documents in place. It doesn’t have to be complicated.”

**Where to start**

While there are online options that can help one draft estate planning documents on one’s own, most experts recommend contacting a professional.

Joseph Kampman, Esq., a partner at law firm Ziegler Metzger, says estate planning for doctors is not much different from estate planning for others who own businesses, though each case is unique. He says the goal of estate planning is to have the client’s assets pass to their beneficiaries in the most efficient, tax-effective and private way possible. To do this well, he recommends that doctors new to practicing assemble a team.

“My advice to a young doctor would be to line up a good attorney, a good accountant and a good financial planner and have that team work together to make sure everything is the way it needs to be,” he says. “There's interconnection; the financial planner has all the assets and if the attorney doesn't know how the assets are registered, or what the beneficiary designation is, that is problematic when it comes to preparing the documents.”

Greg Klucher, senior vice president and trust officer at Huntington National Bank, says younger physicians should approach estate planning separately from their financial planning, though the two should intersect at times.

“What you do at that point is just try and get some general concepts from the doctor and ask, how do you want the story to end? Did you want to be stinking rich? Do you want to be comfortable? Are you planning on having a big family?”

The answers to these questions can change the best course of action for estate planning.

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**The most important decision you must make when creating a living trust**

by David Robinson, CFP Contributing Author

When creating a living trust, many people designate an adult child as successor trustee—without first discussing it with that person.

As a result, many designated trustees are completely unaware that they’ll be assuming this role until the trust’s creator, their parent, become incapacitated or dies.

When spouses are designated trustees, they tend to be aware of this eventual role far in advance, as couples usually discuss such matters. But many parents are reluctant to discuss the inevitable with their adult children and vice-versa.

Thus, successor trustees often have no awareness of this role until they must assume it. And when the time comes, even if they’re willing, they may not be prepared or able to execute the duties required.

This scenario can lead to poor estate administration, declining estate values and conflicts among heirs that can lead to litigation, resentment and a boatload of stress for everyone involved.

But if successors are aware of this role and what it involves well in advance, these problems might be avoidable.

Selection and preparation of suitable successor trustees can be assured by acknowledging the parent’s mortality and discussing eventualities (Typically, adult children are designated when only one parent is alive). These discussions should center on the wishes of the parent creating the trust, the common interests of

» Continues on Page 28
Continued from Page 27

the beneficiary children, and the best ways to serve these interests fairly, transparently and efficiently.

Usually, the best context for such discussions is a family meeting where all considerations are aired and, ideally, family members agree on whom the successor trustee will be. Also, families should outline the specific duties of the trustee, the guiding principles for performing them and the preparation necessary, if any, to assume them. These items can then be included in trust documents by a qualified estate attorney, contingent on that professional’s advice.

Items for discussion at such meetings include:

**Trustee selection**

Does the candidate have the time, skills and experience to fulfill this role? Would serving as trustee be too inconvenient? (It might be if he or she lives in a different state.) Does the person have the expertise, based on his or her education and profession?

**Skills over seniority or gender**

Traditionally, many parents have reflexively appointed their eldest child, especially if that child is male. But neither the eldest nor any of their male children may be the best candidate. And for many parents, of course, confining candidates to male children of course reflects an outdated view of gender roles. In a society with an abundance of women lawyers and an increasing number of women in financial professions, many trustors might have obvious candidates in their daughters. Whoever is selected, the trustee must be willing and ready to assume the role, and ideally should have the endorsement and support of their siblings. This can go a long way toward preventing problems down the road.

**Specific duties**

These fall into two categories: duties during incapacitation of the trustee and those assumed after the trustee’s death. Though incapacitation is common, many families don’t seem to be aware of this likelihood. For trustees, incapacitation can mean long-term handing of the trustor’s day-to-day financial affairs, ensuring that accounts are kept up to date, property is managed, and bills are paid.

**Managing principles for investment accounts**

Without stipulations in trust documents, the trustee could have unlimited leeway in managing these accounts, so all family members should be on the same page about how this is to be handled. For example, it’s in all beneficiaries’ interest to avoid high-risk investments and to avoid unqualified, imprudent investment managers.

**Differences between financial advisers**

Trustees should know — or, if not, should become educated about — the difference between non-fiduciary advisers (such as brokers, who basically act as salesmen) and fiduciary advisors, who are legally bound to adhere to fiduciary standards requiring that they always put their clients’ interest ahead of their own.

**This is only appropriate and logical, as trustees and estate executors are themselves fiduciaries**

If the trustor has a relationship with qualified, professional fiduciary advisors, it’s a good idea for the trustee to meet them upon accepting the role so the relationship can be smoothly transferred. Not uncommonly, beneficiaries have had the disappointment of seeing their inheritances shrink after the trustee invested estate funds in high-risk assets that promptly went south. Placing some parameters on investments and advisors in trust documents, where legally feasible and advisable by qualified estate attorneys, can help preserve estate values and help avert disappointing investment outcomes.

Of course, family discussions on these topics can be difficult in dysfunctional families or those where longstanding distrust among siblings fosters fears of self-dealing by the trustee.

In such cases, siblings’ fears may be allayed by including specific guidelines for estate administration, during incapacitation and after death, in trust documents.

All too often, naming a successor trustee is treated as an afterthought when creating trusts, though it’s one of the most important decisions involved.

Discussing the duties in advance with the designated trustee — and getting the whole family involved — is the best way to avoid bequeathing problems to heirs.

David Robinson, a Certified Financial Planner, is founder/CEO of RTS Private Wealth Management, an SEC-registered firm in Phoenix that provides fiduciary services to help clients achieve their financial goals. His practice focuses on helping wealthy individuals with custom financial plans, using a holistic approach to grow/protect wealth, manage taxes, identify insurance solutions, prepare for retirement and manage estate plans.
When approaching an estate plan, Kampman says it is wise to take stock of what assets the physician has. Do they own their own practice? Are they employed by a hospital or physician group?

“Those are factors you have to look at because the valuations and that type of thing are obviously different,” he said.

**Powers of attorney**

Part of the estate planning process includes the creation of documents that govern who can make financial and medical decisions. A financial power of attorney designates an agent to handle financial matters.

“If it’s a husband-and-wife situation, it typically will name the spouse with a potential for naming an additional, alternate agent,” Kampman says.

Health care directives are essentially medical powers of attorney as they designate an agent to make health care decisions on one’s behalf. There is also the living will, which is a person’s declaration of what they want done medically if they’re ever in permanently unconscious state or have a terminal condition.

“It’s what I call the ‘pull the plug’ decision,” Kampman explained.

**Wills and trusts**

The core of the main estate planning documents is the last will and testament, which covers the disposition of the physician’s property upon death, names a guardian for the deceased’s children, names an executor for the estate and specifies how to dispose of any other assets that may fall under probate, according to Kampman.

He says it is advisable to avoid probate as it can lead to costly fees of 2 to 4% of the estate. This can be done in a few different ways, including establishing a trust. Any assets placed into a trust are made payable to that trust and thus avoid the probate process.

Trusts can also be used as a way to ensure that, if one dies with young children, the funds left to them in trust are held until the children are mature enough to manage the assets. There are also special kinds of trusts that protect assets from creditors, but those should be pursued only if the physician is exposed to a high level of liability, Kampman says.

According to Klucher, unless the physician has a high level of risk and a high dollar amount, the creation of asset protection trusts just isn’t worth the cost.

“The types of people that are using asset protection trusts are people that are in high-income professions that protect at least some of their money,” he said. “It’s really not a bank account, you can’t pull the money in and out, necessarily. You kind of have to be wealthy enough to want to put some of that money on the sidelines.”

When a physician starts out, federal estate taxes aren’t likely to be an issue with the current exemption set at $11.7 million, meaning that any estate below that point, or below $23.4 million for married couples, will pay no federal estate taxes. They can still be required to pay state estate taxes, but states including Ohio have abolished their own estate taxes, Kampman says.

**Keeping up with the times**

Andrews says it is important to review estate planning documents on a regular basis to ensure everything is up to date.

“So if you do have a change in life circumstances like divorce, death in the family, an inheritance, you want to go back and look at your documents and just make sure that they still are reflective of what you want to have happen,” she says. ■

“If you die intestate, which means you die without a will, you’re just making it very difficult for those left behind.”

—Julianne Andrews, principal, Atlanta Financial Associates
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Hiring a financial adviser after tax season

Tax season is finally over and hopefully the results of your 2020 return landed in your favor. But what should you do now? Sure, you've gotten last year out of the way, but what about your future? What about the long term? Now that you know your numbers, is it time to hire a financial adviser?

Getting your taxes done is great, and of course, if you were able to save money on them this year, that outcome is even better. But do you know if you are on track to retire when you expect? Do you have an estate plan in place? Would you bet your life on your investment strategy? If you answered no to any of the above, you should start looking for a financial adviser.

Here are three surefire signs you need to hire a financial adviser:

**You Don’t Have a Long-Term Plan in Place**
When it comes to your financial future, the decisions you make today will have a profound effect on the way you live your life tomorrow. Unfortunately, we have seen many physicians’ life plans thrown off course and retirement dates become unknown because of a lack of planning.

Simply being a high-income earner does not guarantee a successful retirement. In fact, being a high-income earner, in many ways, complicates the challenge. You are charged with accumulating more wealth in tax-efficient ways to maintain your lifestyle as you age during retirement. There are far too many medical professionals working well into their 60s and 70s who express regret about not hiring a financial adviser sooner.

**You’re Making Your Own Investment Decisions**
Physicians are rarely ever financial experts. They simply don’t have time to be, not to mention that an investor’s biggest threat to his financial success is generally himself. When it comes to money, emotions can get the best of an investor’s decision-making and cause premature, untimely and costly investment errors.

For 25 years, a financial services market research firm known as Dalbar has been performing a Quantitative Analysis of Investor Behavior (QAIB) that measures “the effects of investor decisions to buy, sell and switch into and out of mutual funds over short- and long-term time frames.” Time and again, this research indicates that solo investors underperform market averages as a result of their own emotion-driven money moves.

Fiduciary financial advisers don’t just guide you in the direction of your goals, they also support you when market conditions get scary. They know how to handle fluctuations in the market to protect your assets and provide you peace of mind until conditions improve.

**You’re Aren’t Working with a Specialist**
No one needs to remind you that the nature of your career presents unique financial challenges. You likely started earning income years later than your peers because of medical school. And if you’re like the millions of other physicians who financed their education, you began your career with a sizable amount of debt.

Many physicians are surprised to learn this, but these are challenges that not all advisers are familiar with and equipped to handle. Luckily there are advisers who specialize in helping physicians overcome these obstacles to save and build wealth for the future.

Let’s put it another way. Would you visit a cardiologist for gastrointestinal issues? Or a neurologist for a broken bone? When you work with a professional who specializes in working with physicians, you increase your overall probability of success.

As a physician, it’s best to work with professionals to understand the nuances and complexities of your chosen career and can strategize the best plan for your needs.

Julianne F. Andrews, MBA, C.F.P., A.I.F., is a principal and co-founder of Atlanta Financial Associates. She specializes in working with physicians and executives in the health care industry. Her passion for working with physicians comes from being a pediatrician’s spouse for more than three decades. Julie has been featured on Forbes’ list of America’s Top Women Wealth Advisors since 2017 as well as Forbes’ Best-in-State Wealth Advisors since 2018. Julie can be reached at jandrews@atlantafinancial.com.
Overlooked financial aspects of selling a practice

by Todd Shryock Managing Editor

Selling a successful practice and cashing in on a lifetime of hard work is what many practice owners envision. But there is far more to the transaction than just cashing the check and heading into a bountiful retirement. Taxes, regulations and just establishing a fair price can all complicate the transaction.

Medical Economics® spoke with Lori Robbins, JD, managing director, Washington National Tax; and Chris Ober, MBA, managing director, U.S. health care valuation, both with KPMG, an international accounting and advisory firm, about the challenges of selling a practice. The transcript has been edited for clarity and brevity.

ME: Why are there currently so many transactions for physician practices?

Lori Robbins: Physician practice sales are one of the biggest growth areas for health care transactions right now. We’re on pace to reach over 300 deals this year, up from over 200 last year. And this continuing increase in deal volume is likely attributable to a few different things. For example, the pandemic created some financial pressures on medical practices since many patients were deferring care last year. As a result, some practices are looking to attract some capital investment, especially in areas like telehealth. We’re seeing private equity buyers in the space of buying physician practices, and that can be for a variety of reasons ranging from expanding geographically to deepening their investments in specific medical specialties. And of course, you’ve got the hospital systems and the health plans that are continuing to buy physician practices looking to integrate that care into their health system and in some instances, preparing to diversify.

ME: How does the Stark Law influence the purchases of physician practices?

Chris Ober: Pretty significantly, actually. The Stark Law and anti-kickback statutes were put in place to prevent remuneration paid to physicians to refer patients to facilities within certain health systems, and that does not really consider what’s in the best interest for the patient in general. They essentially require that any payments to physicians from health systems or any other buyers need to be within the context of a fair market value premise. And without really getting into the precise, long-winded definition of fair market value, it really just suggests that what’s being paid for physician practice is in line with the current productivity and current operations of that business without paying additional incentives to the physician practice for additional patient referrals going forward. The way that it really influences physician practice acquisitions is it does set up a guardrail for what can be paid for that practice. For example, if a health system really is interested in an aspiring cardiology practice, they can’t just go and pay two or three times premium in order to secure that transaction because it needs to be within that fair market value. While there still may be competitive bidding for that practice, the range will be a little bit more minimized due to the fact that most of those health systems need to be within that framework of-value guardrail. Where it does come into play is a lot of times physicians feel like they ought to be paid significantly more than what that fair market value range is, so that it does throw a kind of a kink into the negotiation.

But the one thing I would add is, can a health system actually pay a significant premium? And that raises the question, is a fair market value actually required? It isn’t. But we’ve all seen some of the significant settlements and sanctions that have been applied to some health systems across the country historically for violation of those Stark and anti-kickback rules. So most of our clients do like to have a third-party...
fair market value analysis performed, just in case there are governing bodies that come in and want to scrutinize some of their contracts or their acquisitions or practices that they've acquired. If they don't have the support, that what they're paying is in line with fair market value, or if there’s any evidence that there are overpayments being deployed, then it leaves them kind of in a tough spot.

**ME: How is a practice’s value determined? And what sort of documentation is necessary to establish it?**

**Ober:** There are a few different ways that we generally look at physician practice acquisitions, and we’ll generally start with an income approach, with a discounted cash flow method. And then we’ll look at a market approach.

Basically, investors are interested in what the return on investment would be in terms of the cash flows being generated in the business going forward. And they’re also interested in what other third-party buyers have paid for similar assets, what multiples of earnings and other types of multiples they paid, which might inform them on their decision on what they might pay for this practice. The market approach really can consider two different things. You can look to the publicly traded market, so you can look to the stock exchange and find publicly traded, similar companies and extract pricing multiples for what folks are investing in those businesses. Or you can look to private transactions. We have several databases that have information around physician practice acquisitions, and what multiples were paid for those transactions, whether it’s controlled or minority. As you would imagine, we don’t look to the guideline public company method as often because there aren’t many physician practices that went public. But it’s too early to really extract any data from those trades.

So generally speaking, we don’t look to the guideline company method, because you could pull hospitals, you could pull payers, and yes, they’re in the health care space, but a physician practice is an entirely different animal. It’s not really a comparable metric. So we do look more to physician practice acquisitions to extract pricing multiples for those valuations from an income approach perspective for physician practices. A lot of times, we run into a situation where there isn’t a lot of profitability left in the practice at the end of the day after salaries are paid out. Oftentimes, it’s a challenge to run a discounted cash flow method if there isn’t profitability in the business because you end up getting a number that is not meaningful. To some extent, especially for the smaller practices,

“Physician practice sales are one of the biggest growth areas for health care transactions right now.”
that tends to be the case, and especially if there aren’t any ancillary services involved that might drive more cash flow. At the end of the day, if we’re unable to use that approach, then we’ll corroborate the market approach with basic cost approach, which is really going in and valuing the underlying assets of the business. We generally like to have two different value conclusions to corroborate together from a documentation standpoint. It’s not as cumbersome as some of the financial reporting valuation work that we do in the health care space for purchase price allocations and goodwill impairment. In this case, what our general counsel and other regulatory bodies are satisfied with is a detailed set of exhibits and work papers, and then really a summary report — could be 15 pages or so — that just documents the methodologies used in the assumptions.

**ME: For doctors running small practices, are there any special caveats they need to be aware of when it comes to valuation?**

**Ober:** We touched on it a little bit on that last question. It’s the smaller practice, like primary care practices and other nonspecialty-type physician groups. Generally, if you think about the way that those entities operate, you may have two to three physicians that are running one, maybe two locations. And they’re really just seeing patients, that’s what they love to do. They see patients, they bill the insurance, they collect, and then they pay their expenses, and then what’s left at the end of the day is generally their salaries. And so when you pull all of that out, that generally leaves little to no cash flow in the business. Because unless they’re planning on opening several locations where they have major capital investments, then they’re planning for some ancillaries — maybe that’s X-ray machines or diagnostic equipment. But for primary care physicians, for example, there really isn’t much investment need in it. But generally what’s left in the business they’re taking home as their salary, so when they are entering an acquisition opportunity, if they want to align with the health system or a private equity firm, they may have higher expectations of what their practice is worth, because maybe they created that practice, and have been running it for years and years, and very been very highly successful.

But when you take that discounted cash flow method out of the equation, and if there aren’t a lot of earnings in the business to apply a multiple to, then you’re really applying a multiple to a revenue number, which really is less meaningful in this industry. So you end up having to go to that alternative cost approach. You’re looking at the cost. You’re looking at the tangible and intangible assets within that practice. And now what you’re really talking about is desks, chairs, tables, computers, filing cabinets, whatever it may be. Then what tends to happen is the fair market value conclusion usually comes in a little bit under where the physician’s expectations were. And so there’s that initial sit-down with the health system and the physician practice where there’s not real alignment at first, and then the negotiation process gets them to somewhere within that reasonable fair market value range.

The other thing I might add is, when you’re a primary breadwinner — I keep using primary physician practice, but really any physician practice in general that’s just private and run by the physicians, can pay themselves whatever is left in the business. So if they’ve historically been paid above what fair market value ranges for physicians of similar productivity and similar collections and so forth, based on the benchmarking data, then they may expect that when they align with that health system. That may be adjusted because that needs to be within that fair market value boundary.

**ME: Are specialty practices valued differently from primary care practices?**

**Ober:** Not really. It really is the same methodologies that would apply for those types of practices, but you’re going to have several different expense structures. A primary care practice, you have your general operating expenses, your utilities, your salaries and wages, and those types of things. But when you get into oncology, maybe now you have drug costs. And it’s just really in the expense structure. I think in terms of billing the insurance, you’re billing under different codes and so the collections will be different based on what specialty you’re referring to, but you’re still looking at net collections in terms of what CPT (Current Procedural Technology) codes are being hit and what reimbursement rates are tied to those CPT codes and then getting to net collections. That operating expense structure will be a little bit different; you may see a lot more profitability in a radiology business or urology business than you would in maybe a primary care practice. But the methodologies still apply across all specialties.

**ME: Do the different payment models that practices use factor into the evaluation at all?**

**Ober:** What I would say is in the first place, we’ve been talking about the volume-to-value shift for years and years, and it’s a very...
ME: One aspect that’s often overlooked by the physician selling a practice are the tax implications. What will the selling physician face after the sale?

Robbins: Before I really get into the specifics of your question, I think it’s really important to note that doctors should always have their own tax adviser in these physician transaction deals because every deal is unique, and their interests may not be aligned with the buyer’s interests. The physician shouldn’t be relying on the buyer’s tax advisers to watch out for their own interest. But I think the answer to what kind of tax consequences physicians face really depends on a couple of factors. First of all, whether you’re talking about a stock or an asset sale. For example, in a stock sale, a selling position, really is going to recognize a gain or loss based on the difference between the price paid for his practice and his or her current basis in the stock or their equity in the practice, if you will.

And that’s usually subject to capital gains treatment and there can be some exceptions to that. But in an asset sale, we’re talking about recognizing a taxable gain or loss based on the difference between that purchase price that the buyer’s going to pay and the assets and liabilities that Chris was talking about valuing. So that can be both the hard assets and also there are intangible assets like goodwill, which can be a significant asset for physician practice. But I also want to say that the physicians really need to remember that tax consequences can also depend on their structure. We see some physician practices set up as actual corporations, and they’re subject to a different regime of tax than those that are partnerships or LLCs. They could be taxed as a flow-through entity; maybe they’re just having that single level of taxation. And that can actually alter tax consequences as well. And finally, I do want to note that where physicians get something other than cash in a deal for the sale of their practice, that can complicate and create a more complex tax situation. We see these when the doctors are interested in retaining a piece of interest in their own practice after the sale, or in some cases, the physicians actually want an equity interest in the buyer of their practice after the sale. Those kinds of complications can lead to some really complex tax issues. And that’s another reason that physicians should probably get their own tax advisers, because sometimes a buyer will come to a physician practice and want them to actually do some restructuring before the sale ever occurs. And the doctor should be looking to make sure their own interests are being protected and not just rely on the buyer to represent them. 

Robbins: I think that we’re slowly moving that direction. But I think we’re still largely in the health care space that is mostly a fee-for-service business right now. And I think it’s going to continue to remain that way. Now, maybe some of the developments that Chris just mentioned will spur some momentum in that direction. But right now, we’re seeing more alternative payment models, but it’s still a very small portion of the health care business.

Slow-moving animal. And it was put into place to cut costs in the health care infrastructure and to also provide better health outcomes. But what we’ve seen is historically, physicians don’t like massive, sweeping changes to their practice; they like to see their patients, they like stability in their practice. They’ve been a little bit reluctant to invest the large amounts of money in technology and other aspects that are necessary to comply with these bundled payments. There’s also apprehension around whether or not anti-kickback laws prohibit some of those, those incentive payments that really align with value-based care. I know they did just have a final ruling on some Stark and anti-kickback revisions that loosen some of those restrictions to kind of foster better cooperation between payers and providers and push some of that risk to the provider side. But whether or not that will result in these alternative payment models kind of remains to be seen. So I think for the most part, we still see mostly the hybrid-based draw, and some incentive tied to productivity or maybe quality metrics. That’s kind of what we see across most of our practices.

Once those value-based payments do kind of kick in and become more preferable, then you should see better cash flow, because the purpose of those is to cut costs in the business and increase the quality of outcome. So at the end of the day, that should result in higher profitability, but we just haven’t really seen too much of it yet.

Medical Economics.com
More than 34 million Americans have diabetes and about 90% of them have Type 2 diabetes, according to the latest figures from the CDC’s division of diabetes. While this most often develops in people over 45 years of age, recently, more children, teens and young adults are developing Type 2 diabetes or are at extreme risk to do so because of obesity.

Puja Uppal, DO, chief medical officer for Think Healthy.Doctor, has managed patients with Type 2 diabetes for more than a decade. “I am not shy to discuss the potential complications of uncontrolled diabetes and find patients appreciate this greatly,” she says. “I’ve come to describe Type 2 diabetes as a cardiometabolic vascular disease, and I find this descriptor helps my patients grasp diabetes’ massive multisystem involvement. It’s not just about one’s blood sugar.”

Still, she assures patients that it isn’t a death sentence, and they can do so much to help themselves, such as improving their cardiometabolic health.

With more than 20 years of experience managing patients with Type 2 diabetes, Jay Anders, MD, chief medical officer of Chantilly, Va.-based Medicomp Systems, says the start of the conversation for new patients with diabetes always begins by explaining that their lifestyle is most likely going to need some adjustment.

“I also try to assure them that this particular illness is very treatable and controllable, usually with increased exercise, weight loss and possibly new medications,” he says.

**General management**

Jaydeep Tripathy, MD, a primary care doctor at DoctorSpring, notes that in patients with obesity, the body releases more nonesterified fatty acids, glycerol, proinflammatory cytokines and imbalanced hormones, which can lead to insulin resistance. B cells in the pancreas are also affected by the excess fats in obesity that affect the body’s natural production of insulin.

“Because the body cannot produce enough insulin and the body’s ability to react to insulin is affected, glucose or sugar is slowly building up in the body and their blood sugar levels increase,” he says. “Trulicity and metformin are often prescribed together for Type 2 diabetes patients.”

Tripathy notes a healthy lifestyle is most important for patients with diabetes.

“Patients should manage their blood glucose by watching what they eat while also keeping in check their blood pressure and cholesterol,” he says. “The easiest acronym to remember is the ABCS for managing diabetes. The A1C test is your average blood sugar over three months, which should be below 7%. Blood pressure should be around 140/90mm Hg. Cholesterol should be within the healthy normal range as determined by the physician. S is for
smoking, which they should stop immediately if they do.”

Scott Kirkley, MD, an internist with Parkland Health Center in Farmington, Missouri, spends 75% of his time doing outpatient work with patients averaging over 70 years of age and has experience working with those with diabetes.

“I like to sit down with a patient personally to discuss a new diagnosis of diabetes,” he says. “Explaining what diabetes is and necessary monitoring and management is crucial early on. This includes medications, diet and regular blood sugar, foot exam and eye exam monitoring.”

He recommends all patients start taking metformin immediately if tolerated.

“We order diabetic eye exams and check urine tests for protein called microalbumin,” Kirkley says. “We discuss long-term use of ACE (angiotensin converting enzyme) inhibitors/ARBs (angiotensin receptor blockers) to control blood pressures and protect kidneys. We discuss proper foot care and need for monitoring. We discuss if they would benefit from daily aspirin use as well as risk for strokes, heart attacks and peripheral artery disease.”

Additionally, Kirkley likes to order statin therapy to lower risk for cardiovascular events.

“We discuss diet and utility of home glucose monitoring and I recommend a proper diet and diettian evaluation as well as use of home glucose monitoring for symptoms of hypoglycemia as well as management of insulin,” he says.

Managing Type 2 diabetes is often patient dependent. Uppal says a patient’s past medical history will help determine if she chooses a SGLT2 inhibitor or GLP-1 agonist. She also finds it beneficial to always involve a diabetic educator or a nutritionist.

A challenge is that the cost of SGL2 inhibitors, GLP-1 agonists and insulin can be high. Also, social determinants of health also play a large role here, as in other chronic medical conditions.

“Cost may be prohibitive. You must fight for your patient if cost is an issue,” Uppal says. “Prior authorizations and patient assistance programs are valuable options.”

Explaining to patients that they may be able to reverse diabetes is key.

“For my patients, this means that they are empowered to make a difference in their disease process and we may be able to de-escalate some meds when clinically appropriate,” Uppal says.

Stephen Wander, DC, author of “Reverse Your Diabetes, Change Your Life,” says one of the biggest challenges is a patient’s friends and family sabotaging them with food and/or peer pressure. He makes sure to talk with any patient about their responsibilities if they truly want to get better.

“Patients who want to reverse it will have to work hard and it won’t be easy, but it’s possible and physicians should do whatever they can to help them meet this important goal,” he says.

Anthony Comfort, vice president of product management at VisiQuate, says one of the most important weapons in this battle against diabetes is data.

“There is certainly no lack of data, or data-gathering capabilities, in U.S. health care,” he
CHRONIC CONDITIONS / TYPE 2 DIABETES

says. “Between electronic health records, formal remote patient monitoring programs and the health data generated by consumer devices such as the Apple Watch, digital scales and glucose and blood pressure monitoring devices sold at the local Walgreens or CVS, the capacity to keep a close eye on patient health has never been larger.”

Adherence tips
Type 2 diabetes requires patients to follow up every 6 months, at a minimum, and in certain cases, it may need to be more frequent.

“You need to work with your patients and their schedules to make sure they can access the care they need and provide other support networks such as patient support groups,” Anders says. “Nurse practitioners and physician assistants also can be employed to create that constant touch for diabetic patients. It has been shown that this approach, usually on a monthly basis, improves compliance and control.”

When it comes to adherence by patients, there’s no big secret, but physicians need to make sure they are listening to their patients and understanding what motivates them.

“If you can speak to that, they are much more compliant with your recommendations,” Anders says.

Close follow-up is vital to success.

“I ask them to be honest with me and only then can we actually make shared decisions,” Uppal says. “There’s a lot they can do to improve their overall health; this means they can live a long, healthy life with diabetes.”

The biggest challenges for many come down to logistics.

“Getting to appointments, overcoming learning on how to monitor diet and glucose and getting and taking medication regularly are really common,” Kirkley says. “I advise every patient that if they want to live a longer and healthier life with diabetes, it is imperative to keep regular follow-ups and take metformin and statin therapy if tolerated. They need to be their own advocates for care and not be afraid to address issues with caring for diabetes.”

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CODING CASE STUDY

TYPE 2 DIABETES FOLLOW-UP

by Renee Dowling, CPC Contributing Author

In the medical billing and coding field, getting paid requires accurate documentation and selecting the correct codes. In our Coding Case Studies, we explore the correct coding for a specific condition based on a hypothetical clinical scenario. This scenario involves a patient presenting for a follow-up visit with symptoms of Type 2 Diabetes. See if you can choose the correct codes.

**Clinical Scenario**

**Chief Complaint**
Patient, a 52-year-old male, came to the office for follow up of Type 2 diabetes mellitus (T2DM), hyperlipidemia, hypertension, urine micro albumin. Patient reports he was diagnosed with T2DM at age 45. Patient has been on insulin since 2010. Since last visit, patient reports blood sugars are stable.

**Current Treatment:**
- Current diabetic regimen includes Tresiba 36 units daily and Xigduo (5/1000mg) 2 tab daily.
- Reviewed medication list - medication compliance is good.
- Glucose records reviewed.
- Blood glucose monitoring is done 0-1 times daily.
- The patient denies hypoglycemia or hypoglycemic symptoms, i.e. no dizziness, sweating, confusion or headaches.

**Diet / Exercise / Weight:**
Patient is overweight but generally follows a healthy diet. Goes to gym two to three times per week.

**Diabetic Related Complications:**
**Neuropathy symptoms:** Positive stocking/glove numbness or tingling.
No mononeuropathy. No postprandial bloating.

**Retinopathy:** Up-to-date on routine surveillance. First diagnosed 1/22/2018.

**Nephropathy:** Positive. Up-to-date on routine surveillance.

**Review of Systems**
**Constitutional/Endocrine/Musculoskeletal:** Negative.

**Social History**
**Smoking** status: Does not smoke.

**Physical Exam**
**BP:** 140/82
**Pulse:** 78
**Weight:** 271 lb 12.8 oz (123.3 kg)
**BMI:** Body mass index is 36.86 kg/m²
**General:** Alert, NAD with normal affect.
**Eyes:** EOMI, no icterus.
**HENT:** Atraumatic, oropharynx clear with moist mucous membranes.
**Neck:** Supple, normal size thyroid, no palpable nodes.
**Respiratory:** Normal respiratory effort.
**Cardiovascular:** Regular rate & rhythm, no edema.
**Musculoskeletal:** FROM, no synovitis.
**Neurological:** Reflexes 2+ at biceps, relaxation phase normal, no tremor.
**Skin:** No rash, no ulcerations.
**Diabetic Foot Exam:** No Lesions, good pulses.

**Assessment**
- Type 2 diabetes mellitus with hyperglycemia, with long-term current use of insulin
- Type 2 diabetes mellitus with polyneuropathy
- Type 2 diabetes mellitus with microalbuminuria, with long-term current use of insulin
- Type 2 diabetes, uncontrolled, with retinopathy
- Class 2 severe obesity due to excess calories with serious comorbidity and body mass index (BMI) of 36.0 to 36.9 in adult
- Hyperlipidemia associated with type 2 diabetes mellitus
- Hypertension associated with diabetes
- Vitamin D deficiency

**Documentation Coding Requirements**

When documenting diabetes, include the following:

**Type:**
- Type 1
- Type 2
- Due to underlying condition
- Drug or chemical induced diabetes mellitus
- Diabetes mellitus in pregnancy, childbirth, and the puerperium

**With or without complication**

**With or without coma**

**Eye:**
- Left  = Right  = Bilateral

**DIAGNOSIS CODES**

E11.65 Type 2 diabetes mellitus with hyperglycemia
E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy
E11.29 Type 2 diabetes mellitus with other diabetic kidney complication
E11.319 Type 2 diabetes with unspecified diabetic retinopathy with macular edema
E11.69 Type 2 diabetes mellitus with other specified complication
E11.59 Type 2 diabetes mellitus with other circulatory complications
E66.01 Morbid (severe) obesity due to excess calories
Z68.36 Body mass index (BMI) 36.0-36.9, adult
Z79.4 Long term (current) use of insulin
E55.9 Vitamin D deficiency, unspecified
R80.9 Proteinuria, unspecified
E78.5 Hyperlipidemia, unspecified

For a list of Type 2 diabetes codes, MedicalEconomics.com
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BRIEF SUMMARY

SHINGRIX [Zoster Vaccine Recombinant, Adjuvanted]

The following is a brief summary only; see full prescribing information for complete product information.

1 INDICATIONS AND USAGE

SHINGRIX is a vaccine indicated for prevention of herpes zoster (shingles) in adults aged 50 years and older.

Limitations of Use:

• SHINGRIX is not indicated for prevention of primary varicella infection (chickenpox).

2 DOSAGE AND ADMINISTRATION

2.2 Administration Instructions

For intramuscular injection only.

After reconstitution, administer SHINGRIX immediately or store refrigerated between 2° and 8°C (36° and 46°F) and use within 6 hours. Discard reconstituted vaccine if not used within 6 hours.

2.3 Dose and Schedule

Two doses (0.5 mL each) administered intramuscularly according to the following schedule: A first dose at Month 0 followed by a second dose administered anytime between 2 and 6 months later.

4 CONTRAINDICATIONS

Do not administer SHINGRIX to anyone with a history of a severe allergic reaction (e.g., anaphylaxis) to any component of the vaccine or after a previous dose of SHINGRIX [see Description (11) of full prescribing information].

5 WARNINGS AND PRECAUTIONS

5.1 Preventing and Managing Allergic Vaccine Reactions

Prior to administration, the healthcare provider should review the immunization history for possible vaccine sensitivity and previous vaccination-related adverse reactions. Appropriate medical treatment and supervision must be available to manage anaphylactic reactions following administration of SHINGRIX.

5.2 Guillian-Barré Syndrome (GBS)

In a postmarketing observational study, an increased risk of GBS was observed during the 42 days following vaccination with SHINGRIX [see Adverse Reactions (6.2)].

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a vaccine cannot be directly compared with rates in the clinical trials of another vaccine and may not reflect the rates observed in practice. There is the possibility that broad use of SHINGRIX could reveal adverse reactions not observed in clinical trials.

Overall, 17,041 adults aged 50 years and older received at least 1 dose of SHINGRIX in 17 clinical studies.

The safety of SHINGRIX was evaluated by pooling data from 2 placebo-controlled clinical studies (Studies 1 and 2) involving 29,305 subjects aged 50 years and older who received at least 1 dose of SHINGRIX (n = 14,645) or saline placebo (n = 14,660) administered according to a 0- and 2-month schedule. At the time of vaccination, the mean age of the population was 69 years; 7,286 (24.9%) subjects were aged 50 to 59 years, 4,488 (15.3%) subjects were aged 60 to 69 years, and 17,531 (59.8%) subjects were aged 70 years and older. Both studies were conducted in North America, Latin America, Europe, Asia, and Australia. In the overall population, the majority of subjects were white (74.3%), followed by Asian (18.3%), black (1.4%), and other racial/ethnic groups (6.0%); 58% were female.

Solicited Adverse Events

In Studies 1 and 2, on solicited local and general adverse events were collected using standardized diary cards for 7 days following each vaccination dose or placebo (i.e., day of vaccination and the next 6 days) in a subset of subjects (n = 4,886 receiving SHINGRIX, n = 4,881 receiving placebo with at least 1 documented dose). Across both studies, the percentages of subjects aged 50 years and older reporting each solicited local adverse reaction and each solicited general adverse event following administration of SHINGRIX (both doses combined) were pain (78.0%), redness (38.1%), and swelling (25.9%) and myalgia (44.7%), fatigue (44.5%), headache (37.7%), shivering (26.8%), fever (20.5%), and gastrointestinal symptoms (17.3%), respectively.

The reported frequencies of specific solicited local adverse reactions and general adverse events (overall per subject), by age group, from the 2 studies are presented in Table 1.

Table 1. Percentage of Subjects with Solicited Local Adverse Reactions and General Adverse Events within 7 Days of Vaccination in Adults Aged 50 to 59 Years, 60 to 69 Years, and 70 Years and Older (Total Vaccinated Cohort with 7-Day Diary Card)

<table>
<thead>
<tr>
<th></th>
<th>Aged 50-59 Years</th>
<th>Aged 60-69 Years</th>
<th>Aged ≥70 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SHINGRIX %</td>
<td>Placebo %</td>
<td>SHINGRIX %</td>
</tr>
<tr>
<td>Local Adverse Reactions</td>
<td>n=1,315</td>
<td>n=1,312</td>
<td>n=1,311</td>
</tr>
<tr>
<td>Pain</td>
<td>88.4 ± 3.0</td>
<td>82.8 ± 1.1</td>
<td>69.2 ± 0.8</td>
</tr>
<tr>
<td>Pain, Grade 3*</td>
<td>10.3 ± 0.5</td>
<td>6.9 ± 0.5</td>
<td>4.0 ± 0.2</td>
</tr>
<tr>
<td>Redness</td>
<td>38.7 ± 1.2</td>
<td>38.4 ± 1.6</td>
<td>37.7 ± 1.2</td>
</tr>
<tr>
<td>Redness, &gt;100 mm</td>
<td>2.8 ± 0.0</td>
<td>2.6 ± 0.0</td>
<td>3.1 ± 0.0</td>
</tr>
<tr>
<td>Swelling</td>
<td>30.5 ± 0.8</td>
<td>26.5 ± 1.0</td>
<td>23.0 ± 1.1</td>
</tr>
<tr>
<td>Swelling, &gt;50 mm</td>
<td>0.8 ± 0.0</td>
<td>0.5 ± 0.0</td>
<td>1.3 ± 0.0</td>
</tr>
<tr>
<td>General Adverse Events</td>
<td>n=1,315</td>
<td>n=1,312</td>
<td>n=1,309</td>
</tr>
<tr>
<td>Myalgia</td>
<td>56.9 ± 3.0</td>
<td>49.0 ± 1.2</td>
<td>35.1 ± 1.9</td>
</tr>
<tr>
<td>Myalgia, Grade 3*</td>
<td>8.9 ± 0.9</td>
<td>5.3 ± 0.8</td>
<td>2.8 ± 0.4</td>
</tr>
<tr>
<td>Fatigue</td>
<td>57.0 ± 3.0</td>
<td>45.7 ± 1.6</td>
<td>36.6 ± 1.4</td>
</tr>
<tr>
<td>Fatigue, Grade 3*</td>
<td>8.5 ± 1.0</td>
<td>5.0 ± 0.8</td>
<td>3.5 ± 0.8</td>
</tr>
<tr>
<td>Headache</td>
<td>50.6 ± 2.1</td>
<td>39.6 ± 1.5</td>
<td>29.0 ± 1.1</td>
</tr>
<tr>
<td>Headache, Grade 3*</td>
<td>6.0 ± 1.7</td>
<td>3.7 ± 0.2</td>
<td>1.5 ± 0.4</td>
</tr>
<tr>
<td>Shivering</td>
<td>35.8 ± 2.6</td>
<td>30.3 ± 2.5</td>
<td>19.5 ± 2.9</td>
</tr>
<tr>
<td>Shivering, Grade 3*</td>
<td>4.8 ± 0.7</td>
<td>4.5 ± 0.3</td>
<td>2.2 ± 0.3</td>
</tr>
<tr>
<td>Fever</td>
<td>27.8 ± 3.0</td>
<td>23.9 ± 3.4</td>
<td>14.3 ± 2.7</td>
</tr>
<tr>
<td>Fever, Grade 3*</td>
<td>0.4 ± 0.2</td>
<td>0.5 ± 0.2</td>
<td>0.2 ± 0.1</td>
</tr>
<tr>
<td>GI*</td>
<td>24.3 ± 3.0</td>
<td>16.7 ± 3.8</td>
<td>13.5 ± 3.3</td>
</tr>
<tr>
<td>GI, Grade 3*</td>
<td>2.1 ± 0.7</td>
<td>0.9 ± 0.6</td>
<td>1.2 ± 0.4</td>
</tr>
</tbody>
</table>

Total vaccinated cohort for safety included all subjects with at least 1 documented dose (n).

* 7 days included day of vaccination and the subsequent 6 days.

a Data for subjects aged 50 to 59 years and 60 to 69 years are based on Study 1. Data for subjects 70 years and older are based on pooled data from Study 1: NCT01165177 and Study 2: NCT01165229.

Placebo was a saline solution.

Grade 3 pain: Defined as significant pain at rest; prevents normal everyday activities.

Grade 3 myalgia, fatigue, headache, shivering, GI: Defined as preventing normal activity.

Fever defined as ≥37.5°C/99.5°F for oral, axillary, or tympanic route, or ≥38°C/100.4°F for rectal route; Grade 3 fever defined as ≥39.0°C/102.2°F.

GI = Gastrointestinal symptoms including nausea, vomiting, diarrhea, and/or abdominal pain.

The incidence of solicited local and general symptoms was lower in subjects aged 70 years and older compared with those aged 50 to 69 years.

The majority of solicited local adverse reactions and general adverse events seen with SHINGRIX had a median duration of 2 to 3 days.

There were no differences in the proportions of subjects reporting any or Grade 3 solicited local reactions between Dose 1 and Dose 2. Headache and shivering were reported more frequently by subjects after Dose 2 (28.2% and 21.4%, respectively) compared with Dose 1 (24.4% and 13.8%, respectively). Grade 3 solicited general adverse events (headache, shivering, myalgia, and fatigue) were reported more frequently by subjects after Dose 2 (2.3%, 3.1%, 3.6%, and... (continued on next page)
3.5%, respectively) compared with Dose 1 (1.4%, 1.4%, 2.3%, and 2.4%, respectively).

Unsolicited Adverse Events

Unsolicited adverse events that occurred within 30 days following each vaccination (Day 0 to 29) were recorded on a diary card by all subjects. In two studies, unsolicited adverse events occurring within 30 days of vaccination were reported in 50.5% and 32.0% of subjects who received SHINGRIX (n = 14,645) and placebo (n = 14,660), respectively (Total Vaccinated Cohort). Unsolicited adverse events that occurred in ≥1% of recipients of SHINGRIX and at a rate at least 1.5-fold higher than placebo included chillis (3.5% versus 0.2%), injection site pruritus (2.2% versus 0.2%), malaise (1.7% versus 0.2%), arthralgia (1.7% versus 1.2%), nausea (1.4% versus 0.5%), and dizziness (1.2% versus 0.8%).

Gout (including gouty arthritis) was reported by 0.18% (n = 27) versus 0.05% (n = 8) of subjects who received SHINGRIX and placebo, respectively, within 30 days of vaccination; available information is insufficient to determine a causal relationship with SHINGRIX.

Serious Adverse Events

In the 2 studies, SAEs were reported at similar rates in subjects who received SHINGRIX (2.3%) and placebo (2.2%) from the first administered dose up to 30 days post last vaccination. SAEs were reported for 10.1% of subjects who received SHINGRIX and for 10.4% of subjects who received placebo from the first administered dose up to 1 year post last vaccination. One subject (<0.01%) reported lymphpadenitis and 1 subject (<0.01%) reported fever greater than 39°C; there was a basis for a causal relationship with SHINGRIX.

Optic ischemic neuropathy was reported in 3 subjects (0.02%) who received SHINGRIX (all within 5 days post vaccination) and 0 subjects who received placebo; available information is insufficient to determine a causal relationship with SHINGRIX.

Deaths

From the first administered dose up to 30 days post last vaccination, deaths were reported for 0.04% of subjects who received SHINGRIX and 0.06% of subjects who received placebo in the 2 studies. From the first administered dose up to 1 year post last vaccination, deaths were reported for 0.8% of subjects who received SHINGRIX and for 0.9% of subjects who received placebo. Causes of death among subjects were consistent with those generally reported in adult and elderly populations.

Potential Immune-Mediated Diseases

In the 2 studies, new onset potential immune-mediated diseases (pIMDs) or exacerbation of existing pIMDs were reported for 0.6% of subjects who received SHINGRIX and 0.7% of subjects who received placebo from the first administered dose up to 1 year post last vaccination. The most frequently reported pIMDs occurred with comparable frequencies in the group receiving SHINGRIX and the placebo group.

Dosing Schedule

In an open-label clinical study, 238 subjects 50 years and older received SHINGRIX and 238 subjects who received placebo in the 2 studies. From the first administered dose up to 1 year post last vaccination, deaths were reported for 0.8% of subjects who received SHINGRIX and for 0.9% of subjects who received placebo. Causes of death among subjects were consistent with those generally reported in adult and elderly populations.

6.2 Postmarketing Experience

The following adverse reactions have been identified during postapproval use of SHINGRIX. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to the vaccine.

General Disorders and Administration Site Conditions

Decreased mobility of the injected arm which may persist for 1 or more weeks.

Immune System Disorders

Hypersensitivity reactions, including angioedema, rash, and urtica.ria.

Nervous System Disorders

Guillain–Barré syndrome.

Postmarketing Observational Study of the Risk of Guillain–Barré Syndrome following Vaccination with SHINGRIX

The association between vaccination with SHINGRIX and GBS was evaluated among Medicare beneficiaries aged 65 years of age using Medicare claims data, from October 2017 through February 2020, vaccinations with SHINGRIX among beneficiaries were identified through National Drug Codes, and potential cases of hospitalizations among recipients of SHINGRIX were identified through International Classification of Diseases codes.

The risk of GBS following vaccination with SHINGRIX was assessed in self-controlled case series analyses using a risk window of 1 to 42 days post-vaccination and a control window of 43 to 183 days post-vaccination. The primary analysis (claims-based, all doses) found an increased risk of GBS during the 42 days following vaccination with SHINGRIX, with an estimated 3 excess cases of GBS per million doses administered to adults aged 65 years or older. In secondary analyses, an increased risk of GBS was observed during the 42 days following the first dose of SHINGRIX, with an estimated 6 excess cases of GBS per million doses administered to adults aged 65 years or older, and no increased risk of GBS was observed following the second dose of SHINGRIX. These analyses of GBS diagnoses in claims data were supported by analyses of GBS cases confirmed by medical record review. While the results of this observational study suggest a causal association of GBS with SHINGRIX, available evidence is insufficient to establish a causal relationship.

7 DRUG INTERACTIONS

7.1 Concomitant Vaccine Administration

For concomitant administration of SHINGRIX with inactivated influenza vaccine [see Clinical Studies (14.8) of full prescribing information].

7.2 Immunosuppressive Therapies

Immunosuppressive therapies may reduce the effectiveness of SHINGRIX.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

There are no available human data to establish whether there is vaccine-associated risk with SHINGRIX in pregnant women [see Use In Specific Populations (8.1) of full prescribing information].

8.2 Lactation

It is not known whether SHINGRIX is excreted in human milk. Data are not available to assess the effects of SHINGRIX on the breastfed infant or on milk production/excretion [see Use in Specific Populations (8.2) of full prescribing information].

8.5 Geriatric Use

Of the total number of subjects who received at least 1 dose of SHINGRIX in the efficacy trials (n = 14,645), 2,243 (15.3%) were aged 60 to 69 years, 6,837 (46.7%) were aged 70 to 79 years, and 1,921 (13.1%) were 80 years and older. There were no clinically meaningful differences in efficacy across the age groups or between these subjects and younger subjects [see Clinical Studies (14.1, 14.2, 14.3) of full prescribing information].

The frequencies of solicited local and general adverse events in subjects aged 70 years and older were lower than in younger adults (aged 50 through 69 years) [see Adverse Reactions (6.1)].

17 PATIENT COUNSELING INFORMATION

Inform patients of the potential benefits and risks of immunization with SHINGRIX and of the importance of completing the 2-dose immunization series according to the schedule.

Inform patients about the potential for adverse reactions that have been temporally associated with administration of SHINGRIX.

Provide the Vaccine Information Statements, which are available free of charge at the Centers for Disease Control and Prevention (CDC) website (www.cdc.gov/vaccines).

Storage:

Store vials of Lyophilized gE Antigen and Adjuvant Suspension Components refrigerated between 2° and 8°C (36° and 46°F). Protect vials from light. Do not freeze. Discard if the vials have been frozen.
YOU CAN’T
SOCIAL DISTANCE
FROM YOURSELF.

THE VIRUS THAT CAUSES SHINGLES IS ALREADY INSIDE YOUR PATIENTS.1,2

99.5% of adults aged 50 years and older are infected with the varicella zoster virus.1,2 1 out of 3 people will get shingles in their lifetime.2  Fortunately, you can do something today to prevent it.

HELP PROTECT YOUR PATIENTS AGED 50 YEARS AND OLDER WITH SHINGRIX.3

Get the inside story at SHINGRIXhcp.com

Not an actual patient.

Indication
SHINGRIX is a vaccine indicated for prevention of herpes zoster (shingles) in adults aged 50 years and older.

SHINGRIX is not indicated for prevention of primary varicella infection (chickenpox).

Important Safety Information
• SHINGRIX is contraindicated in anyone with a history of a severe allergic reaction (eg, anaphylaxis) to any component of the vaccine or after a previous dose of SHINGRIX
• Review immunization history for possible vaccine sensitivity and previous vaccination-related adverse reactions. Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of SHINGRIX
• In a postmarketing observational study, an increased risk of Guillain–Barré syndrome was observed during the 42 days following vaccination with SHINGRIX
• Solicited local adverse reactions in subjects aged 50 years and older were pain (78.0%), redness (38.1%), and swelling (25.9%)
• Solicited general adverse reactions in subjects aged 50 years and older were myalgia (44.7%), fatigue (44.5%), headache (37.7%), shivering (26.8%), fever (20.5%), and gastrointestinal symptoms (17.3%)
• SHINGRIX was not studied in pregnant or lactating women, and it is unknown if it is excreted in human milk. Therefore, it cannot be established whether there is vaccine-associated risk with SHINGRIX in pregnant women or if there are effects on breastfed infants or milk production/excretion
• Vaccination with SHINGRIX may not result in protection of all vaccine recipients


Please see Brief Summary of Prescribing Information for SHINGRIX on the previous pages.

You are encouraged to report vaccine adverse events to the US Department of Health and Human Services. Visit www.vaers.hhs.gov to file a report, or call 1-800-822-7967.

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SGXJRNA210003 April 2021

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Partner with a national leader for your most complex pediatric heart patients.

Delivering Nationally Ranked Pediatric Cardiovascular Care

From fetal diagnoses to complex surgical interventions, our cardiac-dedicated specialists deliver care for the most complex, but also the most common, conditions patients experience. The care team within the Riley Heart Center includes pediatric cardiologists, cardiac intensivists, cardiac anesthesiologists and neonatologists.

Committed to a Unique Continuum of Care

As an internationally recognized program for complex heart care, Riley Children’s Health provides a depth and a breadth of pediatric cardiovascular care with expertise and options not available everywhere. Our integrated continuum care model focuses on promoting excellent sub-specialty care coordination with a re-imagined approach to cardiac intensive care, including inpatient navigation and home monitoring.

With world-class facilities and the latest technology, Riley Heart Center experts provide the full continuum of care from fetuses and premature babies to adults with congenital heart disease, including:

- A cardiovascular intensive care unit with a team of intensive care doctors and nurses who monitor patients 24/7, reacting quickly to changes during critical care and healing.
- A specialty-trained team of advanced providers, nursing staff and navigators dedicated to our cardiac patients and families, keeping the care team and patient’s local physicians connected.
- A consulting team of more than 40 pediatric-trained specialties working alongside the Heart Center team.

Our pediatric heart program is ranked 5th in the nation by U.S. News & World Report.

To refer a patient to the Riley Heart Center or for more information about the program, visit rileychildrens.org/heart
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