

PHYSICIAN PRACTICE OPTIONS™

March 15, 1999

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Health Care Premiums Are Rising, But Physician Income Remains Stagnant

Health care premiums are predicted to increase this year, according to recent surveys, but these increases will not result in increases to physician income, experts say. In fact, physicians are becoming so frustrated by recent stagnant earnings that, some experts predict, they will begin to negotiate forcefully with payers this year to increase reimbursement rates next year.

For physicians, getting a large share of what purchasers pay for premiums will not be easy. Premium increases are being driven by a rise in pharmaceutical costs and consumer demand for increased benefits and access to providers. The cost of practicing medicine is rising so quickly that the increases have eroded the gains physicians have made through increased productivity over the last few years as they have worked to practice more efficiently and effectively as managed care enrollment has increased.

Despite marked increases in productivity, compensation has remained nearly stagnant, according to the *Physician Compensation and Production Survey: 1998 Report Based on 1997 Data* conducted by the Medical Group Management Association. MGMA is an organization in Englewood, Colo., that represents 5,725 physician practices. (See "Compensation Stagnant, Costs and Productivity Rise.")

"Ideally, when premiums go up, physicians should get more income," says Peter Grant, the head of the health law division of Davis Wright Tremaine, a law firm in San Francisco. "There is certainly a pent-up demand among physicians for an

increase in disbursements. But the increases in health care costs and premiums are resulting in large part from drug costs and benefit increases. It may be some time before physicians see any significant growth in their incomes."

Other experts agree. "Generally, I don't see physicians getting a bigger share of premium dollars anytime soon," says Richard Liliedahl, MD, a health care consultant with Milliman & Robertson, actuaries and consultants in Seattle. A member of the editorial Advisory Board of *Physician Practice Options*, Liliedahl believes two factors are helping to keep compensation levels flat: the rising cost of practicing medicine and physicians' lack of business expertise. "Within health systems, there isn't more money to give them," Liliedahl says. "Since most practices aren't run like businesses, costs continue to rise without the leadership and management expertise necessary to implement cost-saving measures."

Seeing production and premiums rising but income remaining stagnant is frustrating to physicians, says John Burns, MD, a health care consultant in Fort Lauderdale, Fla. "You wouldn't be hearing all this talk about physicians organizing unions if they weren't frustrated," says Burns, referring to efforts by physicians in several states, including California, New York, and Pennsylvania, to form collective bargaining organizations. "They know that a huge amount of money in the \$1 trillion health care industry is going to managed care organization stockholders and the busi-

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Today's Aging Baby Boomers Are Tomorrow's Medicare Recipients

By the end of the year, 12 million baby boomers will be age 50 or older. But that 12 million is only 15% of the 80 million born between 1946 and 1964. So many babies were born after World War II that the volume changed obstetrical care dramatically. If past is prologue, these 80 million, as aging adults, could once again alter how health care is delivered.

As increasing numbers of these Americans develop diseases that require medical attention, more physicians will be seeing more of them. It's important, then, for physicians to recognize that attitudes among adults in this age group differ sharply from the attitudes of the current 33.6 million Medicare recipients. Compared with today's older citizens, men and women born between the late 1940s and the early 1960s are likely to:

- Be more inclined to question authority figures and institutional ways of operating
- Use personal computers and other sources more often to obtain consumer health information
- Be more concerned about exercise, diet, health, and wellness
- Be more inclined to seek alternative treatments

Today's middle-age adults have been the driving force behind the multi-billion-dollar alternative medicine business and have done so without any encouragement from the medical establishment. In 1997, these Americans visited alternative health practitioners twice as often as they visited primary care physicians, according to a recent article in JAMA. Of those in this group who visited alternative health practitioners, 72% did so without first consulting their physicians.

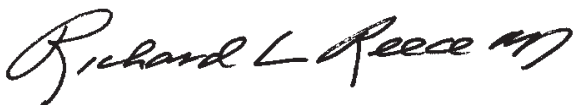
This generation of Americans is seeking patient-centered health care from physicians—a form of practice that could be described as high-tech and high-touch medicine. "High-tech" would include physicians who are highly competent, promote excellence in practice, are highly objective and scientific, and use the latest and best technology. "High-touch" refers to the quality of patient interactions, and would include physicians who are warm, caring, strong patient advocates, and appear to be concerned personally and professionally about their patients.

A survey of 6,000 patients and their family caregivers after hospital discharge shows that patients want physicians who:

- Respect their dignity, values, preferences, and needs, even if these subjective aspects aren't scientifically valid
- Provide information, communication, education, and coordination of care
- Can provide physical comfort, meaning pain management and help with the activities of daily living
- Offer emotional support by alleviating fear and anxiety about their patient's clinical status
- Recognize and accommodate family members and friends as caregivers and decisionmakers
- Help in easing, and in the understanding of, the transition to a new health status with advice on medication, changes in diet, and plans for continuing care

The results of this survey were published in the definitive work on patient care, *Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care*, published in 1993 by Jossey-Bass, San Francisco.

In short, those 80 million patients want cost-effective care that gives them choice, quality, and convenience—and they want physicians to be supportive partners in their health care efforts.



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Physician Practice Options is published by Premier Healthcare Resource, Inc., Parsippany, N.J.

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Subscription Price: \$299, 12 issues
 Issue Price: \$25 each

Practice Values Varying More Widely

Before a home is sold, a buyer or real estate agent has the property appraised. The appraiser examines the property, the condition of the home, and seeks data on comparative recent sales. After analyzing these mostly objective criteria, the appraiser sets a market value on the home.

A similar process is needed if a physician is selling a practice to a hospital or a physician practice management company (PPMC) or if the physician is merging with or acquiring another practice. The difference between selling a home and selling a physician practice, however, is that many more subjective criteria go into the appraisal of a physician practice, making the valuation much more difficult than appraising a home.

"Accurate practice valuation is important to both physicians and purchasers, and it frequently is more subjective than objective," says William Cleverly, president of the Center for Healthcare Industry Performance Studies, researchers in Columbus, Ohio, that have conducted studies on practice valuation patterns and purchase prices. "The method used to value a practice, and issues like payer mix and internal compensation formulas, can result in a wide range of values being placed on seemingly similar practices."

The first step in determining practice value and negotiating a price is to understand the local market for physician practices, says Richard C. Holdren, president of RH Medical Group, a practice brokerage firm in Houston. Appraising the value of a medical practice has never been an exact science, he says, and it requires an understanding of the health care market. "Where hospitals and PPMCs compete for acquisitions, purchase prices have climbed sharply in the last couple of years," says Holdren. "Where demand is low and managed care has eroded earnings, prices have dipped. The market is volatile. Some hospitals have experienced annual losses of \$100,000 per physician on the practices they bought, according to some surveys, and large PPMCs, such as MedPartners, have experienced major losses. Other PPMCs are getting out of the business

altogether. As a result, prices can vary more widely than ever."

Physicians who are approached by purchasers are in the best negotiating position, says George Lowe, MD, chairman of Maryland Personal Physicians Inc., a 60-member group in Baltimore that entered into a partnership with a local hospital system, Mercy Medical Center, also in Baltimore. "We brought excellent assets to the table, especially our reputation, but our biggest strength was that we knew what we were worth," Lowe says.

Market Share Value

The issues to examine when determining a practice's value are the age of the practice, its assets, and its reputation in the community, experts say. A physician is more likely to command a top price if his or her practice is growing and has a significant market share, says David Shuffler, a valuation consultant in Glen Rock, N.J. "Buyers like to see doctors who work hard and attract lots

doctors with diversified income sources that reflect local market trends," he says.

Obviously, market conditions and location play important roles in practice valuation, says Holdren. In rural areas, valuations are likely to be low simply because there are relatively few buyers for such practices. On the other hand, PPMCs sometimes pay high prices when they first enter new territories, including rural areas with an increasing rate of population growth. Hoping to gain credibility with local payers, they may spend whatever it takes to acquire well-known physicians' practices.

But selling a practice to a PPMC can be risky because the PPMC industry is currently experiencing financial problems, Holdren says. "PPMC stocks have fallen through the floor in recent months. Physicians should be very careful about what they're getting into, how much stock they're being offered as part of the purchase price, and what buyout strategy is offered if their management company gets into trou-

"We brought excellent assets to the table, especially our reputation, but our biggest strength was that we knew what we were worth."

—George Lowe, MD, Maryland Personal Physicians Inc.

of new patients," he says. "They also want physicians who can manage costs and have reliable staffs as well as good facilities."

Generally, purchasers also prefer doctors who are likely to continue practicing for years, rather than those approaching retirement, Shuffler says. A practice with lucrative managed care contracts also may have special appeal. "Buyers like doctors who've shown they can work with insurers to control costs," he says.

But purchasers worry about practices that depend heavily on one or two contracts, explains Michael Wiley, a consultant who does appraisals in Bay Shore, N.Y. Purchasers don't want practices that get more than 15% of their revenue from one managed care source. "Purchasers prefer

ble. Physicians should always be careful who they sell to, as well as what they get for a price. They need to understand all the issues related to how their practice is valued before they begin negotiating. It isn't rocket science, but it's important to get professional help," says Holdren.

Seeking Professional Help

Physicians who decide to sell their practice should hire a professional to represent their interests in negotiations and to help set a valuation for the practice, says Arthur S. Shorr, CEO of Arthur Shorr & Associates, a company in Woodland Hills, Calif., that specializes in health care mergers and acquisitions. When seeking a professional, a physician should ensure that the professional has expe-

(Continued on page 4)

(Continued from page 3)

rience in health care acquisitions and mergers, is thoroughly familiar with the local health care market, is accessible, and can see the transaction to fruition, Shorr says.

"A good physician never treats his own family because he doesn't want to have his clinical judgment clouded by emotions," says Shorr. "Likewise, a doctor is the least-equipped person to sell his own practice." Representation can come in the form of an investment banker, physician practice broker, consultant, or an accountant.

A competent representative not only solicits appropriate buyers, but also completes a comprehensive valuation of the practice. Gerald R. Benjamin, a broker in Atlanta, offers suggestions to physicians dealing with brokers. "Once a buyer is found, it is the broker's job to walk the physician through the process, from negotiating an optimal purchase price to drawing up an employment agreement between the parties," says Benjamin, president of Premier HealthCare, a medical practice brokerage that has completed more than \$350 million in merger, acquisition, and financial transactions for health care providers.

Brokers and other experts in negotiations and valuations typically work on a contingency-fee basis and may require a retainer to cover out-of-pocket expenses. Fees usually range from 3% to 5% of the value of the transaction, and some brokers may receive as much as 10%, Benjamin says.

Comprehensive valuations can take two to three days and should cost less than \$5,000, says Darrell L. Schryver, a consultant with the Medical Group Management Association, in Englewood, Colo. "I've seen some physicians pay outlandish fees for valuations," says Schryver, whose organization represents 160,000 physicians nationwide. "But that's not necessary. Shop the valuation. Check with MGMA and several accounting firms."

Some national organizations can supply the names of brokers and merger and acquisition specialists. These organizations include the Institute of Merger and Acquisition Professionals in Chicago, the National Association for Health Care Consultants in Washington, D.C., and the MGMA. "It's crucial to call references about potential brokers," Benjamin says.

Experts Use Three Common Valuation Methodologies

Typically, three approaches—market, income, and cost—are used to determine the value of a medical practice, says Scott Becker, a partner and health care consultant with Ross & Hardies, a law firm in Chicago. "These approaches are used separately or in combinations that make best sense for the particular practice being valued," says Becker.

Market approach. The market approach takes into consideration the sale of practices with similar characteristics. To determine the fair market value of a practice, brokers examine the value of the assets of three to five other practices that have sold recently, and compare these assets to the assets of the practice under consideration, Becker says. Data on other sales can be obtained from a variety of industry sources, including the Medical Group Management Association, in Englewood, Colo., the American Medical Group Association in Alexandria, Va., and the Goodwill Registry, a directory published annually by The Health Care Group in Plymouth Meeting, Pa. The directory lists sale prices of 3,000 practices and includes information on sellers' revenue and location. The value of equipment is available from used equipment dealers and the original manufacturers and distributors.

The most difficult component to value in a market approach relates to the value of intangibles, says Becker. Factors considered in valuing intangible assets are perceived reliability of earnings, client base, practice location, the existence and reliability of patient referral streams, and the strength of the practice's name recognition within the community. "Because of the wide variation that exists in the perceived value of intangibles, the market approach best lends itself to the valuation of real property where impartial and comparable sales data are readily available," says Becker.

Income approach. The income approach involves discounted cash flow. Determining fair market value of a practice using the discounted cash flow (DCF) approach requires determining a practice's available cash flow, meaning the amount of cash that can be removed from the practice in a year without impairing the practice's continued operations. Using the DCF technique, the valuation expert averages the available cash flow over three to five years of the practice's operations. The average cash flow is then projected along with expected charges for the next three, five, or 10 years.

Cost approach. In contrast to the market and income approaches to market valuation, the cost approach sets the value of a practice by determining each of the practice's assets individually rather than as part of a whole. Each asset is valued by determining how much it would cost to replace or reproduce the asset. Next, the replacement value of the asset is reduced by the amount that the asset has been used by the seller prior to sale. After the value of each asset has been determined, the values are added together. After the value of the assets of the practice are determined, the book value of the practice's liabilities is subtracted to arrive at the fair market value of the practice.

—M.S.

"Obtain a fee schedule, inquire about the accessibility and availability of the broker to respond to your concerns, and try to gauge the integrity of the broker and his or her firm. If a broker doesn't score well, look further. Some may not bring a whole lot to the table. It requires professional help to sort out various offers, and to know if you're getting what you are worth."

The years spent building a successful

practice can be its biggest asset, experts say. "When it's time to sell, you'll want to be sure you'll get a fair price," comments Shuffler. "An experienced appraiser can give you an approximate idea of the value. But in the end, the price may depend largely on the perceptions of whatever buyers happen to be shopping in your market."

—Reported and written by Martin Sipkoff, in Gettysburg, Pa.

Unfinished Business: Health Care Debate Will Begin Again

Richard L. Reece, MD, editor-in-chief

If the 106th Congress can avoid the partisan divisiveness that characterized the 105th Congress and focus on issues beyond the Washington Beltway, health care reform is likely to be among the topics that command attention. And the issues surrounding managed care—that is, who shall care for the sick and who shall pay for that care—are surely to be debated

found issue involves capitation. Under fee for service, physicians tended to do more for patients than the patients actually needed. Under capitation, however, physicians' income can be directly and substantially linked to how much money they spend on medical care for their patients, and the consequences could be that they skimp on care to make more money."

Seattle, Tufts Health Plan in Boston, and Harvard Pilgrim Health Plan also in Boston—that were founded by and are run by doctors—have begun to develop capitation plans simply as a way of controlling costs, says Kassirer. "In fact, they're beginning to adopt some of the practices of investor-held managed care companies simply in order to compete," he says.

Compounding the complexity of the health care issue for both physicians and patients is the number of recent consolidations and mergers in health care, such as the Aetna U.S. Healthcare merger and Aetna's more recent bid for Prudential Healthcare. "The larger these entities become," says Kassirer, "the less choice people have and the more restricted they may be in terms of the doctors they can choose to see and the kinds of programs they would like to have."

The huge projected revenue of investor-held HMOs, such as the \$25 billion for Aetna-Prudential and \$18 billion for United HealthCare, make it difficult

Congress and the media will refocus on the issues that concern all Americans: providing health care for the sick and health insurance for the uninsured.

hotly. When Congress refocuses its agenda, the media too will look beyond politics to cover the health care issues that concern all Americans: the sick and the healthy, the insured and the uninsured, the providers and the employers.

To set the stage for Congress's actions this year on the health care front and to get an inside-industry media perspective, *Physician Practice Options* turned to Jerome Kassirer, MD, editor-in-chief of the *New England Journal of Medicine*, and George D. Lundberg, MD, former editor of the *Journal of the American Medical Association*.

Kassirer perhaps captures the current health care dilemma for physicians in this nutshell: A narrow focus on the bottom line, he says, "can force physicians to lose sight of their primary mission—mainly the care of the sick." That's the issue that physicians face nationwide: Who is going to care for the sick and who is going to pay for it?

"Caring for the sick is a responsibility that has been sorely tested recently as a result of remarkable changes in the delivery system," says Kassirer. "Our ethical system never envisioned a market-driven health care system, which often puts physicians in difficult positions in terms of how they view their role. The most pro-

That outcome could add firepower to the arguments of managed care opponents that capitation is subverting physicians and diverting them from providing the best care for the sick. But Kassirer says that the issue isn't so simple.

"There's a complicated tradeoff here," he says. "We're spending a lot of money

"Managed care is one method being touted as having held down cost over the past several years, and it may well have done that. But a lot of costs were also being transferred in the form of copayments and such to people who were partially insured."

— Jerome Kassirer, MD, *New England Journal of Medicine*

on health care and something has to be done to control the cost. Managed care is one method being touted as having held down costs over the past several years, and it may well have done that. But a lot of costs were also being transferred in the form of copayments and such to people who were partially insured."

Even the many good nonprofit health plans, such as Kaiser-Group Health in

for physicians and nonprofit HMOs to compete against these companies.

Richard Huber, chairman and chief executive officer of Aetna, argues that such behemoth plans will have huge databases that will enable the plans to stratify their membership, predict who will get sick, and act to treat chronic illness before it becomes too costly. In other words, with enough data, plans will be

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“I’m perfectly comfortable with individuals buying their own health insurance under two circumstances. First, if they’re provided with good information with which to make intelligent choices; and second, if the country moves toward mandated personal coverage whereby everybody must have health insurance.”

—George D. Lundberg, MD, former editor of JAMA

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better equipped to manage disease and identify those patients who cost the most and treat them appropriately.

Kassirer is not convinced by that argument. “There’s no proof yet that they can do that,” he says. “What they can do is to identify patients who are at the greatest risk of getting sick and then not insure them. After the cherry picking is done, the Medicare population, the Medicaid population, and the single individuals who are sick could be left out in the cold.”

But consumers are finding ways to get out of the cold. “People are becoming quite smart about working the systems,” says Kassirer. “Let’s take the Medicare population as an example. When the elderly get sick, they drop out of Medicare managed care and go back to Medicare fee for service so that they can choose their doctor and be treated where they want to be treated. When they get healthy again, they go back to Medicare managed care, where, at least until recently, they have been able to get coverage for such benefits as eyeglasses and drugs. If patients are going in and out of these plans at the same time that the managed care companies are skimming and creaming, it’s possible that disease management could be part of the health care solution.” Whether disease management strategies will be effective remains to be seen, however, because it’s easier to skim and cherry pick than it is to actually manage illness. Some would argue that managing illness costs more, too.

And so it is that the Medicare population may again be left out in the cold. When the federal Health Care Financing Administration announced last year that it would require more data from managed care companies, says Kassirer, some managed care companies said: “That is going to cost us money, so we’re going to drop

Medicare managed care.” By dropping Medicare managed care, these plans left 440,000 people without coverage. Although they are still making money, the HMOs are concerned that they won’t be making enough money, so they’re pulling out of the Medicare managed care market, he says. “That doesn’t mean they’ll pull out of all markets because presumably they’re still making sufficient money and profits from contracts with other purchasers,” he says.

These days, consumers are not only fighting not to be left out in the cold, they are also demanding more choice when it comes to their health care. Kassirer says that demand will create even more pressure on an industry struggling to redefine itself. “Even the icons of academic medicine, which have never been very consumer-friendly, are having to make drastic cultural changes to adapt to these new demands,” he says. “Patients are voting with their feet and are moving to looser forms of managed care, such as point-of-service plans and PPOs.”

Lundberg sees the stirrings of a movement by individuals to buy their own insurance because many large employers offer employees little choice. “It’s a take-it-or-leave-it sort of thing,” he says. “And people don’t like that. I’m perfectly comfortable with individuals buying their own health insurance under two circumstances. First, if they’re provided with good information with which to make intelligent choices; and second, if the country moves toward mandated personal coverage whereby everybody must have health insurance. Americans don’t like mandates but they don’t like 43 million people being uninsured either, especially if they are one of the uninsured.”

Consumers may not like mandates, but physicians have complaints too. “They’re complaining about the hassles they have

to go through to see patients and to bill for them and about the fact that they are required to see so many patients and in such short periods of time,” says Lundberg. Patients aren’t well served by disgruntled doctors, says Kassirer. “We don’t want to have a bunch of cranky, tired doctors taking care of patients,” he says.

Which brings up the conflict physicians face in trying to earn a living while straddling the line of being in a profession and being in business. “The primary purpose of a profession is to promote the public good and the good of the individual; secondarily, to earn money,” Lundberg says. “The primary purpose of a business, on the other hand, is to make money while providing a product or a service, as well as to generate income. From its beginning, medicine has been both a profession and a business, and the issue has always been one of balance.”

Striking that balance is what most physicians are finding difficult to do under managed care. “One litmus test for determining professional behavior in the field of medicine is whether a person is willing to efface his or her own personal interests for those of the patient,” says Lundberg. “In medicine, the patient must come first.” During the 1980s, he says, the business side of medicine in the United States was becoming more prominent and professionalism was declining. Since the Clinton health care reform effort in the early 1990s, “for-profit medicine—including for-profit hospitals and for-profit health organizations of various kinds—has been extremely strong while the professional side has tended to be fractured and groping to retain its identity. That’s how we find ourselves coming to the end of this decade.”

Some physicians are attempting to strike the balance between being in a profession and being in business by addressing business issues directly; that is, by taking

business seminars and earning advanced business degrees. But, says Kassirer, physicians who get an MBA after earning a medical degree run the risk of getting so caught up in market share, profit margins, and other issues of the business side of medicine that they forget what's important in their profession: patient care.

Lundberg believes that managed care will continue on the American medical scene, at least in our lifetime. "It can control costs better than many other methods," he says, "but it isn't warm and fuzzy, and it's sometimes heavy handed with individuals. There's also a lot of telephone waiting time, and many things get denied or channeled or delayed. And Americans who grew up in an era of instant gratification don't like being turned down for anything."

Compounding those kinds of problems are the huge public relations gaps some managed care companies have created, Lundberg says, particularly when the denial of expensive care gets widespread media coverage, sparks legal battles, or creates an appearance of a lack of compassion. "One denial of care for one patient who goes to the media can cost that managed care company many times more than it saves by denying the care," says Lundberg.

"People are becoming quite smart about working the system. When the elderly get sick, they drop out of Medicare managed care and go back to Medicare fee for service so that they can choose their doctor. When they get healthy again, they go back to Medicare managed care, where, at least until recently, they have been able to get coverage for such benefits as eyeglasses and drugs."

**— Jerome Kassirer, MD, New England
Journal of Medicine**

"Some people—to whom managed care is synonymous with huge profits, overpaid CEOs, and cost-conscious shareholders—get angry at the media coverage of people getting arrested for allegations of keeping Medicare books in one drawer and the real books in another drawer because they see themselves as being ripped off by excessive profiteering. And they don't like that."

In 1998 and at least through the first weeks of 1999, congressional attention and the corresponding media coverage of the issues surrounding health care reform and managed care have been secondary to Congress' focus on impeachment. Once the impeachment issue is decided, it is clear that many issues related to health care need to be resolved.

—Edited by Paula Grant, in Lincoln, Va.

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ness people who run those organizations.”
 William K. Nasser, MD, president of
 Nasser Smith & Pinkerton Cardiology

Group, in Indianapolis, says the 400 physi-
 cian members of his group have seen reim-
 bursements fall while costs have risen for a

number of years. “Our physicians are fru-
 strated and angry,” says Nasser. “Our overall
 costs don’t go down; they go up. But payers
 don’t seem to recognize that simple math.”

Compensation Versus Productivity

Percentage changes in compensation and production (1993 to 1997)

	Primary Care Physicians		Specialists	
	Compensation	Production	Compensation	Production
1993-94	2.7	1.34	2.34	4.67
1994-95	4.46	0.57	1.79	5.59
1995-96	1.42	3.36	2.58	10.61
1996-97	0.86	2.56	-0.48	3.97

Note: Production is defined as all professional charges, excluding technical charges (such as lab fees and x-rays) and the services of physician extenders, such as nurse practitioners. It reflects total gross patient charges, including fee-for-service charges and in-house equivalent gross fee-for-service charges for capitated patients.

Source: *Physician Compensation and Production Survey: 1998 Report Based on 1997 Data*, Medical Group Management Association, Englewood, Colo.

Seeking Changes

Frustration may lead to increased reim-
 bursements, says Susan Cejka, president of
 Cejka & Co., physician compensation
 consultants in St. Louis. Her company
 sponsored the MGMA survey. Any
 increase in physician reimbursements
 from rising health care premiums this year
 will not be felt right away, she says. “But,
 it’s important to remember that premiums
 are just now beginning to rise significant-
 ly, after being relatively stable for years,”
 she explains. “Not all of that will be taken
 up by increased costs in other areas.
 Doctors won’t stand for it. They will begin
 to demand a larger piece of the pie in their
 contract negotiations.”

After several years of annual health care
 inflation rates of 3% or lower, industry ana-
 lysts are saying health care premiums will
 rise significantly this year. The Medstat
 Group, health care consultants in Ann
 Arbor, Mich., has predicted that premiums
 will rise 5% to 7% this year. In 1997, the
 Center for Survey Research in Arlington,
 Va., had reported that health care costs rose
 by only 2.1%. The Center for Survey
 Research is the compensation and benefits
 research department of KPMG Peat
 Marwick, CPAs and health care consul-
 tants in New York. KPMG research director
 Jon Gabel explains that rates are increasing
 this year because managed care organiza-
 tions “underpriced their products” in 1997
 and 1998. “They ran out of profits, and now
 they’re trying to catch up,” he says.

Surveys show premiums rose last year,
 and are expected to rise at an even higher
 rate this year. William M. Mercer Inc.,
 benefits consultants in New York,

Median Compensation for Physicians, 1993-97

	1993	1994	1995	1996	1997	96-97 change	93-97 change
All Primary Care Physicians	\$124,282	\$127,632	\$133,329	\$135,217	\$135,791	0.86%	9.26%
All Specialists	\$207,331	\$212,183	\$215,978	\$221,554	\$220,476	-0.48%	6.34%
Cardiology: Invasive	\$300,540	\$313,211	\$337,000	\$353,769	\$326,537	-7.70%	8.65%
Cardiology: Noninvasive	\$218,424	\$227,169	\$239,406	\$247,133	\$259,961	5.19%	19.02%
Gastroenterology	\$205,060	\$200,992	\$209,913	\$224,382	\$228,122	1.67%	11.25%
Ob/Gyn	\$204,657	\$210,703	\$215,000	\$217,549	\$210,000	-3.47%	2.61%
Surgery: General	\$193,834	\$200,211	\$216,562	\$223,388	\$225,173	0.80%	16.17%

Source: *Physician Compensation and Production Survey: 1998 Report Based on 1997 Data*, Medical Group Management Association, Englewood, Colo.

**“Physicians will expect the gains coming from increased productivity to trans-
 late into an improvement in the bottom line. We expect that stagnant com-
 pensation trends will energize physicians to push harder for increases in their
 slice of the premium pie.”**

—James Rodeghero, Ernst & Young

announced in January that the cost of employer-sponsored health plans rose 6.1% last year, and that its survey of 4,200 employers shows premiums rising an average 9% this year. The Blue Cross Blue Shield Association of Chicago, a lobbying group for the nation's Blue Cross companies, says renewal rates for Blue Cross Blue Shield's managed care contracts are going up at a rate of 5% to 10% this year, according to Mark Psleger, director of marketing.

"The managed care organizations have been losing money," explains Cejka. "So we all knew premiums would rise. But doctors won't let insurers keep all of the money that results from those increases."

In New York City, 10% of the physicians affiliated with New York Presbyterian Hospital dropped out of all managed care plans between October and December of last year, and 50% have reduced the number of plans from which they accept patients, according to Myron Weisfeldt, MD, chairman of the hospi-

tal's department of medicine. Many physicians are seeking to separate themselves from managed care plans, Weisfeldt told *The New York Times*. In California, the 600-physician San Mateo County Individual Practice Association refused to renew its contract with Aetna U.S. Healthcare at the end of last year. Following what it said was a 24% decrease in rates over the previous five years, the IPA rejected a proposed 8% rate increase as inadequate.

Physicians in large medical groups rejected managed care contracts in California last spring because reimbursements were too low. When Blue Cross of California, an HMO in Woodland Hills, called for a reduction in physician fees, physicians for Catholic Healthcare West, a system in San Francisco with 6,000 physicians, and Sutter Health, a system in Sacramento with 4,000 physicians, refused to sign the contracts. Agreements calling for undisclosed increases in Blue

Cross' proposed reimbursements were reached last summer.

"Doctors aren't stupid," says John C. Erb, a vice president in Boca Raton, Fla., for Arthur J. Gallagher & Co., insurance brokers. "They are going to demand an increase in reimbursement as their productivity and costs go up." Until moving to Arthur J. Gallagher & Co. last year, Erb had been the chief researcher for the preeminent survey of employer health care costs that is now done by William M. Mercer Inc.

"All of this is difficult for physicians," says James Rodeghero, a national practice leader in Ernst & Young's Los Angeles office. "Physicians will expect the gains coming from increased productivity to translate into an improvement in the bottom line. We expect that stagnant compensation trends will energize physicians to push harder for increases in their slice of the premium pie."

—Reported and written by Martin Sipkoff, in Gettysburg, Pa.

Compensation Stagnant, Costs and Productivity Rise

Physician compensation has not been keeping pace with the cost of practicing medicine, according to two surveys. One survey, *Physician Compensation and Production Survey: 1998 Report Based on 1997 Data*, was done by the Medical Group Management Association (MGMA) in Englewood, Colo., and the other survey, *1998 Physicians Benchmarking Survey*, was done by Ernst & Young, CPAs and health care consultants in New York. Both studies also show income has been stagnant while physician productivity has risen.

The MGMA survey included responses from 1,675 practices representing 35,254 physicians. It shows that compensation levels for all primary care physicians (PCPs) was \$135,791 in 1997, the most recent year for which complete salary data are available, a 0.86% increase over 1996 levels. Compensation for both internal medicine and pediatric adolescent medicine declined slightly from the previous year. Compensation changes ranged from a decrease of 0.18% for pedi-

atric and adolescent medicine to an increase of 2.69% for family practitioners. Gross charges for all PCPs increased 2.56% in 1997. Within the primary care specialties, gross charges increased 2.44% for family practitioners and 5.9% for internal medicine, and decreased 0.12% for pediatric and adolescent medicine. Compensation levels for PCPs were nearly identical in single-specialty and multi-specialty practices.

Specialists did worse than PCPs, according to the MGMA study. Compensation for all specialists decreased by 0.48% in 1997, to \$220,476. In 1997, gross charges by specialists increased by 3.97%. For specialists, there is a marked difference between single- and multispecialty practice data. Specialists continued to earn more in single-specialty groups. "We believe specialists do better in single-specialty groups because they have to pay only for the costs associated with their own type of practice," says Laurel Weinstein, a project director for the MGMA who is in charge

of the compensation surveys. "In multi-specialty groups, specialists share costs across the board," she adds.

The Ernst and Young survey included responses from 124 medical organizations representing 16,200 physicians, and reflects data through April 1998. It demonstrated that PCPs whose income came solely through fee-for-service reimbursements rose 8%, to an average of \$140,000. But PCPs whose income came primarily through managed care contracts rose only 0.2%, to an average of \$136,000. At the same time, the productivity of the PCPs in the surveyed medical groups increased an average 16%.

The cost of doing business has risen along with productivity. As for costs, the MGMA's *Cost Survey: 1998 Report Based on 1997 Data* shows that net revenue after operating cost per physician fell 5.2% in 1997 from 1996 levels, from \$201,029 to \$190,556 and operating costs increased 13.2%, from an average \$252,618 per physician in 1996 to \$285,959 in 1997.

—M.S.

Health Strategist Says Physicians Can Retain the Capacity to Make Clinical Decisions



Jeff Goldsmith, PhD, is president of Health Futures Inc., health care consultants in Charlottesville, Va. Goldsmith has been involved in health care for 23 years, 16 years as a strategy consultant. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q: In 1981, you wrote a book, *Can Hospitals Survive? A Competitive Health Care Model (Dow Jones-Irwin)* in which you said: "What is not fully appreciated by those who embrace competition is that it will mean a major restructuring of health care and the demise of many existing institutions. Hundreds of hospitals will likely close their doors, and several thousand more may be acquired by large hospital management firms. Increasingly, free-standing units will become available to compete effectively on price and quality of care. Physicians who have enjoyed unprecedented economic freedom face the prospect of declining incomes and escalating threats to fee-for-service practice from prepaid health care plans and integrated health care providers." How does that observation look in retrospect?

A: We've now had almost 20 years of additional experience with the corporate forms of health care organization and have discovered that the industrial logic that enabled simpler industries to consolidate doesn't create measurable value in this field. One part of this forecast was glaringly wrong: Physicians have done spectacularly well as a group in the face of all of these threats. In fact, recent AMA data show that physician income has risen 77% in the last 11 years in the face of managed care's growth. So, we underestimated the vitality of physician practice in the face of these changes, and we've learned a lot about the limits of the corporate enter-

prise in this field. I'm now much less bullish about so-called consolidation strategies and about the relevance of access to capital to success in this field than I was when I wrote that article.

Q: But you have been a consistent critic of the vertical integration aspects. For example, you've spoken about the Veterans Administration being used as an exemplar of a totally vertically integrated organization and have pointed out that that isn't exactly the type of target we want to aim for.

A: Again, it's that industrial model of integration that I've had a problem with; that is, the idea that physicians have to be employees in a huge medical bureaucracy to function effectively in the health care market. That's where I part company. There are marvelous examples of integration strategies that are not capital intensive; that have not only survived but flourished in very unforgiving health care markets. The Hill Physician Group, located in San Francisco's East Bay area, is an example of physicians' ability to retain the capacity to make clinical value decisions.

"The larger the physician enterprise, the more hospital-like it becomes."

It has been able to reach out to its colleagues through IPAs and extend their influence in the contracting arena without selling out or being absorbed into VA-type organizations.

Q: Isn't that true of a lot of the California IPAs?

A: The model that intrigues me in California is the multisite, primary care physician group practice with an IPA wraparound. That hybrid form of physician organization didn't exist 10 years ago. The idea that you can fuse group practice and broad-based physician networks is relatively new. But that's not a VA-type model. Nor is it a Kaiser model. Part of the

problem in exploiting the cost impact of physician group mergers is that it's not obvious that there are economies of scale in group practice. Indeed, the larger the physician enterprise, the more hospital-like it becomes. It seems to have departments and layers of management, and a large administrative staff—a bureaucratic entity that is, in a sense, independent of, even if it's owned by, the physicians who run it. There are problems with that model, particularly where cap rates or net payment is falling.

Q: In an article for *Health Strategist*, you wrote about the problem of health systems that are structurally integrated but culturally disintegrated. Can you expand on that for us?

A: Corporate management and physicians have been diverging for some time in their view of how value is created. During the early part of this decade—particularly with the market panic that ensued with the consideration of health reform—corporate organization, merging and consolidating, and positioning for a marked increase in managed care enroll-

ment became an end in itself. People weren't asking, "How are these things going to improve outcomes or service to patients?" There may have been rhetoric about that, but it was, in reality, largely defensive, panic-driven positioning relative to this gorilla called managed care. Now, it's a sick gorilla, and it's not clear whether it's sensible to fight this sick gorilla with other gorillas.

Q: Are you saying that physicians and consumers are trying to undermine managed care?

A: Undoubtedly, there has been a backlash from physicians and consumers in response to managed care. The managed

care plans overreached; they made fundamental strategic mistakes in growing their franchises; they lost sight of their patients and of the process that they were trying to manage. To be blunt: A lot of managed care executives overreached and there is a cure for that.

Q: *What's that?*

A: An 80% fall in stock prices usually does the trick. Managed care, and health insurance in general, is a notoriously cyclical business. The overreaching is usually followed by consolidation and changes in management, philosophy, and relationships. The firms that listen to the message being sent to them by the political system and by physicians are the ones that will make it out of this cycle. But right now, consolidation is still under way in this field. Take Aetna, for example. It was remarkably aggressive in 1998. Such consolidation will make it very difficult for large enterprises to maintain a human scale and to maintain the types of relationships that will retain a sense of loyalty on the part of physicians and patients alike. I am not persuaded that saving a few dollars per life on overhead will make all that much difference in a plan's ability to deliver good service to its customers, both proximate and distal.

Also, it's simply not possible to maintain a sense of trust in these systems if physicians don't feel that the managed care firms they're dealing with are truly committed to the same values that they are. There can be economic differences, but if there's a fundamental difference in values, physicians will ultimately succeed in subverting any system that they do not feel is consistent with their values. I'll use an analogy to explain further. This latest run-up in cost is like the scene in *Jurassic Park* in which the raptors threw themselves against the fences to find out where the power was out and then blew through the places where it was out.

In a similar fashion, physicians have been testing the limits of this latest generation of managed care, and they've discovered a lot of holes. Physicians have been defeating the current generation of controls on their behavior by accepting more of the financial risk of delivering

care. In fact, managed care plans made a fundamental error in attempting to retain risk, and as long as health plans maintain fee-for-service payment, they can position themselves as the only entity that can protect their business consumers from

based on negotiated rates that withhold a portion of the payment and impose administrative management from a distance. That seems to be the model that's prevailed in this cycle. And I don't think it's a viable model long term. It's certainly not

"Managed care is a sick gorilla, and it's not clear whether it's sensible to fight this sick gorilla with other gorillas."

the so-called 'greedy' doctors. The reality is that physicians have organized themselves to bear and manage risk but in many cases can't get the risk transferred to them because the health plans want to retain it.

Q: *Some physician groups have geared up to accept capitation by installing expensive information systems and so on. Then, when they throw the party, nobody comes.*

A: Or, what's worse than throwing a party and nobody showing up is to throw a party with an invitation that says, "Please come. I want to be capitated" and end up with a \$70 global cap. Quite often, in the panic to try to control an emerging market, aggressive physician organizations and systems have driven capitated rates down to the point that the patients' needs couldn't be met. That's what happened in Southern California. There was an imbalance between the demand for risk and the supply of it.

Q: *But that's not happening all over the country, is it?*

A: No. In the Northeast, for example, there are regional health plans that actually want risk-sharing relationships—plans that are building franchises. Tufts Health Plan and Harvard Pilgrim Health Care, both based in Boston, are two examples of plans that want risk relationships and can't find systems or physician organizations that are willing to assume the risk. But for the most part, the indemnity model has won this round of managed care expansion. And the health insurance system we have in place doesn't look a lot different from Blue Cross. That is, plans

the kind of managed care that public policy advocates of managed competition had expected. If you listen to the talks that the early advocates of managed care, like Paul Ellwood, MD, and Alan Enthoven, are giving these days, you'll note that they're unhappy with the way in which the market has evolved. And I share their concerns. There's a lot missing. As a society, we're not getting the kinds of benefits from managed care that we should be getting.

Q: *I recall vividly my interview with a physician in a large organization who said, "We woke up one morning and found that the market didn't want what we had to offer." Rather, consumers wanted independent doctors in their own neighborhood. They didn't want to go to an institution for care.*

A: What consumers really want is to continue the relationships that work for them. Consumers—particularly women—have been telling health insurers and the health care system that they want to be the architects of their own health care delivery system. They don't want a prepackaged system. They don't want anyone telling them where to go and when, or defining their needs for them. And that's been a very difficult message for a lot of health system architects and engineers to accept.

One thing we're beginning to realize about Americans as managed care has evolved is that we mistrust large institutions, are suspicious of concentrations of power, and don't like being manipulated, directly or indirectly. People pride themselves on their ability to manage their own lives, and managing their relationships in the health care system is important for Americans. They are starting to perceive

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managed care as an abrogation of that responsibility and authority without their having either granted the political mandate or given their consent for it.

Does that mean that the medical care system we had before managed care was working to meet their needs? No, it really

that compounds the complexity.

In fact, the continuing difficulties in applying artificial intelligence and medical logic to decisionmaking should tell us how much uncertainty exists at the point of service. And the reason we hire physicians is to manage that uncertainty for us and

Q. *You don't use a bulldozer to weed the garden. Is that what you're saying?*

A. Prudential was in ruins, and I don't know what the management strategy is for turning it around. The assumption is that you've acquired lives in such consolidations. What Aetna actually acquired was a demoralized work force, a huge number of sick contracts, and a lot of angry customers.

Q. *Some argue that being an executive of these huge health enterprises is the toughest job on earth.*

A. It is. In almost every community in the country now there's a large health enterprise that's struggling to reconnect to its employees and customers, as well as to the professionals who work within it. It's a tremendous challenge, but it's not undoable. But the scale is a handicap, not an asset, and it's an obstacle that needs to be overcome.

Q. *But how do you get physicians and consumers to "bond" with these health systems?*

A. They're not going to do it. Physicians aren't going to be owned, and consumers aren't going to be controlled.

Q. *So, the efforts by health systems to create warm and fuzzy images of compassion and plans that serve the community and raise the health of the population are simply pie in the sky?*

A. A lot of the executives believe it can be done, but making people feel that way at the point of care is the hard part—and what people believe is important. The hard part will be working

"Physicians are defeating the current generation of controls on their behavior because those controls have been imposed on them unilaterally."

wasn't. Patients didn't like the asymmetry in power that existed in the old system, nor did they like its paternalism, or being told to wait when they had an urgent need. They didn't like not getting answers to their questions; in fact, they didn't even feel that they had a right to ask questions about appropriate alternatives to treatment. So, to argue that consumers' response to managed care has been a ringing affirmation of the old status quo would be to read incorrectly the message consumers are now sending.

Q. *Another point you've emphasized is the complexity in all this; in other words, health care is a very difficult thing to understand fully.*

A. On a logarithmic scale, the health care industry is more complex than the other industry sectors from which it borrows management tools and organizational structures. Peter Drucker, the well-known management guru, would tell you that the modern urban hospital is the most complex human organization.

Q. *Because you have no leverage over your sources?*

A. The sources of that complexity are the variability and uncertainty at the point of service and the sheer number of complex people involved in resolving that uncertainty. Clearly what we're seeing with the movement toward evidence-based medicine is an attempt to sort through the variability by looking at variations in treatment patterns within groups for certain important diseases. But there's variation at the point of service, as well as the difficulty in standardizing treatment,

with us. But just that and the sheer number of complicated people who collide and have to work together at the point of service are two factors that have strained the ability of organizations to use management philosophies and models adopted from less complex industries.

Q. *Do you look at information systems as one way to unravel this puzzle?*

A. It's remarkable how little help they've been so far. We're still in a largely paper-driven, 1970s information environment in most health care organizations. Physicians are not entirely off the mark in feeling that information technology is not yet an enabler of what they want to do.

Q. *Some proponents of information technology would argue otherwise. For instance, in discussing Aetna's proposal to buy Prudential and create a \$26 billion managed*

"What Aetna actually acquired [in Prudential] was a demoralized work force, a huge number of sick contracts, and a lot of angry customers."

care company, Richard Huber, Aetna's chairman and CEO, was quoted as saying that the aim is not to reduce the fees of physicians but rather to get a large enough database so enrollees can be stratified for purposes of disease management.

A. Larger numbers help at the margin, but that is a brute force model and he may well create an unmanageable enterprise.

through the eight layers of intervening folks between the executives and the consumers. There's a virtue to simplicity and to having only a few moving parts. What I've learned from health care is that the way you make money is by keeping your overhead low and by being close to the customer.

—Edited by Paula Dawn Grant, in Lincoln, Va.

The Challenge of Merging 23 Practices

By Thomas M. Gorey, JD

Almost six years ago, predictions that managed care would soon make major inroads into the community swept through Greenville, S.C. Although the predictions subsequently proved to be untrue, a small group of physicians began exploring the possibility of forming a new group practice.

At the time—mid-year 1993—most of the physicians had spent their careers practicing in small, independent practices and placed a high value on their professional autonomy. They were convinced that by building on a foundation of a large primary care base, a multispecialty group presented the best strategic option for them. In addition to gaining leverage in contract negotiations with managed care plans, the physicians hoped to achieve increased access to capital by merging their practices.

Early in the process, the physicians leading the formation of the new group recognized that they needed consulting assistance to help them address important strategic and business issues and to help them persuade physicians in the community that it was to their advantage to sell their practices, give up some of their independence, and join a multispecialty group.

In the fall of 1993, the physicians hired a consulting firm in Nashville, Tenn., to help them to form a new multispecialty group, Carolina Medical Associates. About one year later, CMA became a legal entity through the merger of 23 previously independent practices. The new professional association consisted of 60 members—50 physicians and 10 optometrists.

Overcoming Challenges

The founders of CMA faced a number of obstacles in forming the group—some expected and some unanticipated. One challenge was to convince independent-minded physicians that, although they were

doing well financially and managed care had not yet become a significant presence in the Greenville market, long-term benefits were possible by affiliating with a multi-specialty group.

Another challenge, which came as a surprise to CMA's founders, was having to compete against Greenville's hospital systems for the remaining independent primary care physicians in town. Because the hospital systems had been acquiring primary care practices, there were few independent primary care physicians left in the commu-

network of nearly 200 physicians that includes pediatricians and ob-gyns.

Business Details

As part of the merger, CMA purchased the hard assets (primarily furniture and equipment) of the component practices. A consultant valued the assets using a modified book value approach. The purchase of assets was capitalized through a bank loan and by having all of the physicians defer their first \$35,000 of compensation from the group. The loan was secured by equip-

The threat of managed care spurred the practices to form Carolina Medical Associates.

nity. What's more, the hospitals had been making substantial cash offers and offering guaranteed multi-year contracts for many of those practices.

Realizing they could not match the financial incentives the hospitals were offering, CMA's founders appealed to the physicians' desire for professional autonomy and self-determination. As a result, the hospitals' efforts helped CMA ensure that the physicians joining the group were, in fact, the independent-minded physicians CMA was seeking.

In recruiting new members, the founding physicians were extremely selective. In addition to recruiting based on specialty needs, the group assessed the quality of care provided by prospective members and the extent to which they would be "team players" in a group environment.

Because the hospitals purchased a significant number of the area's primary care practices, the specialty composition of CMA ended up being different than had originally been planned. Although CMA had primary care physicians in both internal medicine and family practice, the group did not have any pediatricians or obstetricians-gynecologists because physicians in these specialties sold their practices to the hospital systems. To strengthen the group's ability to negotiate managed care contracts, CMA formed a

ment, accounts receivable, and a note guaranteeing the loan that was equal to \$25,000 per physician member.

CMA did not buy the office buildings owned by its physicians or the physicians' medical records, accounts receivable, or goodwill. CMA leases office space from its physicians, based on a fair market appraisal. Preexisting accounts receivable stayed with the individual practices.

Under the terms of the merger agreement, physicians must give a six-month notification if they want to withdraw from the group. If a physician leaves CMA, the group retains the physician's accounts receivable, but is obligated to repurchase the physician's stock and to pay the departing physician a severance benefit of as much as \$35,000. Other than the founding members, physicians who leave CMA are subject to noncompete provisions.

Managing the Group

Today, CMA has about 70 physicians, 65 employees in its corporate office, and 500 employees in physician offices. With the growth in size, one of CMA's biggest challenges has been to standardize operations and reduce variations in policies and procedures from practice to practice. In the past, there may have been 23 ways of doing business, but CMA is now trying to standardize policies and procedures.

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Thomas M. Gorey, JD, is president and CEO of Policy Planning Associates, a health care consulting firm in Crystal Lake, Ill., that assists physicians in organizational strategy development.

Behind the issue of staffing is the more contentious problem of compensation and its relationship to practice overhead.

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To date, few of the CMA practice sites have consolidated operations, due to financial and strategic obstacles. One reason for the lack of consolidation is that at the time of the merger, five-year leases were signed for the existing practice sites, and these leases remain in effect. A more significant factor, however, is that roughly three quarters of the practice sites are in buildings owned by CMA physicians, meaning it is politically difficult to make significant changes in office configurations.

Despite the lack of physical consolidation, CMA is trying to unify its practices. Although the corporate office does not dictate the days and hours that physicians' offices must be open, it does make what it calls strong recommendations about these issues. Receptionists in each office answer the phone with "CMA" and the specific practice name. CMA has retained individual practice names so as not to confuse patients. Although the process of becoming acclimated to the new CMA identity has taken several years, CMA leaders believe their physicians are looking and acting like a fully integrated group.

Information Systems

Early in the merger discussions, the physicians realized that they would need to implement a new, comprehensive information system. The first step in selecting an information system was to form a task force consisting of practice managers and physicians. CMA eventually selected a system from IDX Systems Corp., a health care information systems vendor in Burlington, Vt. Installed in April 1995, just eight months after CMA was formed, the system affords the group the ability to manage claims, generate financial reports, and track utilization and case management.

Converting to the new information system was difficult, partly because the practice sites had been using 10 different computer systems, and partly because of CMA's ambitious goal of converting four to five practices per month to the IDX system. Looking back on the information system

conversion process, CMA administrators now recognize that they likely tried to accomplish too much too fast. To avoid such problems today, CMA converts new groups to the IDX system before they begin providing services as part of CMA.

Medical Practice Staff

As part of the merger, all employees in the merged practices became employees of CMA and there were no layoffs. CMA's leaders believed that keeping all employees on staff was a political necessity because physicians may have been reluctant to join the group if it meant losing their office staff. Retaining all of the employees from the previously independent, individual practice sites, however, resulted in some redundancies and overstaffing, which contributed to an increase in overhead. CMA has tried to reduce staff gradually through attrition and voluntary employee movement within the organization. To prevent future overstaffing, CMA has developed staffing standards for the practice sites.

Learning to work as part of a large organization was a challenge for long-time employees. Some staff had been working in a physician's office specifically because they did not want to work for a large company. One CMA physician experienced a 100% turnover in office staff following the merger because her employees did not like the new corporate structure and did not like reporting to an office manager. This physician believed, however, that such staff turnover can be of long-term benefit because it enables the group to hire employees interested in working in a group environment.

Behind the issue of staffing is the more contentious problem of compensation and its relationship to practice overhead. As a result, compensation has been one of the most difficult problems CMA has faced. Although, like many groups, CMA's initial philosophy was "share and share alike," over time there has been growing physician concern about inequities in practice overhead. Specifically, physicians at practice sites with low overhead believed they have subsidized practices with high overhead. As a result, an

overhead adjustment factor was added to CMA's compensation formula last year.

Productivity also has become a major issue for CMA as overhead has increased and reimbursements have decreased. As part of its effort to run CMA as a business, the group has established expectations as to the number of days and hours a physician must work.

Governance

CMA ensures physician involvement in its decisionmaking processes through its board of directors and affiliated committees. Initially, CMA was governed by a large board that included representatives from almost every one of the 23 offices. In addition to site representation, the bylaws contained requirements for specialty representation, including that at least 50% of board members needed to be primary care physicians. The board further expanded when an additional group from another county joined CMA and that group was given a board position. The large board became so cumbersome that most matters were handled by a five-member executive committee.

CMA's bylaws have since been amended numerous times and now provide for a 12-member board. With the smaller board, CMA no longer needs an executive committee. As one CMA leader commented, "We are getting away from a representative board because our comfort zone is now to the point that we can put the best leaders on the board without worrying about having someone from every site."

Editor's note: Carolina Medical Associates is one of six medical groups profiled in *Case Study Analysis of Physician Practice Mergers*, a study released last year by Policy Planning Associates. The study was sponsored by the AMA, and six other organizations. For a copy of the study, call the Michigan State Medical Society at 517/336-5769. The price is \$25 for physician members of one of the sponsoring societies and \$95 for others.

Despite Turmoil, Capital Needs Remain

By W.L. Douglas Townsend Jr. and Jill S. Frew

Last year was turbulent for physician practice management companies. It was marked by earnings disappointments, bankruptcies, stock price volatility, and questions about the value of PPMCs. As a result, the pace of physician

future growth opportunities. Possible strategies for them to consider include retrenchment, hospital partnership, bank loans, and physician investment.

Retrenchment. Under this strategy, physician groups allow attrition and ter-

share and its position weakens relative to its competitors. Furthermore, in focusing on protecting salary levels as a basis for strategic decisions, physicians may lose sight of opportunities that would allow them to position their group well in the future.

Hospital partnership. Despite the fact that hospitals have historically lost money on physician practices they've acquired and have had trouble managing practices efficiently, hospitals are still willing to acquire physician groups. In some cases, hospitals can bring needed resources to these groups, primarily in the form of capital. Physicians may find that partnering with a hospital in order to acquire capital means they may need to cede control of their group to the hospital, which has negative implications.

Bank loans. As a source of capital, (Continued on page 16)

Although they have lost money on the physician practices they've acquired, and they have had trouble managing practices efficiently, hospitals are still willing to acquire physician groups.

acquisitions by PPMCs in 1998 slowed considerably when compared with activity in 1997.

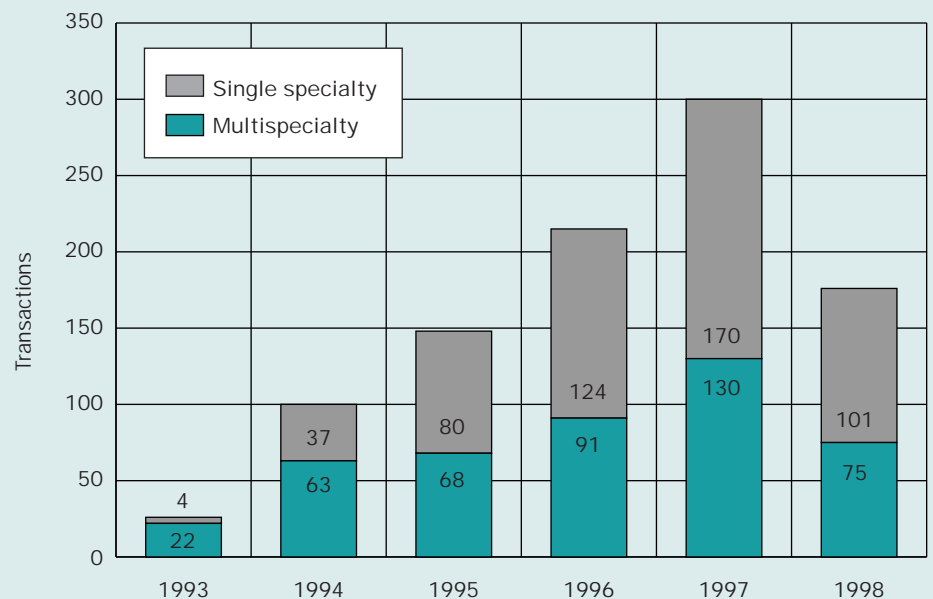
In 1998, PPMCs announced only 176 acquisitions, a 41% decline from 1997 levels and an 18% drop from 1996 levels (see table). Officials at many PPMCs have said their focus in the future will be on operations and that they will not seek growth through acquisitions. Several companies that have managed physician practices have begun to divest some of their physician groups, and other companies are leaving the PPMC business altogether to focus on other opportunities.

In the past, the two primary factors that fueled the acquisitions of physician groups were the need for PPMCs to grow and the need of physician groups to secure capital. While the PPMCs may be rethinking their growth strategies, the need for capital among physician groups continues unabated. Physician groups still need capital to invest in information systems and infrastructure in order to manage their operations effectively as managed care enrollment grows and reimbursement levels decline.

As a result, physicians want to know where they can turn for capital in order to be sure their groups can take advantage of

mination to reduce the number of non-productive physicians in an effort to keep the remaining physicians' salaries from declining. While income may remain steady, the physician group loses market

Number of Announced Physician Practice Acquisitions



Source: Townsend Frew & Co., Durham, N.C., 1998

W.L. Douglas Townsend Jr. is managing director and CEO of Townsend Frew & Co., an investment banking firm in Durham, N.C., that specializes in health care transactions. Also, he is a member of the editorial Advisory Board of Physician Practice Options. Jill S. Frew is managing director of Townsend Frew & Co.

CAPITAL IDEAS

By focusing on protecting salary levels as a basis for strategic decisions, physicians may lose sight of opportunities that would allow them to position their clinic well in the future.

(Continued from page 15)

banks may require a group to meet certain financial standards, but they do not ask for control over clinic operations. One drawback to bank loans is that this option is not accessible to a group that is in financial difficulty. Furthermore, there is a limit to the amount of debt physician groups can handle, and they must be able to make the interest, and often principal, payments.

Physician investment. Physicians can reinvest their own money in their groups, of course. This strategy, however, has never been popular. It is difficult to convince all the physicians in a partnership that part of the money they would have received as salary should be retained in the clinic to finance growth and development. Furthermore, the amount of money physicians could invest may not be sufficient to meet the clinic's capital needs.

While the PPMC industry is changing, physician groups' need for capital to position themselves for the future remains unchanged. As a result, each group must look at its current position and where it wants to go in the future in order to determine its best source of capital to reach its goals. Collectively, the decisions groups make today in this area will shape the clinic landscape of tomorrow. ■

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Richard L. Reece, MD
Editor-in-Chief
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March 15, 1999



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