

# Issues & Updates

Legal and Business Advice for Physicians and Dentists since 1970

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## The Health Care Group®

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### Merging to Survive

By: Daniel M. Bernick, JD, MBA

Like other highly educated professionals, doctors like independence. But they also like security.

As professionals, doctors don't like to be treated as mere employees. But they also value financial stability.

Can they have both?

Traditionally, and for decades, doctors were able to have both, in

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### Should Your Practice Buy Another Practice?

By: Mark E. Kropiewnicki, JD, LL.M

About 42% of physicians in the U.S. are 55 years of age or older. In many medical specialties (e.g. ophthalmology, orthopedic surgery and cardiology) 48% or more of physicians are 55 years of age or older. A great many of them are ready to slow down and eventually retire. Many of those in solo practices are hoping or planning to sell their practices and many often want to continue working, on a reduced basis, for a number of years after the sale.

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## Merging to Survive

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the context of an independent group practice. By developing or joining a group practice, doctors could govern themselves, and earn a good living.

Recent years have presented private practices with too many challenges to count. But here are the big ones, in our experience:

- Carrier reimbursement cuts, payment delays, and attempts to control utilization
- High patient deductibles
- Hospital control/re-direction of referrals from owned PCPs
- Difficulties recruiting qualified doctors and higher pay needed to sign them
- Regulatory requirements that slow doctor productivity (e.g., EMR) or result in reduced Medicare reimbursement (for non-compliant practices)
- Emergence of a dominant local competitor
- Difficulties recruiting good staff

These challenges have certainly not ended private practice. But they have induced some doctors to seek refuge with hospital owners, and they have forced the remainder to work harder to keep their independence.

For years we have been urging practices to consider “bulking up” (getting larger) as a means for physicians to retain their independence and position in the marketplace. Here are some of the potential benefits:

- Spread the cost of expensive new IT and medical technology
- Greater ability to afford higher level management and more sophisticated quality

reporting

- Efficiencies from centralized billing
- (Possibly) improved negotiating position vis a vis insurers (must grow quite a bit to make this happen).
- Gathering of sufficient internal referrals to support expensive ancillary testing/imaging
- Greater sharing of call responsibilities
- Greater recruiting abilities: newly trained physicians value collegiality, security of a larger group, less call share, and more flexibility in terms of part-time hours
- Greater attractiveness for private equity buyers, who look to buy “platform” practices that have multiple doctors and multiple locations
- Regional dominance, via multiple locations and absorbing competitors

So there are many benefits to bulking up. There are three major avenues:

- Internal growth
- Acquisition
- Merger

Internal growth is the least disruptive to current operations, and often produces the best and most durable groups. But it requires long periods of time for growth, and time is in short supply.

In another article in this edition of *Issues and Updates*, we discuss buying another practice. That can also be an excellent strategy, especially in the current environment, with many solo baby boomer doctors looking for an exit

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## Merging to Survive

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strategy (sale of their solo or small practices). But it requires capital (for purchase of practices), a suitable practice for acquisition, and strong management skills, at the physician and administrator level, to plan the acquisition and absorb the target.

The final option is merger. This is not necessarily easy to achieve. However, in the right circumstances, it can produce a big or bigger group, with enhanced resources and ability to compete, in a relatively short space of time.

There are two merger models used for physician practices.

The first model is a traditional merger. Two separate practices merge into a single LLC or PC. Thereafter, they are legally and functionally one entity. All charges are billed through a single set of provider numbers. The entity has a single tax return and single retirement plan. Finances are merged; even if physician compensation is still based on productivity, there is some sharing of expenses, as the newly formed group explores operational changes to achieve greater efficiency. Employees are potentially shared among the merger partners, as operations are made more efficient. Governance is merged; there is a single Board of Directors or management committee, with representatives from each of the predecessor entities.

The traditional model “works,” but can be tough to achieve. Often each merger partner suspects or believes that bottom line, it can survive without the merger. This kind

of attitude makes it hard to stay the course, and overcome all the transitional difficulties that traditional merger entails. Everyone will likely agree that “in principle” they should merge; however, the reality of merger involves a host of nitty gritty decisions to be made: Which practice management system will be used by the consolidated practice? Which EMR? With which carriers will the merged entity participate? How will expenses and revenues be shared? What will the new buy-sell arrangements be? These are hard decisions, and there will often be much resistance and back sliding on the path to compromise.

A second, newer model is the “group practice without walls” (GPWW) or “clinic without walls.” This model was developed to make it easier for physician practices to merge, while still obtaining some of the key benefits of merger, such as ability to negotiate collectively with insurance carriers.

In a GPWW or clinic without walls, a single entity is formed, the same as with the traditional merger, and insurers are billed with a single provider number per carrier. However, each of the merging practices retains its identity for many non-legal purposes, including operations and finances.

For example, in a GPWW or clinic without walls, all charges to Medicare will be billed under a single NPI. But when the checks come in, they are “unwound” by the central billing office of the GPWW, so that each component service is allocated back to the originating doctor group (called a “Division”) that produced the charge. Each

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## Should Your Practice Buy Another Practice?

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This "once in a lifetime" set of circumstances provides established (typically group) practices with tremendous buying opportunities to increase their patient bases, market share, and geographic scope.

### **Seller motivations**

Older and other physicians are motivated to sell their practices for many and varied reasons.

Some physicians can see the "light at the end of the tunnel" and want to sell before they slow down too much and the practice values (goodwill, in particular) decline appreciably. Others are reluctant to invest their time and money in an EMR system. They fear that they are too old to change and learn a new way of doing things and that the not insubstantial investment in EMR will not be recouped during their remaining time in practice. Some simply want a job for a few more years before they fully retire. Still others fear future reimbursement cutbacks or simply are tired of managing the business, administrative, and regulatory aspects of their practices. Lastly, some have heard stories about big pay days to other physicians who have sold to hospitals or private equity firms.

You never know for sure if an older physician is looking to sell. Keep in mind that not all potential sellers will be older. Look for any physician who cannot (or does not want to) manage their practice and is not able or willing to hire someone to manage it well for him/her. Therefore, it makes good sense to be vigilant for any potential opportunities. Don't be afraid to ask.

### **Buyer motivations**

Given the numerous opportunities to buy the practices of older (and other) physicians, should you?

Some of the fears/concerns that older physicians have about their practices apply equally to group and other medical practices that are likely buyers (e.g. reimbursement cuts and increasing administrative and regulatory burdens and costs).

Countering such concerns is that some medical practices are well positioned to survive, if not thrive, in the future (e.g. ophthalmology, orthopedic surgery, cardiology and other specialties that see a lot of the aging baby boomers). Demand for medical services is going to be strong in the years ahead as the baby boomers age. Some specialties (e.g. ophthalmology) have been able to access many new or additional sources of income over the years such as optical, ASC facility fees, elective refractive surgery, and premium lenses. Also, as new treatments and options for medical care continue to be developed, physicians should be well positioned to benefit from any new income sources.

Although some medical practices choose marketing and public relations activities to build their market share, expand geographically, and increase their flow of patients, medical practices should definitely consider buying the practices of older and other physicians (especially competitors) as a viable and perhaps significantly better alter-

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native to protect against possible erosion of the practice economics and profitability.

Other medical practices need to expand patient volume to cover existing costs. For example, a practice with a new associate who is not yet fully scheduled with patients can quickly become much busier if the patients of a purchased practice are suddenly added to his/her schedule. Still other practices may benefit from such a purchase by allowing an ongoing practice to be able to afford to hire a new doctor.

Some practices want to increase a particular other surgical procedure. A purchased practice can bring more surgical volume while possibly also increasing medical (non-surgical) care services for other members of the existing practice or for the selling physician if he/she wants to continue working after the sale.

Similarly, multispecialty medical practice can increase the utilization of the practice's subspecialists by purchasing an existing medical practice along with all of the potential subspecialty medical services that the seller was referring out to other subspecialists who were not part of the purchasing practice. Such a purchase could allow an ongoing multispecialty medical practice to bring on an additional subspecialist or bring current subspecialists up to full patient volume.

A practice acquisition can also be used simply as a defensive tactic to prevent the other practice's sale to an ambitious physician or group practice (or a hospital) that could become a much more serious competitor than

the other physician ever was.

Lastly, the economics of the typical practice purchase often makes a practice purchase quite desirable and can offer a significant return on investment.

### **Established advantage**

Existing practices usually have an advantage in buying another physician's practice over a physician just entering private practice from residency or fellowship or coming into the area from practicing elsewhere. An established practice can far more easily afford the purchase price and can often pay the entire purchase price in cash at closing. Even if the purchase price is financed by the seller, the selling physician has greater assurance of payment from an established practice. Since the purchaser's credit worthiness is a common concern in most practice sales, an already established practice is generally preferred by sellers.

Furthermore, many established physicians want to transfer their practice only to a successor that can provide high-quality medical care. Thus, again, an established practice (solo or group) will often be preferred since its patient care quality is more easily known compared to the unknown patient care quality of newer or less experienced physicians.

### **Weighing options**

Taking everything into account, it is a very good time for medical practices to buy another medical practice, if in a position to do so. It is an excellent way to build and maintain a practice's patient bases, and changing economic circumstances could make such a

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course of action prudent, if not desirable.

Unfortunately, many medical practices ignore such valuable opportunities, assuming they will inevitably receive a significant share of the patients when the older or other physician retires or leaves town. That will be a bad assumption if the other physician sells to someone else, because another practice purchaser can usually expect to retain more than 80% of that practice's patients.

Deciding to buy another medical practice is just the first step. Actually purchasing a practice requires careful planning and knowledgeable and experienced business and legal advice to assure a fair purchase price and the actual transfer of the purchased practice's goodwill and conversion of patients to the purchaser. However, an established practice with existing and experienced staff, good management, and a decent reputation should be able to maintain the transferred practice better than new physicians in the area.

### **Summary**

This "once in a lifetime" set of circumstances provides established (typically group) medical practices with tremendous buying opportunities to increase their patient bases, market share, and geographic scope. ■

## Merging to Survive

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Division gets credit for its collections, and each Division is charged with its site expenses, just as in its former separate practice. However, there will also be an internal charge or "tax," to fund centralized operations.

Governance is likewise a blend of the individual Division and the larger group. Most operational, day-to-day decisions are made by the individual Divisions. However, decisions that affect the entire group, such as selection of PM system or EMR, or how to do billing, are made centrally, by a representative Board of Directors for the larger group.

In this way, by preserving substantial financial and operational autonomy at the site level, the GPWW makes it easier to merge. It reduces the amount of autonomy that the doctor must give up, and makes the decision to merge less painful.

Both the traditional merger and the GPWW/clinic without walls have benefits and drawbacks. To explore these issues further, talk with your HCG attorney/consultant to see how he or she can help. ■

## Drug Diversions: Is your Practice Prepared?

By: Jennifer B. Cohen, JD

The Centers for Medicare & Medicaid Services defines “drug diversion” as the diversion of a licit drug for illicit purposes. A drug diversion takes place when legal and medically necessary drugs are diverted from their intended purpose for uses that are illegal and/or not medically necessary. Examples of drug diversion include the following: medication theft with no documentation, medication theft with falsified documentation, theft of syringes from a sharps container to collect remnants, using or taking possession of a medication without a valid order or prescription, forging or modifying a prescription, and using or taking possession of medication waste (e.g., leftover, expired, unused, spilt, and contaminated medications).

The diversion of controlled substances from medical practices is not a new problem, but, with the opioid epidemic currently plaguing our country, it’s also not an abating problem. The potential for drug diversion is a legal and compliance issue but, more so, it is an employee health and patient safety issue.

Internal controls are essential to protect your practice and its employees and patients. The following should be done in order to prevent a drug diversion:

1. **Conduct background checks.** If your practice maintains an inventory of controlled substances, consider a policy that would require that a criminal background check be conducted for potential employees with controlled substance

access. If the employee is a physician or another practitioner with a state or federal controlled substances registration, also check to see if the potential employee’s controlled substances registrations have ever been revoked, surrendered, or denied.

2. **Prepare policies and procedures.** Prepare policies and procedures regarding the ordering, storing, inventorying, and administration of controlled substances. Also implement a policy for how drug diversions will be prevented, detected, reported, and investigated, as well as what corrective action will be taken. Remember that consistency is key – there should be policies for how diversions should be handled and they should be followed no matter what employee is suspected of diversion.
3. **Set the tone.** Orientation to the practice should include training regarding the policies and procedures related to controlled substances (e.g., how inventories and counts are to be conducted and how documentation should be completed and maintained). Emphasize the importance of recognition and reporting. Also include information related to disciplinary action in the case of diversion. Make sure that, from the beginning of employment, workers know that drug diversions are taken seriously and may result in termination. Thereafter, training related to controlled substances should take place at least annually.
4. **Implement audit procedures.** Random,

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## Drug Diversions: Is your Practice Prepared?

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unannounced audits should be conducted regularly. One of the telltale signs of diversion is sloppy record keeping. Your practice should set up an audit program to ensure that records are examined regularly to ensure completeness and accuracy.

5. **Secure controlled substances and limit access appropriately.** Controlled substances should be secured in a locked area at all times. The storage area should only be accessed to remove a dose of medication and it should be relocked before the accessing employee leaves the area. Access should be reasonably limited to certain individuals to minimize those who may be able to divert.
6. **Utilize video cameras.** Cameras are useful to monitor access to areas containing controlled substances. They can help deter diversions; they will also be useful in investigating if a diversion takes place.
7. **Drug test.** Have a reasonable suspicion drug testing policy. All employees who have access to controlled substances in your practice should be subject to drug testing if you have reasonable suspicion that they are stealing and/or using drugs. Failure to cooperate in a drug investigation (including failure to submit to a drug test) should be grounds for termination.
8. **Hold employees accountable.** Employees should be made aware that they will be held accountable for com-

pliance with laws as well as policies and procedures related to controlled substances. You should determine what types of repercussions are associated with different types of violations. What will happen to an employee who violates a record keeping policy? What happens to an employee who diverts controlled substances? The discipline should be consistent with the seriousness and frequency of the violation. Consider a zero-tolerance policy for diversion and impairment.

Sometimes, you do everything right but your practice still experiences a diversion. What should be done in response to a suspected drug diversion?

### 1. **Investigation**

- a. **Inventory Drug Supply.** Inventory the current drug supply, immediately. Note drugs, dosages, and quantity.
- b. **Audit records.** Review documentation to determine whether the drug counts reveal a loss. Compare drug counts against the inventory.
- c. **Interview staff.** Start with the individual that first reported the possible diversion. Ask open ended questions. Encourage confidentiality but don't promise absolute confidentiality. Document all of the facts, including alleged employees involved, locations, dates, and times. Gather as much information as possible before confronting the alleged diverter.

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- d. Review surveillance footage, if any.
- e. Suspension. If there is enough support for the allegation, suspend the alleged diverter, pending conclusion of the investigation.
- f. Confront alleged diverter. Try to identify when the diversions began, the method of diversion, what records need to be corrected, and an estimated amount of drug loss. You will need this information to satisfy your reporting obligations, which are discussed below.
- g. Conduct reasonable suspicion drug tests.

### **2. Review Findings and Determine Appropriate Corrective Action**

- a. Quality Assurance Reviews. Conduct reviews of patient charts to determine any quality assurance or liability issues.
- b. Notification. There are a number of reports that must be made after a drug diversion has been detected.
  - i. Drug Enforcement Agency. Appropriate reports, including an initial notification and DEA-106 form should be submitted to the DEA.
  - ii. State Enforcement Agency, if applicable. Depending on your state, you may be required to make a report to a local state enforcement agency. Be sure to seek legal counsel as to whether this is required.
  - iii. Professional Licensing Board. If the diverter is a licensed professional, he/she should be reported to his/her licensing board.

- iv. National Practitioner Data Bank. If the diverter is a physician or dentist, he/she should also be reported to the National Practitioner Data Bank.
  - v. Local Police. If you are able to determine who committed the drug diversion, whether it is an employee, patient, or visitor to your practice, you may consider contacting the local police department.
  - vi. Patient. If it is determined that a patient was harmed by the drug diversion, the patient should be informed of the circumstances of the drug diversion and its impact on the patient. Note that different jurisdictions have varying rules about patient reporting, so be sure to seek legal counsel to determine whether this is required and in what situations.
- c. Disciplinary Action. If an employee is determined to have committed drug diversion, he/she should be subject to discipline in accordance with your practice's policies and procedures. The employee should be disciplined in accordance with your practice's policies and procedures, whether the diversion occurred within the scope of employment or while the employee was off-duty. If the offender is someone other than an employee (e.g., a patient, a member of the cleaning staff, etc.), consider calling the police. Again, how you will handle different scenarios should be outlined in your policies and procedures.

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- d. Analysis Policies and Procedures. Take some time to identify the weaknesses in your policies and procedures (or implementation of the same) that allowed for a diversion to take place. Now is the time to revise any policies that failed, resulting in a diversion. ■

## Asset Purchase Agreements and Continuation of Coverage Under COBRA

By: Jennifer B. Cohen, JD

You have made the decision to sell your practice and retire or take a position where you are no longer responsible for the day-to-day decisions associated with owning a business. Buyer will be acquiring your Practice via an asset sale. But, if you sell, what happens to your employees?

Ideally, all of your employees would be retained by the buyer of your practice. Unfortunately, that is not always the case. Suddenly, your employees learn that they will be subject to termination as well as a fear that they will lose their health insurance benefits. You know about the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) but you're unsure how it works after you've sold your practice.

In case you are not all *that* familiar with COBRA, here's a primer: COBRA applies to employers with twenty or more employees. (Employers with fewer than twenty employees may be subject to COBRA-like requirements under state laws. These state law requirements are known as "mini-COBRA" laws.) It requires group health plans to provide continuation of coverage to employees,

former employees, spouses, former spouses, and dependent children when the employee's group health coverage is terminated because of a specific event, including death of the employee, termination or reduction in the employee's hours for any reason other than gross misconduct, an employee becoming entitled to Medicare, divorce or legal separation of an employee and his/her spouse, and a dependent's loss of coverage under the group health plan because he/she no longer qualifies as a dependent. Employers may require the employee to pay one hundred percent of the premiums for his/her COBRA continuation coverage, plus a two percent administration fee.

Now that you have the background - you're at the point where you are ready to discontinue your group health plan. You want to reassure your employees but are unsure what to tell them. After all, what are the responsibilities of the parties in an asset purchase under COBRA?

A group health plan is only required to offer COBRA continuation coverage to **qualified beneficiaries** and only after a **qualifying**

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# Asset Purchase Agreements and Continuation of Coverage Under COBRA

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event takes place.

**Qualified Beneficiaries.** A qualified beneficiary is any individual who was covered by your group health plan on the day before a qualifying event (more on this later) occurred. The individual must be an employee, the employee's spouse or former spouse, or the employee's dependent child. A child born or adopted by the employee during a period of continuation coverage is also automatically considered a qualified beneficiary.

**Qualifying Events.** Qualifying events are events that cause an individual to lose group health coverage. An asset sale, which results in the termination of the employee and loss of coverage under the seller's group health plan, is a qualifying event because the employee was terminated for a reason other than gross misconduct. Note that if the employee is hired by the buyer, the employee has not experienced a qualifying event.

Assuming you have identified qualified beneficiaries who have experienced a qualifying event, the final question is: which party (buyer or seller) is responsible for providing the COBRA continuation coverage?

So long that the seller maintains a group health plan after the sale, the seller's group health plan has the obligation to make COBRA continuation coverage available to

qualified beneficiaries with respect to that sale. However, if the seller ceases to provide any group health plan to any employee in connection with the asset sale, then the buyer may have the obligation to make COBRA continuation coverage available. The buyer will be required to provide COBRA coverage to qualified beneficiaries if it has a group health plan and if it continues the business operations of the seller without

***If the seller ceases to provide any group health plan to any employee in connection with the asset sale, then the buyer may have the obligation to make COBRA continuation coverage available.***

interruption or substantial change. In this situation, the buyer's group health plan has the obligation to begin such coverage on the later of the following two dates: (1) the date the seller ceased to provide any group health plan to any employee or (2) the date of the asset sale.

What if the buyer and seller wish for their COBRA obligations to be treated differently?

The seller and buyer can contractually allocate the responsibility to make COBRA continuation coverage available to the qualified beneficiaries. However, if the contractually responsible party fails to perform, then the party responsible under the regulation continues to have the obligation to make COBRA continuation coverage available to the qualified beneficiaries.

Discuss your obligations with an attorney. Critical questions include: whether the seller has ceased to provide group health plan benefits and whether the buyer is continuing the business without interruption or substantial change. ■

## Seven Steps to Developing a New Service

By: Joseph W. Gallagher, JD, LLM

Competition, reduced reimbursements, and new technology place pressure on your practice to develop new services. Whether you are contemplating a dramatic addition to your practice such as adding a new medical specialty to your multispecialty group, or simply adding a new diagnostic test – you should follow these steps to assure that you make a sound business decision.

### Step 1 – Measure Patient Demand

Nothing is more disappointing than launching a new service and not having any patients. But how do you measure patient demand without having the service?

First, count all your referrals out for the service. Most practices do not keep track of their referrals. To capture this information, create a form that your receptionist merely needs to check off each time a referral is made. If you track your referrals for a two week period, you can reliably extrapolate a year's utilization. The annual estimate that you calculated is probably lower than your actual patient demand since some of your patients will self-refer to specialists without your involvement. If your practice has a large referring network of health care providers, then you must assume that these providers are sending all of their patients elsewhere for services that you do not provide. To estimate the support you might receive from your referring sources, you need to compare the referrals you receive for bellwether diagnosis and relate the bellwether to the proposed service. As an ex-

ample, an ophthalmology practice wants to add a retina service. The practice receives 500 physician referrals a year for cataract. Cataract utilization is about as common as retina problems. Therefore, the practice can count on approximately 500 referrals for retina cases, assuming the quality of the service is equal to that of other providers and assuming that those referrals will change their own retina referral pattern.

How do you estimate the demand for a new service, one that has just recently become available? This is a little more difficult, but it is approached in the same manner. First, research the patients in your practice with the diagnosis that corresponds to the service. Of those patients, you have to estimate the percentage that may require the proposed service. To that amount, add those new patients who might be attracted to the practice as a result of your offering the service.

The last item to consider is the population trend within your market to project the long-term need for the service. Many diseases are linked to demographic segments of the populations, either by sex, by age, ethnically or otherwise. You need to adjust your demand projections based upon the trend (either positive or negative) in your key demographic.

### Step 2 – Research Payors

You need to contact your top ten payors and ask them their policy toward your service. Will they pay for referrals you make to

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yourself? What level will they reimburse you for the service? Are there limits as to how many times the service can be provided annually? Is the service linked to a particular diagnosis? Can only those patients with that diagnosis receive the service? Example: Some tests may be used for different diseases. Some payors will allow the tests only this way if there is a family history or other reasons to support providing the service. You need to know what the payors' requirements are for reimbursement so that you may adjust your utilization estimates.

Once you have established the payor payment requirements, you can project revenues from the service. To do this, you take the case potential as calculated in step 1, and spread the utilization according to payor, similar to that of other services within your practice. If 40% of your work utilization is Medicare, then allocate 40% of the service utilization allocated to Medicare. Be particularly aware of age, sex, and ethnic factors as they affect your payer mix. Once you've made the proper adjustments, you can project the potential annual revenues for your new service.

### **Step 3 – What Are Your Costs?**

You need to estimate all of the costs that you will incur when providing the services. These include costs of the new technology, personnel, facility, and supplies. When considering the equipment cost, you must consider the cost to purchase the equip-

ment and the cost to maintain the equipment. When estimating your facilities expense, you need to factor in any leasehold improvements required to accommodate your service in addition to the monthly rent. Personnel are always a large expense in providing any health care service. You need to consider cost of training, recruiting, and the benefits associated with any new hires. And lastly, don't overlook supplies. Diagnostic tests especially have a significant supply component that you must calculate. When calculating supplies, you need to calculate the amount that you will need to have "in inventory" in order to accurately project your monthly/annual expenses.

### **Step 4 – How Will You Operate the Service?**

A crucial step in considering the operational impact of any new service is to accurately judge your ability to produce that service. This is referred to as throughput planning. To determine your capacity, you need to consider the amount of time it will take to provide the service. In making these calculations, don't forget the time it takes to bring the patient to the service and the recovery time necessary after the service has been provided. Allow for delays to occur, due to problem patients.

Your personnel resources are an important factor when estimating your capacity. You might be able to operate at a much higher level if you have more people. You need to consider how your schedule will be affect-

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ed by your new service. Will you cluster all of the new service patients into one or two sessions per week, or will you provide the service as needed throughout the day? If you choose the latter, then allow for delays to occur due to lack of personnel, particularly if the service requires special training to provide.

Once you have estimated the throughput, you may need to reevaluate your potential new service income.

### **Step 5 – Create a Proforma**

The first year of any new service is the most critical. You should project monthly revenues and expenses for your new service for the first twelve months in order to get a clear picture as to the impact on your practice. When creating these projections, you should consider the amount of time your payors take in paying you. This delay must be factored into the revenue stream in order to properly estimate the cash flow impact to your practice. Typically, you will need to finance your investment in technology, equipment, and start-up cost for your new service. When creating your proforma, don't forget to include your promotional and finance cost as part of your start-up expenses.

### **Step 6 – How Will You Promote the Service?**

Any new service needs to be promoted. You need to get the word out to your ex-

isting patients, potential new patients and referring sources about your new service. Certainly, your website and social media are good forums for announcing the new service and offering potential referral sources and patients for the service educational and other pertinent material concerning the medical condition being addressed and its treatment options. Mailers, advertising are all part of getting the word out. Additionally, you might be able to get coverage of your new service in your local newspapers or radio talk shows. How easily that is accomplished is based upon your ability to show the press the uniqueness and benefit of the service being offered. A good way to get your point across is to relate a story about how your service has profoundly affected a patient's life. Being armed with this information is critical when presenting your story ideas to editors.

### **Step 7 – What are the Benefits?**

At the end of your analysis you have to decide whether this service is the right thing to do. First and foremost should be the medical reasons — does this service help patients? Next, you should consider the financial economic impact upon the practice. And lastly, don't overlook the strategic importance of providing the service such as securing your referring relationships, providing one-stop shopping and completing your "continuum of care."■

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## 2017 Goodwill Registry & Goodwill Registry Toolkit (Book & CD)

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The *Goodwill Registry* contains data organized by medical/dental specialty, state, location, and other practice characteristics. Many medical/dental practice advisors, valuation experts and others find the information published in the *Goodwill Registry* to be an extremely useful tool, not only for ad hoc and formal practice valuations, but also for practice value trend analysis and more.

For more information go to [www.healthcaregroup.com](http://www.healthcaregroup.com) online store click on Annual Surveys.

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