
# Leveraging Cost Accounting at Physician Practices

Anne Farmer
Vice President
TriNet Healthcare Consultants
October 23, 2013

# Outline

I. Introduction / Drivers

II. Approaches to Physician Costing Models

III. Macro Level: Practice Costs

IV. Micro Level: CPT and Encounter Costing



Strata Decision Summit 2013
CHICAGO | October 22 - 23

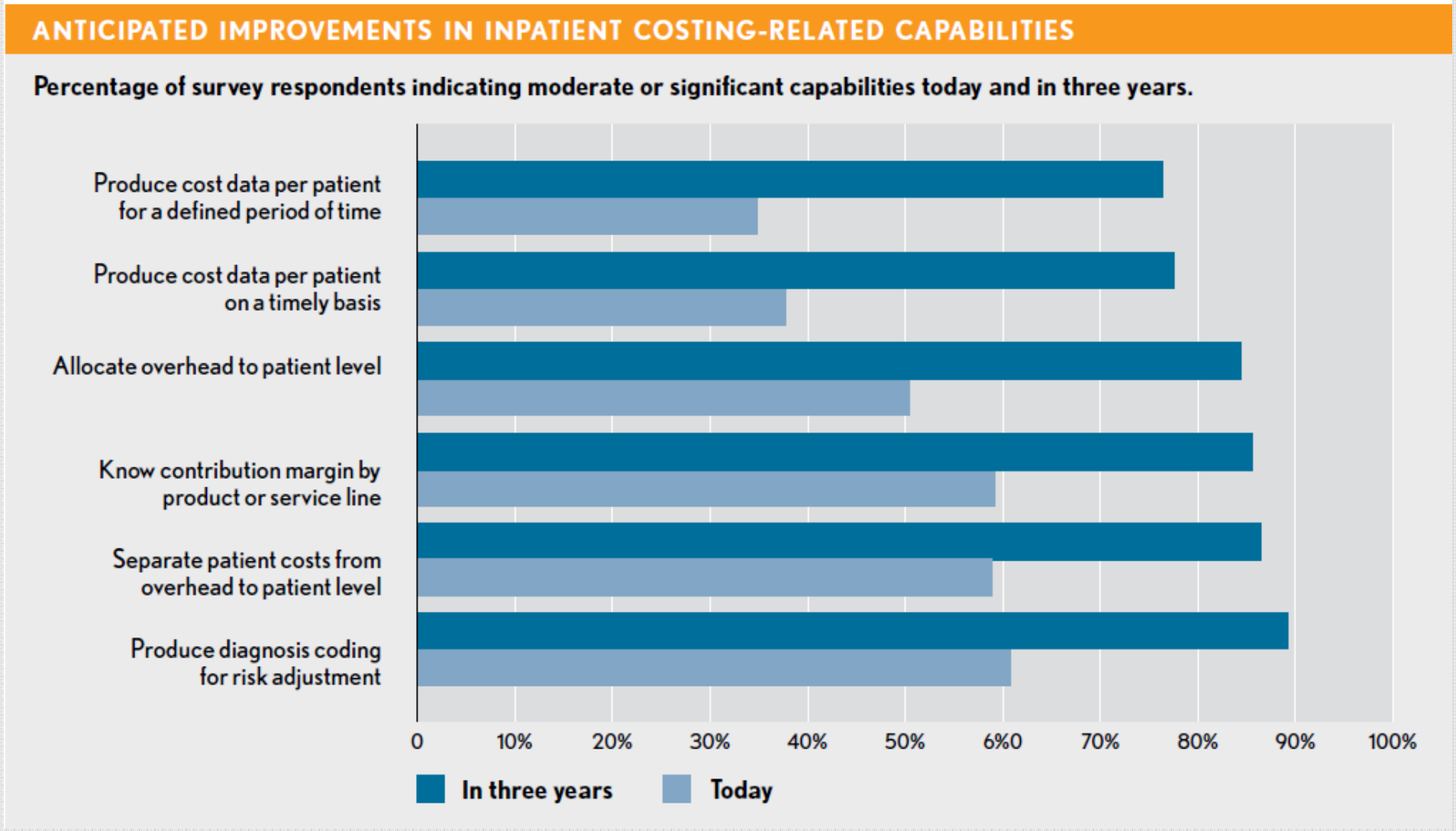
# New Role of Cost Accounting

***"Costing systems will have to be redesigned, repositioned, and re-implemented as providers create new, innovative organizational structures and relationships to capture market opportunities, update transactional systems, and make decisions based on data that went relatively unexamined before."***

| | Cost Accounting: The Present | Cost Accounting: Post Reform |
|---|---|---|
| **Focus** | . Product/Service Line<br>. Payer<br>. Overall Patient Population | . Specific services<br>. Specific population clusters<br>. Specific patients, in some instances |
| **Data Usage** | . Market volume and profit trends across several years<br>. Strategic planning and priorities<br>. Budgets | . Comparing financial results of care choices<br>. Evaluating bundled payment arrangements<br>. Evaluating make/buy opportunities<br>. Finding best practices<br>. Setting tactical priorities around departmental efficiencies and/or affecting outcomes |
| **Costing Approach** (method and frequency) | . Ratio of cost to charge<br>. RVUs<br>. Limited microcosting<br>. Annual cost finding | . Enhanced RVUs<br>. Increased microcosting<br>. More frequent standards revisions<br>. Monthly and/or "real time" costs |

Paul Selivanoff, "The Impact of Healthcare Reform on Costing Systems", Healthcare Financial Management, May 2, 2011.

# HFMA Value Project: Survey indicates healthcare organizations will improve costing capabilities significantly over next 3 years

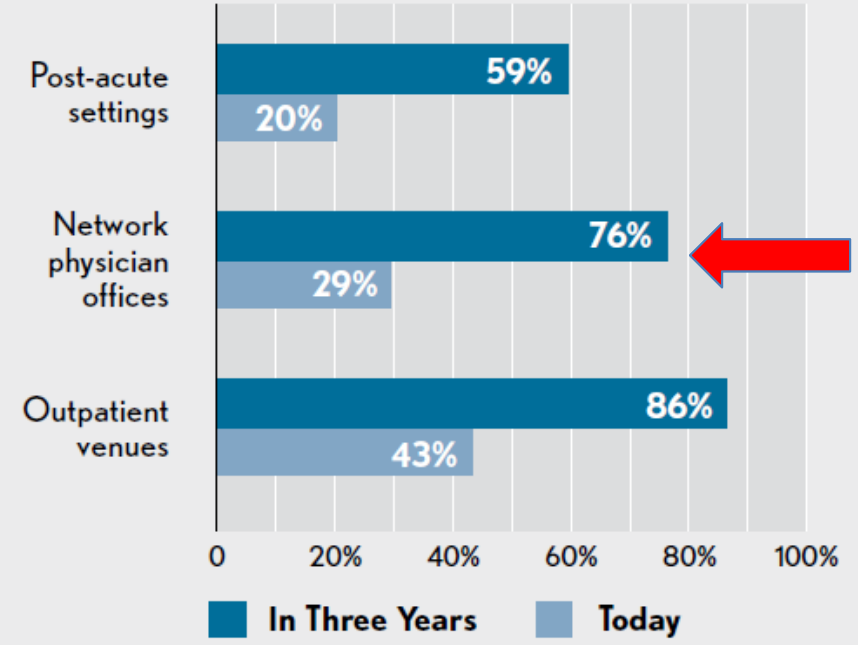



*Source: HFMA Value Project February 2012*

# HFMA Value Project: Cost accounting will expand to encompass other care settings (beyond hospital)

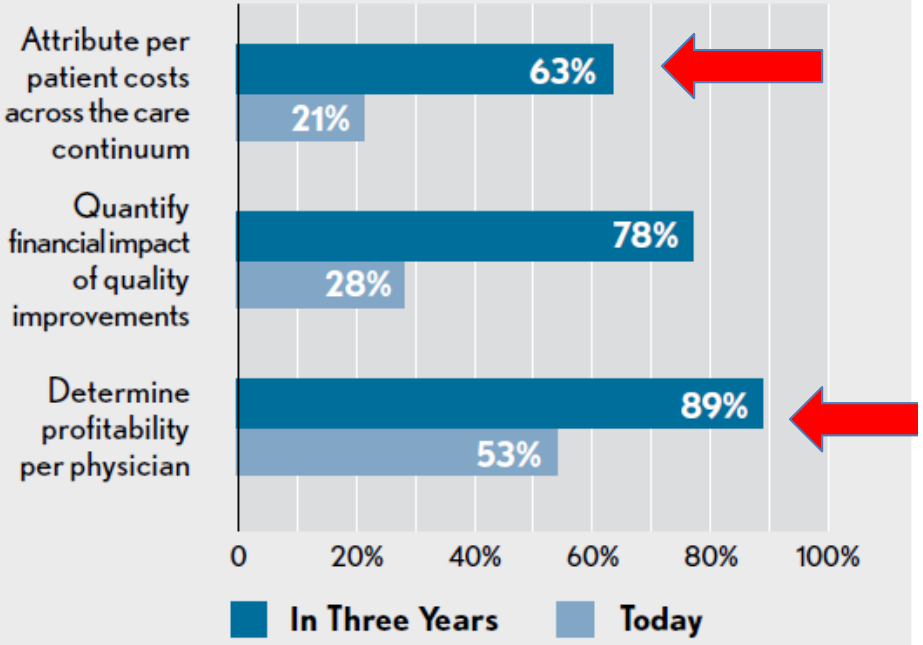
## ANTICIPATED IMPROVEMENTS IN COSTING-RELATED CAPABILITIES ACROSS CARE SETTINGS

Percentage of survey respondents indicating moderate or significant capabilities today and in three years.




## ANTICIPATED CROSS-ORGANIZATIONAL STRATEGIC COSTING DATA USE CAPABILITIES

Percentage of survey respondents indicating moderate or significant capabilities today and in three years.




*Source: HFMA Value Project February 2012*

# Drivers pushing healthcare organizations to develop physician cost data

- The now-critical need to know costs for the healthcare enterprise:
  - Hospital
  - Physician Practices
  - Nursing Home
  - Other entities
- ACO, bundled payments, and other global pricing
- Service line profitability analysis across the enterprise



Strata Decision Summit 2013
CHICAGO | October 22 - 23

# How does Physician Cost Accounting differ from Hospital Cost Accounting?

- Salary costs are the area of focus because they comprise the bulk of costs. In most practices, supply and drug costs are minimal.
- Important costs include:
  - Physician salaries
  - Malpractice (considered DIRECT)
  - Space/facility costs
- **Specialty** and **location** are important in physician costing, yet general ledger structures may not break out expenses at this level.
- Depending on accounting practices, there may be minimal or no overhead costing (i.e. corporate and overhead allocations may already be taking place in the G/L via journal entries).
- In many physician costing models, the challenge is not with service-item costing, but rather, with aligning costs by practice/specialty/location (or even physician, depending on the model) even before any service item or encounter level costing.



Strata Decision Summit 2013
CHICAGO | October 22 - 23

# EXAMPLE
# Cost Components for a Group Practice

- ***Salaries: Physician***
- ***Salaries:  Mid-Level Practitioners***
- Salaries: Clinical
- Salaries: Contract
- Salaries:  Mgmt/Supervisory
- Salaries: Support
- ***Benefits: Physician***
- Benefits: Other
- Drugs
- Medical Supplies
- Other Expenses
- Other Supplies
- Professional Fees
- Purchased Services Medical
- Purchased Services Other
- ***Rent & Lease***
- ***Insurance: Malpractice***
- Insurance: Other
- Interest
- Internal Purchased Services
- Maintenance & Repairs
- Bad Debt
- Depreciation
- Utilities
- *Allocated Central Admin*
- *Allocated Central Medical*
- *Allocated Corporate Services*
- *Allocated Site Specific*
- *Allocated Specialty Clinical*

# How does Physician Cost Accounting differ from Hospital Cost Accounting?

**SERVICE ITEM AND ENCOUNTER LEVEL COSTING**

- Service item costing is at the CPT level: The charge code/service item for costing will be the CPT code with possible exceptions of "homegrown" CPT codes to capture certain non-billable activities.
- Patient care activities encompass a broad range of activities for both physician and staff.
- In addition to direct caregiver time, a multitude of other activities are necessary to coordinate the care for the patient, including;
  - Responding to phone calls
  - Reviewing results of diagnostic tests
  - Dictation

*If the organization's cost accounting goals are centered on practice or physician profitability, CPT and encounter level costing may be low priority and perhaps not a part of the costing model at all!*



Strata Decision Summit 2013
CHICAGO | October 22 - 23

# Physician Cost Accounting CONSIDERATIONS

***Consider the type of physician practice model in determining the costing approach.*** *There are various models under which a physician practice may conduct business (e.g., a traditional medical group, a hospital-owned clinic, a professional corporation/management services organization, and more). Each of these models has different systems setups that dictate the way in which the costing model is to be built and implemented. These setups heavily influence how the feeder systems are interfaced and how costing and activity (billed and nonbilled) structures are to be built*.

"5 Ways to Better Understand Costing for Physician Practices"
David Clingo and Cesar Fernández-Mansilla
http://www.hfma.org/Content.aspx?id=3326

# Cost Accounting of Physician Practices

## *Macro Level*

## *Department / Practice Costing*

| Approach | Pro (Advantage) | Con (Disadvantage) |
|---|---|---|
| By Practice | Uses existing expense structures in the GL or accounting system<br><br>Costs of a CPT (e.g. 99201 New Patient Visit) will vary by each individual practice | Does not reflect unique cost of each physician |
| By Provider | More granular, reflects unique cost of each physician (compensation, staffing, other costs) | Will involve assignments and allocations of shared costs, including RN's and other Clinical Staff, Admin Staff, and Mid-Level Practitioners. |



Strata Decision Summit 2013
CHICAGO | October 22 - 23

# Example: Costing by Practice

## DERMATOLOGY

| | $ Month |
|---|---|
| NET REVENUE | $122,669 |
| | |
| DIRECT EXPENSES | |
| SALARY AND BENEFITS | $69,916 |
| OTHER EXPENSE (MALPRACTICE, SUPPLY, ETC). | $3,388 |
| TOTAL DIRECT COSTS | $73,304 |
| | |
| SUPPORT COSTS | $60,637 |
| TOTAL PRACTICE COSTS | $133,941 |
| | |
| DIRECT MARGIN | ($11,272) |
| | |
| INDIRECT COSTS (Allocation Statistic) | |
| CLINICAL FLOATS (Provider FTE's) | $1,182 |
| FINANCE (Provider FTE's) | $763 |
| CODING/CHARGE (Gross Rev) | $1,765 |
| PRE REGISTRATION (Gross Rev) | $514 |
| CASH/CENTRAL REGISTRATION (Gross Rev) | $1,166 |
| TRANSCRIPTION (Gross Rev) | $251 |
| TELECOMMUNICATIONS (Provider FTE's) | $1,115 |
| INFO SYSTEMS (Provider FTE's) | $1,243 |
| ADMINISTRATION (Provider FTE's) | $3,594 |
| FACILITIES (Provider FTE's) | $8,864 |
| REFERRAL MGMT (Gross Rev) | $889 |
| PURCHASING (Provider FTE's) | $1,841 |
| HUMAN RESOURCES (Provider FTE's) | $419 |
| SUBTOTAL INDIRECT COSTS | $23,606 |
| | |
| PROFIT (LOSS) | ($34,878) |

# Physician-Specific Costing Models

***IMPLICATIONS***

- Cost accounting systems are generally *not* structured to accept this detail.
- A physician-specific department would need to be created within the encounter data, via the data integration from the practice management system.
- Assuming that expenses are not detailed by provider in the general ledger, detailed breakouts of expenses by provider will need to be developed and then maintained.
- The organization needs to consider whether, philosophically, physician-specific costing makes sense and is aligned with its goals and incentives.



Strata Decision Summit 2013
CHICAGO | October 22 - 23

# Physician Cost Accounting

## Approach: Physician-Specific Costing

| Type of Cost | Strategy |
|---|---|
| Physician Salary & Benefits | Break out by individual physician (create physician "cost centers" within the cost model) |
| Clinical Salaries & Benefits (RN & Other) | Assign to physician level based on a time study or staffing schedules |
| Mid-Level Practitioners | Assign to individual physicians based on time study or other allocation assumptions |
| Malpractice | Use physician-specific amounts |
| Education / Travel | Use physician-specific amounts |
| Supplies & Other | Allocate across physicians based on RVU's, physician FTE's, or another statistic |
| Support & Overhead Costs | Allocate to practices first (using relevant statistic), then to physician level using an MD-specific statistic such as RVU's, physician FTE's, or billed charges |

# Cost Reclassifications and Allocations

Reclassifications will need to be set up to realign costs across practices and/or locations:

Provider Costs with Non-Provider costs: In some multi-specialty practices, Provider costs may be centralized while Non-Provider costs are not (or vice versa)

Practice Support: includes Primary Care and Specialty Administration and Support departments; e.g.

- OB/Gyn Support
- Surgical Specialty Support
- Behavioral Health Admin

*By reassigning these costs via reclassifications, they are treated as **direct** costs in the cost model rather than indirect.*



Strata Decision Summit 2013
CHICAGO | October 22 - 23

# Overhead Allocation

**Compile Statistics**: The list of necessary overhead allocation statistics within a physician costing model is typically shorter than a hospital's:

- Total FTE's
- Physician/Provider FTE's *
- RVU's
- Square footage
- Revenue

* *Physician/Provider FTE's are often selected as the "default" statistic for fixed costs; those costs that the physicians feel should be borne equally by all.*



Strata Decision Summit 2013
CHICAGO | October 22 - 23

# Examples: Allocation Statistics

| Statistic | Cost to Allocate |
|---|---|
| Physician FTE's | I.T.<br>Finance<br>Admin and General<br>Physician Recruitment<br>Other Fixed Costs |
| Work RVU's | Specialty Support Services<br>Other types of Practice Support<br>Medical Records<br>Care Coordination |
| Total FTE's | Human Resources<br>Payroll |
| Square Footage | Rent/Occupancy Costs<br>Facilities Management |
| Revenue | Billing / Revenue Operations<br>Contracting<br>Payor Relations |
| Clinical Equipment – Estimated Value | Biomedical Engineering |



Strata Decision Summit 2013
CHICAGO | October 22 - 23

# Overhead Allocation

**Categorize Indirect Costs**: If practice support costs are part of the overhead allocation process (vs. being reclassed), it will be important to categorize indirect costs into reporting categories: (see sample definitions below)

| Category of Overhead | Definition |
|---|---|
| Practice Support | Costs not incurred directly by the practice that are related to (a) the provision and care or services at the practice location and/or (b) could be reasonably expected to be a cost a practice would have to incur to conduct business as a standalone practice. |
| Corporate Overhead | Centralized costs/functions that (a) enhance the service, value and efficiency of the practice and/or (b) provide necessary legal, regulatory, and policy consistency across the organization. |



Strata Decision Summit 2013
CHICAGO | October 22 - 23

# Cost Accounting of Physician Practices

## *Micro Level*

## *CPT & Encounter Costing*

| Approach | Pro (Advantage) | Con (Disadvantage) |
|---|---|---|
| **Medicare RBRVS Values** | **Industry standard, explainable to physicians** | **Not customized to the individual practice or organization**<br><br>**RVU values not available for any "homegrown" codes used in billing** |
| **RVU Studies (practice-specific)** | **Specific to the practice**<br><br>**Buy-in from physicians** | **Requires significant resources for implementation as well as maintenance on an ongoing basis** |



Strata Decision Summit 2013
CHICAGO | October 22 - 23

# Cost Accounting of Physician Practices

| Approach | Pro (Advantage) | Con (Disadvantage) |
|---|---|---|
| Activity Based Costing (ABC) | Views costs by activity rather than financial category<br><br>Activity-based approach can result in more accurate assignment of costs to service item/CPT level | Activity breakout introduces more complexity<br><br>Potentially significant time to implement |
| Time-Driven Activity Based Costing (TDABC) | "Pull" or bottom-up methodology identifies unused efficiency and/or unused capacity cost variance | Requires developing time standards or collecting actual times (vs. using RVU's)<br><br>Quest for perfect cost drivers will have impact on implementation timeline, and ongoing maintenance |



Strata Decision Summit 2013
CHICAGO | October 22 - 23

# RBRVS (Resource-Based Relative Value Scale) Types of RVU's

- **Work RVU's**: Measures the work effort of a physician to complete the procedure.
- **Practice RVU: Non-Facility:** Measures the cost of the practice to complete the procedure in a physician's office.
- **Practice RVU: Facility:** Measures the cost of the practice to complete the procedure in a non physician office setting.
  - Hospital
  - ASC – Ambulatory Surgery Center
  - CORF – Comprehensive Outpatient Rehabilitation Facility
  - IDTF – Independent Diagnostic Testing Facility
- **Malpractice RVU**: Measures the cost of the Malpractice for the procedure.

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html



Strata Decision Summit 2013
CHICAGO | October 22 - 23

# ACTIVITY-BASED COSTING

- Definition: A method of measuring cost and performance of activities and products. ABC assigns costs to activities based on their use of resources, and assigns costs to products based on their use of activities.




Strata Decision Summit 2013
CHICAGO | October 22 - 23

# Activity-Based Costing

- How does ABC differ from traditional costing?
  - Costs traditionally treated as fixed or overhead receive more attention in ABC, and are assigned on a true "cause-and-effect" basis.
  - Views costs by activity rather than financial category.

- ABC introduces a language that can be used by the cost accountant and the clinician, who already views costs by activity.

- "An activity-based system aligns organizational information with the business mission and operations rather than financial transactions. It tears down the barriers that segregate financial information from other information."

Mary Lee Geishecker
"New Technologies Support ABC"
Management Accounting, March 1996



Strata Decision Summit 2013
CHICAGO | October 22 - 23

# Benefits of Activity-Based Costing

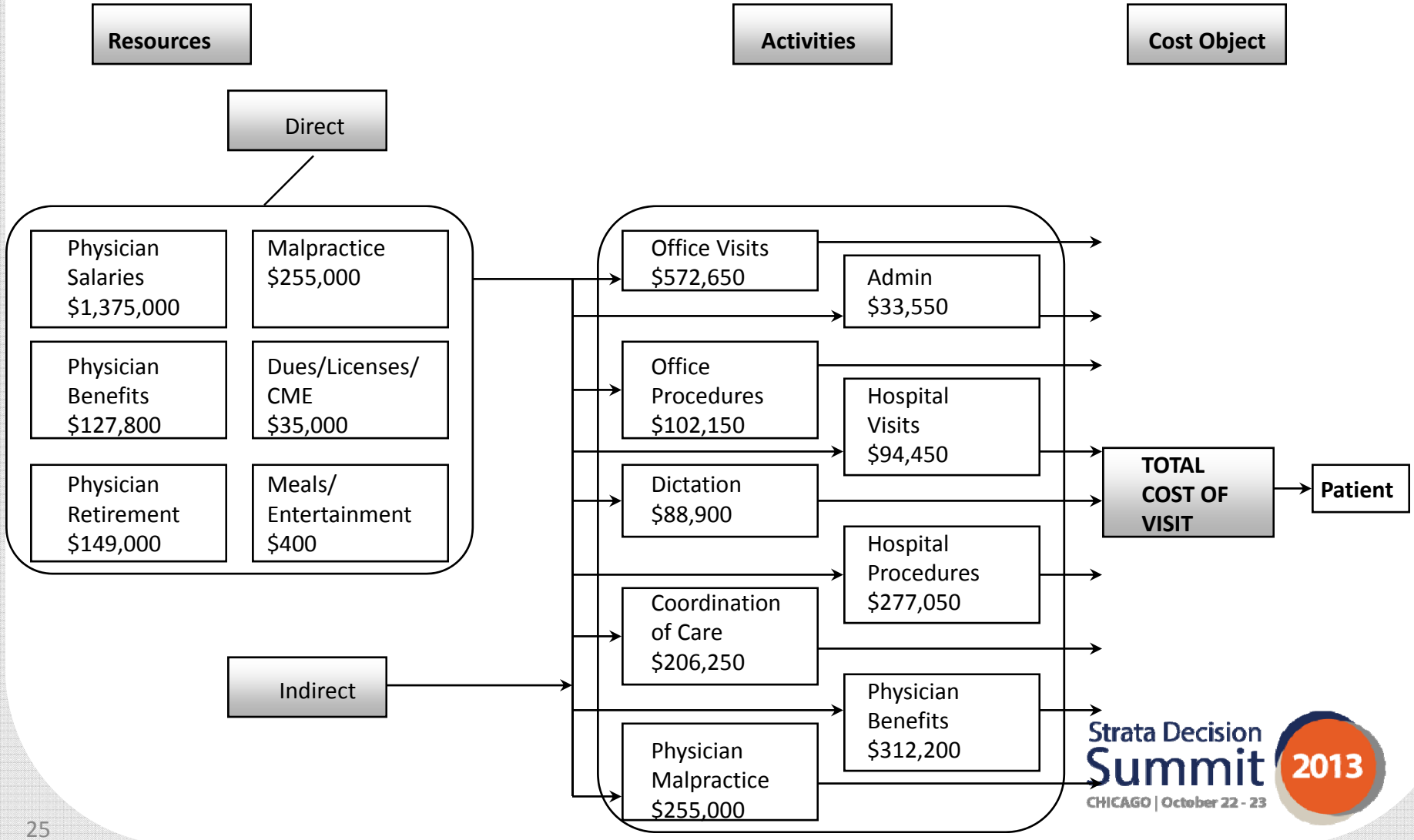
- Leads to an increased understanding of the chain of activities that help determine costs.
- Helps organizations obtain better information about their existing processes and activities so the efficiency of operations can improve continuously.
- An organization is able to rationalize and optimize its deployment of people, capital and other assets.



Strata Decision Summit 2013
CHICAGO | October 22 - 23

# Activity-Based Flow Chart

## *Step 1: Assign Costs to Activities*



# ABC Example

## *Step 2: Assign Activities to Products*

## Compile RVU's (Medicare RBRVS Values)

| | | | *RVU Values* | | | | | | *Weighted RVU's* | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CPT | CPT Name | Volume | Work | Work: Office Visits | Work: Office Procedures | Work: Hosp Procedures | Practice Expense | Malpractice | Work | Work: Office Visits | Work: Office Procedures | Work: Hosp Procedures | Practice Expense | Malpractice |
| 99201 | New Patient Level 1 | 4 | 0.48 | 0.48 | | | 0.77 | 0.04 | 1.92 | 1.92 | | | 3.08 | 0.16 |
| 99202 | New Patient Level 2 | 6 | 0.93 | 0.93 | | | 1.19 | 0.07 | 5.58 | 5.58 | | | 7.14 | 0.42 |
| 99203 | New Patient Level 3 | 70 | 1.42 | 1.42 | | | 1.61 | 0.14 | 99.40 | 99.40 | | | 112.70 | 9.80 |
| 99204 | New Patient Level 4 | 225 | 2.43 | 2.43 | | | 2.18 | 0.23 | 546.75 | 546.75 | | | 490.50 | 51.75 |
| 99205 | New Patient Level 5 | 25 | 3.17 | 3.17 | | | 2.55 | 0.27 | 79.25 | 79.25 | | | 63.75 | 6.75 |
| 99211 | Est Patient Level 1 | 550 | 0.18 | 0.18 | | | 0.41 | 0.01 | 99.00 | 99.00 | | | 225.50 | 5.50 |
| 99212 | Est Patient Level 2 | 870 | 0.48 | 0.48 | | | 0.77 | 0.04 | 417.60 | 417.60 | | | 669.90 | 34.80 |
| 99213 | Est Patient Level 3 | 410 | 0.97 | 0.97 | | | 1.09 | 0.07 | 397.70 | 397.70 | | | 446.90 | 28.70 |
| 99214 | Est Patient Level 4 | 180 | 1.50 | 1.50 | | | 1.53 | 0.10 | 270.00 | 270.00 | | | 275.40 | 18.00 |
| 99215 | Est Patient Level 5 | 10 | 2.11 | 2.11 | | | 1.95 | 0.14 | 21.10 | 21.10 | | | 19.50 | 1.40 |
| 99384 | Prev visit new age 12-17 | 5 | 2.00 | 2.00 | | | 1.82 | 0.13 | 10.00 | 10.00 | | | 9.10 | 0.65 |
| 99385 | Prev visit new age 18-39 | 35 | 1.92 | 1.92 | | | 1.79 | 0.13 | 67.20 | 67.20 | | | 62.65 | 4.55 |
| 99386 | Prev visit new age 40-64 | 10 | 2.33 | 2.33 | | | 1.95 | 0.15 | 23.30 | 23.30 | | | 19.50 | 1.50 |
| 99394 | Init pm e/m new pat 65+ yrs | 15 | 1.70 | 1.70 | | | 1.57 | 0.10 | 25.50 | 25.50 | | | 23.55 | 1.50 |
| 99395 | Prev visit est age 18-39 | 2250 | 1.75 | 1.75 | | | 1.59 | 0.10 | 3,937.50 | 3,937.50 | | | 3,577.50 | 225.00 |
| 99396 | Prev visit est age 40-64 | 830 | 1.90 | 1.90 | | | 1.65 | 0.12 | 1,577.00 | 1,577.00 | | | 1,369.50 | 99.60 |
| 99397 | Per pm reeval est pat 65+ yr | 60 | 2.00 | 2.00 | | | 1.83 | 0.13 | 120.00 | 120.00 | | | 109.80 | 7.80 |
| 59400 | Obstetrical Care | 880 | 32.16 | | | 32.16 | 22.07 | 8.96 | 28,300.80 | | | 28,300.80 | 19,421.60 | 7,884.80 |
| 59510 | Cesarean delivery | 425 | 35.64 | | | 35.64 | 24.05 | 10.15 | 15,147.00 | | | 15,147.00 | 10,221.25 | 4,313.75 |
| 54150 | Circumcision | 775 | 1.90 | | | 1.90 | 2.46 | 0.23 | 1,472.50 | | | 1,472.50 | 1,906.50 | 178.25 |
| 59400 | Amniocentesis | 260 | 32.16 | | 32.16 | | 22.07 | 8.96 | 8,361.60 | | 8,361.60 | | 5,738.20 | 2,329.60 |
| 59025 | Non-Stress Test | 1030 | 0.53 | | 0.53 | | 0.79 | 0.13 | 545.90 | | 545.90 | | 813.70 | 133.90 |
| 58100 | Endometrial Biopsy | 70 | 1.53 | | 1.53 | | 1.49 | 0.26 | 107.10 | - | 107.10 | | 104.30 | 18.20 |
| | ***Total Weighted RVU's*** | | | | | | | | **61,633.70** | **7,698.80** | **9,014.60** | **44,920.30** | **45,691.52** | **15,356.38** |



Strata Decision Summit 2013
CHICAGO | October 22 - 23

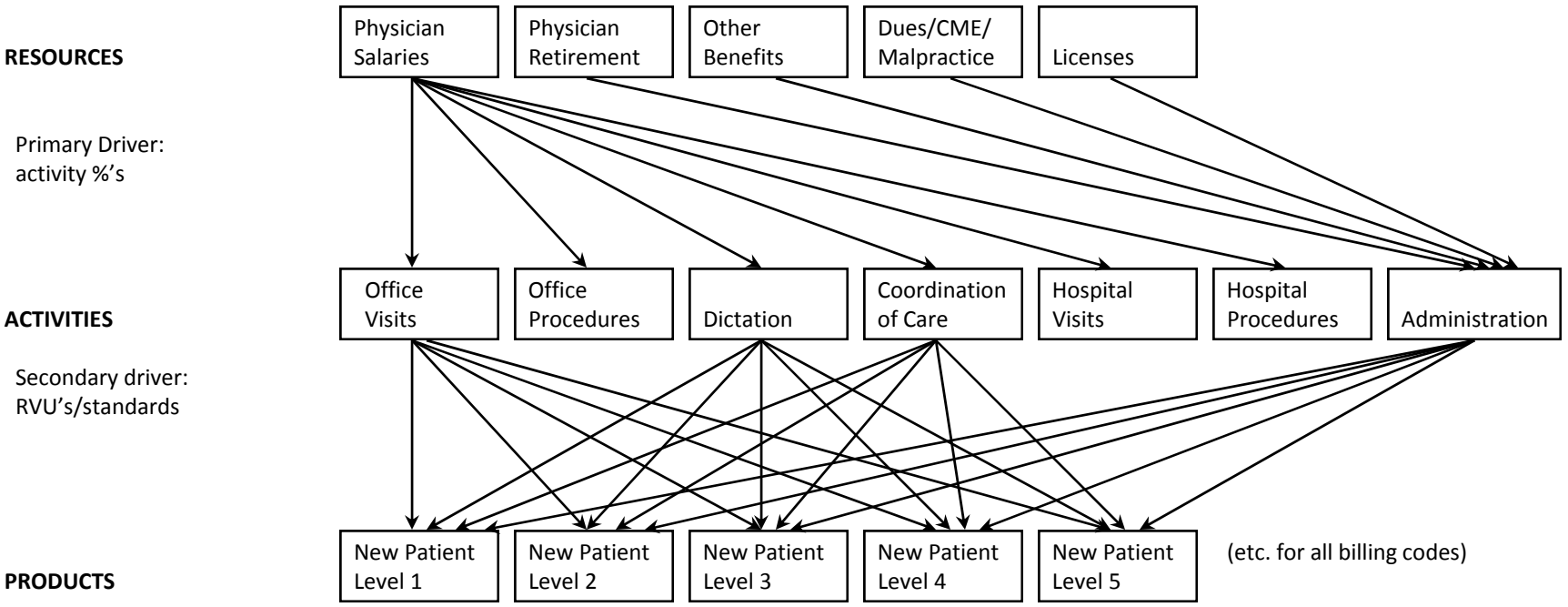
# ABC Example:
# Determine Per Unit Cost, by Activity

| | | *Per Unit Cost* | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| CPT | CPT Name | Office Visits (Work RVU's) | Office Procedures (Work RVU's) | Dictation (PE RVU's) | Coord of Care (PE RVU | Admin (PE RVU) | Hospital Procs (Work RVU's) | Physician Benefits (Work RVU's) | Malpractice (Malpractice RVU's) |
| 99201 | New Patient Level 1 | $35.70 | $0.00 | $1.50 | $3.48 | $0.57 | $0.00 | $2.43 | $0.66 |
| 99202 | New Patient Level 2 | $69.18 | $0.00 | $2.32 | $5.37 | $0.87 | $0.00 | $4.71 | $1.16 |
| 99203 | New Patient Level 3 | $105.62 | $0.00 | $3.13 | $7.27 | $1.18 | $0.00 | $7.19 | $2.32 |
| 99204 | New Patient Level 4 | $180.75 | $0.00 | $4.24 | $9.84 | $1.60 | $0.00 | $12.31 | $3.82 |
| 99205 | New Patient Level 5 | $235.79 | $0.00 | $4.96 | $11.51 | $1.87 | $0.00 | $16.06 | $4.48 |
| 99211 | Est Patient Level 1 | $13.39 | $0.00 | $0.80 | $1.85 | $0.30 | $0.00 | $0.91 | $0.17 |
| 99212 | Est Patient Level 2 | $35.70 | $0.00 | $1.50 | $3.48 | $0.57 | $0.00 | $2.43 | $0.66 |
| 99213 | Est Patient Level 3 | $72.15 | $0.00 | $2.12 | $4.92 | $0.80 | $0.00 | $4.91 | $1.16 |
| 99214 | Est Patient Level 4 | $111.57 | $0.00 | $2.98 | $6.91 | $1.12 | $0.00 | $7.60 | $1.66 |
| 99215 | Est Patient Level 5 | $156.95 | $0.00 | $3.79 | $8.80 | $1.43 | $0.00 | $10.69 | $2.32 |
| 99384 | Prev visit new age 12-17 | $148.76 | $0.00 | $3.54 | $8.22 | $1.34 | $0.00 | $10.13 | $2.16 |
| 99385 | Prev visit new age 18-39 | $142.81 | $0.00 | $3.48 | $8.08 | $1.31 | $0.00 | $9.73 | $2.16 |
| 99386 | Prev visit new age 40-64 | $173.31 | $0.00 | $3.79 | $8.80 | $1.43 | $0.00 | $11.80 | $2.49 |
| 99394 | Init pm e/m new pat 65+ yrs | $126.45 | $0.00 | $3.05 | $7.09 | $1.15 | $0.00 | $8.61 | $1.66 |
| 99395 | Prev visit est age 18-39 | $130.17 | $0.00 | $3.09 | $7.18 | $1.17 | $0.00 | $8.86 | $1.66 |
| 99396 | Prev visit est age 40-64 | $141.33 | $0.00 | $3.21 | $7.45 | $1.21 | $0.00 | $9.62 | $1.99 |
| 99397 | Per pm reeval est pat 65+ yr | $148.76 | $0.00 | $3.56 | $8.26 | $1.34 | $0.00 | $10.13 | $2.16 |
| 59400 | Obstetrical Care | $0.00 | $0.00 | $42.94 | $99.62 | $16.21 | $265.97 | $162.90 | $148.79 |
| 59510 | Cesarean delivery | $0.00 | $0.00 | $46.79 | $108.56 | $17.66 | $294.75 | $180.53 | $168.55 |
| 54150 | Circumcision | $0.00 | $0.00 | $4.79 | $11.10 | $1.81 | $15.71 | $9.62 | $3.82 |
| 59400 | Amniocentesis | $0.00 | $364.42 | $42.94 | $99.62 | $16.21 | $0.00 | $162.90 | $148.79 |
| 59025 | Non-Stress Test | $0.00 | $6.01 | $1.54 | $3.57 | $0.58 | $0.00 | $2.68 | $2.16 |
| 58100 | Endometrial Biopsy | $0.00 | $17.34 | $2.90 | $6.73 | $1.09 | $0.00 | $7.75 | $4.32 |
| | **Total Weighted RVU's** | 7,698.80 | 9,014.60 | 45,691.52 | 45,691.52 | 45,691.52 | 44,920.30 | 61,633.70 | 15,356.38 |
| | **Total Costs** | $572,650 | $102,150 | $88,900 | $206,250 | $33,550 | $371,500 | $312,200 | $255,000 |
| | ***Cost per RVU*** | **$74.38** | **$11.33** | **$1.95** | **$4.51** | **$0.73** | **$8.27** | **$5.07** | **$16.61** |



Strata Decision Summit 2013
CHICAGO | October 22 - 23

# Activity Based Costing
# Process View






Strata Decision Summit 2013
CHICAGO | October 22 - 23

# COSTING GOALS FOR PHYSICIAN PRACTICES

- Approach must support goals of:
  - Analyzing managed care contracts and pricing proposals
  - Providing costs-of-care information for the healthcare enterprise
  - Managing group practice profitability
- System must be maintainable.
- System should not be overly complex: “Be directionally right, not precisely wrong!”
- Approach should recognize uniqueness of each specialty and practice, yet achieve consistent results to the extent possible.



Strata Decision Summit 2013
CHICAGO | October 22 - 23

Contact information:

Anne Farmer
Vice President
TriNet Healthcare Consultants
P.O. Box 361
Westford, MA 01886
617-899-6760
annef@trinethealth.com