The scene: Three solo internists are concerned about the financial health of their practices. Reimbursements are, at best, stagnant while overhead continues to climb. While discussing their common plight at their local medical society meeting, they begin to wonder about the feasibility of getting together to share expenses. They don’t want to give up their individual practices, but are eager to explore their options.

All three doctors pull patients from within a 10-mile radius, with some overlap. They range in age from late 30s to mid-40s; the oldest is 45.

Dr. A leases space in a medical office building. He sees about 20 patients a day with the help of two medical assistants and a receptionist. His wife manages the practice. Aside from blood draws, he offers no ancillary services.

Dr. B owns the building that houses her practice. She has five full-time equivalents (1.5 billing clerks, 1.5 receptionists, a medical assistant, and an office manager) and offers ECGs, spirometry, and Botox injections. She also has an arrangement with a technician who comes in and gives echocardiograms once a month. Dr. B sees 28 patients a day, plus those who may be having ancillary services done.

Dr. C also owns his building. He has two employees: a receptionist and a medical assistant. He has no office manager, preferring to handle those duties himself. He sees only 12 patients a day. An avid runner, he has tailored his practice to include treatment of the hip, knee, and leg problems that runners typically develop, seldom referring those patients to an orthopedist. He does refer them for physical therapy, though, and has an arrangement with a therapist to whom he rents space in his building.

None of the physicians has an EHR, although Dr. C uses an SRS scanning system to create, in effect, an electronic paper chart. Drs. A and B use the same practice management system.

That’s the scenario Medical Economics posed for...
Can expense sharing work?

Our roundtable panel of management consultants outline how neighboring physicians can join forces to cut costs and boost profits.

By Gail Garfinkel Weiss
SENIOR EDITOR

three practice management experts at a roundtable held at the 2006 annual meeting of the National Association of Healthcare Consultants (NAHC)* in Denver. We asked them to offer outside-the-box solutions for soloists who want to remedy cash-flow problems without ceding their independence. The panelists—certified healthcare business consultants Michael P. Brady of Healthcare Business Consultants in Asheville, NC; Virginia Martin of Healthcare Consulting Associates of Northwest Ohio, in Waterville; and H. Christopher Zaenger of Z Management Group in Barrington, IL, rose to the challenge, developing a plan whereby the physicians would remain soloists but practice in a jointly owned building: share some employees, equipment, an electronic health record, and a practice management system; and develop ancillary services together. Such an arrangement, the consultants said, worked best for physicians who shared call and were comfortable clinically with each other—stipulations that the doctors in the scenario met. Still, the physicians in question had different practice styles, patient loads, and staffing needs. The consultants’ proposal focuses

*At the Denver conference in June, the NAHC completed a merger with the Institute of Certified Healthcare Business Consultants and the Society of Medical-Dental Management Consultants to become the National Society of Healthcare Business Consultants. Michael Brady was named as the combined organization’s first president.

Our panelists

Michael P. Brady, CHBC
Healthcare Business Consultants
Asheville, NC
President, National Society of Healthcare Business Consultants, Washington, DC

Virginia Martin, CMA, CPC, CHCO, CHBC
Healthcare Consulting Associates of Northwest Ohio
Waterville, OH
Member, Medical Economics Practice Management Editorial Board

H. Christopher Zaenger, CHBC
Z Management Group
Barrington, IL
Member, Medical Economics Practice Management Editorial Board
on structuring the communal venture and reconciling differences.

**Practicing separately, but together**

Because housing accounts for a large chunk of overhead costs, the consultants’ chief recommendation is that Drs. A, B, and C set up shop in a jointly owned building. As Chris Zaenger points out, “Getting into the real estate business together is less traumatic than getting into the medical business together.”

Why not use Dr. B’s or Dr. C’s building? “Because the physicians are relatively young, it’s unlikely that any of the three will be retiring soon,” says Mike Brady, then president of the NAHC. “Rather than trying to restructure an

existing space, it makes sense to purchase a suitable piece of property and construct a building that can accommodate all three physicians over the long term.” The new building would also house the physical therapist who’s been renting space from Dr. C, allow Dr. B to expand her ancillary offerings, and give Drs. A and C the square footage to develop ancillary services.

The consultants propose that the doctors begin by engaging an attorney with a healthcare background and forming a limited liability company (LLC), which would own the building and lease it back to the physicians. That would allow for tax breaks and shield the physicians from liabilities that might arise in the operation of the real estate business or from problems with commonly employed personnel. At the same time, in forming an LLC the doctors could share staffers, who, as employees of the LLC, would be authorized to handle sign-in, pull charts, and access protected health information for all three practices. (Note: HIPAA privacy disclosure forms should include all three practices.)

For example, in their shared quarters the three physicians wouldn’t need four receptionists; one or two full-time equivalents could handle the job. Rather than lay off the others, the physicians would realign them to handle added services, thus balancing staff costs with increased revenue. So a one-time receptionist might be cross-trained to do the billing for a new ancillary service.

Dr. A’s spouse, who had been working as his office manager, probably wouldn’t blend well into the newly consolidated office, the consultants agree. They propose that Dr. B’s manager assume that role for all three practices and that Dr. A’s spouse work offsite, perhaps doing the physicians’ bookkeeping or accounts payable—assuming that Drs. B and C are amenable to that.

In addition to staff consolidation, the consultants’ plan calls for the creation of as many common areas as possible, to use space efficiently and cost-effectively. “Each combined function—patient check-in and chart storage are prime candidates—will require advanced planning, because obviously if things are being done three different ways overhead will rise,” says Ginny Martin. Her chart-storage solution: color-code the charts by putting, say, a red sticker on all of Dr. A’s charts, a blue sticker on Dr. B’s, and a yellow sticker on Dr. C’s.

**Taking advantage of economies of scale**

“Many practices are sending specimens to Quest Diagnostics and other venues when—if their managed care contracts permit it, or if they have many nonmanaged care patients—they could put a lab in their combined office and add to their revenue stream,” says Zaenger. The three physicians can share the lab equipment and personnel, but because they’re not a group practice they’d have to get separate CLIA numbers and bill patients out of their individual practices. Still, because the doctors are practicing in the same building, the lab should meet the requirements of Stark’s in-office ancillary exception. (For more on this, see “Adding

—Michael P. Brady, CHBC

—H. Christopher Zaenger, CHBC
Ancillaries: Waived lab services,” March 3, 2006; also at www.memag.com.)

Other ancillary possibilities that the consultants mention specifically for these physicians are bone densitometry and X-rays. “Expenses for these services would be set up on a fixed and variable basis,” says Martin. “Fixed expenses would include rent, insurance, and staff. Expenditures for supplies and other variables would be based on volume.” And three physicians working under the same roof would probably be able to negotiate group purchasing discounts that were unavailable when they were going it alone.

In addition to shared fax machines, printers, and copiers, a common office space means pooling resources on big-ticket items like computer networks. By agreeing to work with a single server, the doctors could purchase a state-of-the-art electronic practice management system and then add the EHR that all three had been doing without. “Purchases of this magnitude won’t save them money up front,” says Martin, because the systems are costly and money has to be laid out for training. “But it’s well worth the investment. With the new technology the doctors will ultimately save money—and time—because these systems allow for greater efficiency, improved workflow management, and more accurate billing and claims processing.” (For more, see “The best EHRs for small practices,” in our Sept. 1 issue; also at www.memag.com.)

An EHR also offers opportunities for reassigning employees, says Brady: Someone who’s no longer needed at the front desk can scan documents into the EHR, and make sure that electronic charts are kept up to date.

**Dealing with operational issues**

The day-to-day operations for three soloists sharing space, equipment, and personnel can be much more difficult to work through than the big-ticket items, especially if the doctors don’t participate in the same health plans or have different fee schedules. What happens, for example, if a patient who’s covered by Aetna makes an appointment with Dr. A, who isn’t an Aetna participant? But while she’s in the waiting room, the patient discovers that Dr. B participates in Aetna, and asks to see him instead? Or what happens when one of Dr. B’s self-pay patients gets to talking with one of Dr. C’s self-pay patients, and learns that Dr. C charges less for an office visit?

“The doctors are going to have to put guidelines in place that address these issues,” says Brady. “Are they going to refer patients to a doctor who participates in their plan? Will they all enroll in the same plans? What about Medicare participation? Are they going to adjust their fees to eliminate disparities?

“But they have to tread carefully,” he emphasizes. “Because they have separate practices and have separate tax ID numbers, they may be accused of price-fixing if they set their fees at the same level.”

Other issues that need to be agreed upon, in writing and reviewed by an attorney:

- Will all three physicians have similar personnel policies, including comparable work schedules, salary scales, retirement and healthcare benefits, and paid vacation and sick days?
- And if the practices decide to offer similar benefits, do they offer the most generous package of the three? If not, how will that affect the employees who, in essence, will lose perks?

- How will the physicians promote their combined venture? To avoid liability problems, the doctors will need to indicate in advertisements, signage, telephone listings, billheads, and stationery that they’re three separate practices, to avoid giving the erroneous impression that they’re practicing as a group. They’d also be wise to have separate websites.

- Will each practice have its own phone number? Or will there be a common phone number and separate extensions for the individual practices?

- What happens if one of the physicians wants to leave, or becomes disabled, or dies?

“Few of these knotty problems would exist if the doctors merged into a group,” Ginny Martin says. “But because each one wants to maintain at least some of the controls that being a soloist affords, this office-sharing arrangement is the way to go.”

<<Each combined function will require advanced planning to avoid a rise in overhead.>>

—Virginia Martin, CMA, CPC, CHCO, CHBC