

PHYSICIAN PRACTICE OPTIONS™

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A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

CONTENTS

Features

Strategy

Communication Aids
Patient Compliance 3

Commentary

Why Managed Care Is
Doomed to Failure 6

Organizational Options

Health System, Doctors
Form New Group 10

Interview

PPMC Veteran Says
All Physician Practice
Management Companies
Are Not the Same 12

Departments

Editorial

Here's How to Manage
the Art of Medicine 2

Capital Ideas

When and Why to
Consider a Partnership 15

Some Specialists Find More Income, Less Stress Under Capitated Payment Plans

Many specialists dislike managed care because they have to get permission from a case worker for many of the procedures they wish to perform. In addition, many fear prepaid, or capitated, reimbursement systems because they feel such systems put them at risk for the financial cost of delivering care.

But two ob-gyns in Dayton, Ohio, decided five years ago that the best way to conquer the enemy was to join it: They started their own ob-gyn management company that accepts capitation from HMOs and passes a capped rate to the physicians in their networks. In doing so, they have eliminated preauthorizations, and they say most of their network physicians are earning more money for services rendered than they did under fee for service.

"In dealing with our network ob-gyns, we begin with the assumption that good utilization means providing the right amount of care," says Stuart Weprin, MD, 49, who founded Ob/Gyn Management (OGM) with his practice partner James Huey, MD, 56, in 1994. "We also believe no one knows better than physicians what's best for their patients."

By 1993, the Dayton market had a 50% managed care penetration rate and was dominated by two large HMOs, UnitedHealthcare in Minneapolis and the regional Blue Cross Blue Shield HMO subsidiary, Health Maintenance Plan in Worthington, Ohio (now Anthem Blue Cross Blue Shield of Ohio). As their market share increased, the HMOs attempted to reduce specialty utilization by reducing fees. But that approach wasn't working, says Weprin.

Reimbursements fell, but utilization rates remained about the same. "It wasn't really saving the HMOs any money, and the physicians who had to argue about every procedure and still see their reimbursements fall felt emasculated," he says.

That year the HMOs approached local specialists and asked whether they would accept a capitated reimbursement system, says Weprin. "Most doctors were not receptive to the idea," he says. "In fact, some got pretty upset because they saw it as one more intrusion into their practices."

But Weprin and his partner saw an opportunity where other physicians saw a threat. "We responded by offering to manage the ob-gyn care within the HMOs' networks," Weprin says. "They would pay us a capped rate and we'd pay the physicians a capped rate."

UnitedHealthcare agreed to the idea. "We feel that the biggest thing a specialty management company like OGM can do for us is manage utilization rationally," says Lee Newcomer, MD, United's chief medical officer and a member of the editorial Advisory Board of *Physician Practice Options*. "No one knows better than the specialists themselves who's playing games with utilization."

Making It Work

Weprin and Huey thought they could make capitation acceptable to their peers if they could make it clear to them that a prepaid reimbursement "realigns the financial incentives under which physicians practice by removing financial

(Continued on page 8)

Here's How to Manage the Art of Medicine

Why don't physicians spend as much time managing the art of patient care as they do managing the business of medicine? Why do so many physicians fail to take a systematic, organized, and purposeful approach to finding new patients and keeping present ones? Why don't physicians think more about what attracts patients and satisfies them? The recently published *Managing Patient Expectations: The Art of Finding and Keeping Loyal Patients* (Jossey-Bass, San Francisco, 1998), by Susan Keane Baker, raises these and other such interesting questions. Baker is a practice management consultant in New Canaan, Conn., who has written several books for physicians and other health care providers. Her current book offers fascinating insights into the workings of physician offices and provides useful remedies for physicians who fail to keep patients.

Physicians struggle with the subtle aspects of patient care for many reasons. For one, the art of medicine is considered by many to be an inborn psychological trait, meaning physicians either have a warm bedside manner, or they do not. Physicians may believe that learning the "soft stuff" is not sufficiently dignified or professionally rewarding. They may think it's more important to be high tech than it is to be what might be called "high touch." Some may believe that the art of medicine is innately acquired and is therefore not something on which one can concentrate or practice, such as reading professional journals, gaining medical education credits, or learning the latest procedures. As I read *Managing Patient Expectations*, it became clear that these ideas can hurt a physician's practice.

"Satisfied patients are the key to professional success and the personal rewards of medicine," Baker writes in the preface. "Every physician prefers loyal patients who are satisfied with the care they receive. When a patient is not satisfied, he may seek care elsewhere or may even seek retribution by filing a malpractice claim. The need to satisfy patients is also fueled by the financial and other rewards given by managed care companies and health systems to those physicians and medical groups that score well on patient satisfaction surveys. Those incentives and the publication, by practice, of regional and national patient satisfaction survey results provide data that are difficult to dismiss or dispute."

Baker offers objective examples of what physicians can do to raise patient satisfaction scores. A physician can increase "word of mouth" referrals by making himself or herself more memorable in the patient's mind by posting a list of how the practice would handle HMO financial conflicts, for example. Physicians have only the first 60 seconds to achieve a favorable impression in a patient's mind, she says. Therefore, physicians might consider administering a "first impressions test" to patients to determine their initial reactions and then make the necessary improvements. Physicians should practice the fundamentals of effective listening, she says. Also, Baker identifies what she calls the 15 "moments of truth" when a patient is deciding whether to stay with a particular practice or choose another. A patient who does choose a different physician, Baker believes, is often not rejecting the doctor but rather deciding based on any of several other factors in a physician's practice.

For any physician seeking to sustain or build a practice in the managed care environment that dominates so many markets today, Baker's book is a must read.



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Communication Aids Patient Compliance

Physicians and patients commonly lament that the quantity and the quality of patient-physician communication are not what they were. When physicians saw patients in their homes, communication between the two parties was enhanced. Today, however, communication is severely constricted after a patient sits in a waiting room for many minutes before a brief visit with the physician in an exam room.

While brief office visits have improved physicians' productivity and efficiency, they leave little time for physicians to explore the social and emotional context of patients' conditions or for patients to express their ideas, concerns, and expectations of care. Despite the increasing focus on patients and providers working together to improve patients' health, the episodic nature of their interactions makes such teamwork challenging and often frustrating.

Although their roles have changed somewhat, and they spend less time together, physicians and patients still have two common goals during the medical encounter: to discover the nature of the patient's illness and find a solution.

"For physicians, there is a third goal," says Stanford P. Gwin, PhD, professor of health and corporate communication at the University of Southern Mississippi in Hattiesburg. "The third goal is to get patients to comply with the treatment plan." Because physicians need patient participation and cooperation to provide the best possible care, it is imperative that they have optimal communication with their patients, he says.

In an article, "Control, Compliance, and Satisfaction in the Family Practice Encounter," published in the October 1997 issue of the Canadian journal, *Family Medicine*, researchers reported that the level of patient compliance increased when patients participated in clinical conversations with physicians. "Patients are also a primary source of information," says Gwin. "Therefore, if communication effectiveness is not a priority, physicians may miss vital information that only the patient can provide."

With the time constraints of office visits, however, improving communication with patients often becomes a low priority, says Sheila C. Bentley, PhD, principal of Bentley Consulting, a company in Collierville, Tenn., that trains its clients to listen more effectively. Bentley also is past president of the International Listening Association, a nonprofit, professional association in Overland Park, Kan. "A common belief is that the physician-patient relationship is not that important, as long as patients get better," she says. But without

effective communication aimed at gaining the patients' cooperation and compliance, outcomes can suffer, she explains. "Regardless of a physician's education and credentials, if patients don't feel that the physician has listened to them, it is unlikely that they will trust the physician's diagnosis," she says. "In turn, patients may decide not to take the prescribed medication, change their lifestyle behaviors, or follow through with the treatment plan because they believe the diagnosis is wrong," Bentley says.

While brief office visits have improved physicians' productivity and efficiency, they leave little time for physicians to explore the social and emotional context of patients' conditions or for patients to express their ideas, concerns, and expectations of care.

A 1995 study conducted by the Center for Studies in Family Medicine at the University of Western Ontario, in London, was designed to ascertain whether the quality of physician-patient communication makes a significant difference to patient health outcomes. In the study, researchers confirmed that outcomes are affected by the ability of physicians and patients to communicate with each other. In particular, the study found that the quality of communication in both the history-taking segment of the medical encounter and during discussion of the management plan improved outcomes in emotional health, symptom reso-

Communication Difficulties

To improve communication between patients and physicians, factors that influence how they interact during the medical encounter should be examined, says Gwin. Commonly, patients come to the physician's office because they are in pain or are anxious about their symptoms. "It's difficult for anyone, not just physicians, to commu-

nicate well with people who are sick and scared," he says. "They don't listen well, and they may complain or be reluctant to talk." In short, he says, patients often behave in ways that make them difficult to communicate with, and even easy to dislike.

"Patients are also vulnerable when they come into the physician's office," says Bentley. Not only do they usually have some kind of physical worries, but patients tend to interpret some nonverbal messages as signifying that they are in an inferior position to the physician. "In the exam room, patients don't have their own clothes on; they're sitting while the physician is standing; and the physician tends to call them by their first name, while they refer to the physician by his or her title and last name," Bentley says. While not intended to make patients feel vulnerable or inferior, these nonverbal cues about position and power can inhibit communication, she says. Because of such issues, patients may wait until asked specific questions by the physician to offer information, for example.

When communicating with patients, physicians usually do not offer a step-by-step accounting of their reasoning, Gwin

(Continued on page 4)

(Continued from page 3)

says. “Physicians’ work is largely problem-solving in nature and is done with a much more sophisticated knowledge base than patients have,” he says. “As a result, physicians tend to skip steps when they talk to patients, such as telling them what may have caused the condition.” While the process of determining a differential diagnosis—a list of possible diagnoses based on the patient’s symptoms—is almost automatic for physicians, it is not obvious to patients, says Gwin. Nonetheless, patients usually want to understand why the doctor believes that their symptoms point to a particular illness or disease, as well as what the diagnosis means. In fact, a 1995 study published in the British journal, *Family Practice*, titled “Patient Expectations: What Do Primary Care Patients Want From the General Practitioner and How Much Does Meeting Expectations Affect Patient Satisfaction?” revealed that patients wanted an explanation of their conditions or problems more than any other type of information. Patients may refrain from asking questions, however, for fear of appearing ignorant or because they believe that asking questions might be interpreted by the physician as questioning his or her judgement.

Following a Physician’s Lead

Communication is a two-way process. Patients tend to follow the physician’s lead, so by responding to—rather than by initiating—communication, physicians are in the best position to break the “don’t ask, don’t tell” cycle that often characterizes such interactions. But what factors encourage patients to provide information, or ask questions—or discourage them from doing so?

“There are four variables that affect how patients perceive the quality of communication with their physicians,” says Bentley. “During the medical encounter, patients observe the physician’s behavior to ascertain how receptive the physician is to their comments, whether the physician likes them, whether he or she cares about them, and what the balance of power is in their relationship,” she says. The balance of power refers to whether the physician is seen as being in a subordinate, peer, or superior position.

“In terms of communication, from the patient’s perspective, receptiveness and car-

“Regardless of a physician’s education and credentials, if patients don’t feel that the physician has listened to them, it is unlikely that they will trust the physician’s diagnosis.”

—Sheila C. Bentley, PhD, Bentley Consulting

ing are the most important attributes for physicians to have,” Bentley says. Most patients are less concerned about whether their physician likes them, she says, but they tend to equate caring with a physician’s motivation to provide them with high-quality care.

What patients want in terms of the balance of power in the relationship, however, depends on the nature of the medical encounter, Bentley says. “In most cases, the more pain the patient is in, the more the patient wants the physician to be in a superior role—to take over and be paternal,” she says. If the interaction involves a considerable amount of decisionmaking, however, most patients prefer their physician to behave more like a partner, she says. But patients seldom, if ever, want physicians to behave as subordinates. “This is in contrast to other service-related industries, where if you’re the customer, you generally want the customer service person to be in a subordinate position,” she says.

Research in business settings has shown that reducing the perceived “power imbalance” between managers and employees improves employees’ motivation and compliance with job requirements. Companies that have initiated casual-dress days, when management and workers wear casual clothing, have found that this practice helps to break down communication barriers in the workplace.

Gwin strongly cautions that a casual-dress approach is not appropriate for physicians and patients, however. “When the CEO of a company is not in his high-authoritarian navy blue suit, he becomes more approachable for employees,” says Gwin. “But if you impose that paradigm on the physician—suggesting that he or she become the patient’s peer—then you’re basically attacking the underlying premise

of why the patient goes to the doctor,” he says. “Taking away the physician’s white coat, stethoscope, and other badges of the trade, diminishes the physician’s aura of expertise and authority,” Gwin says. In part, patient compliance depends on the patient’s perception of the physician as a recognized expert in treating medical problems, he adds.

Improving Quality

Since patients closely observe what the doctor says and does during the medical encounter, they interpret the doctor’s receptiveness, caring, and interest from the physician’s behavior, Bentley says.

Therefore, it is important for physicians’ behaviors to be directed toward gaining compliance, enhancing credibility, and developing cooperation with the patient, says Gwin. Unlike managers and employees who interact almost daily, physicians may see patients infrequently and for short periods of time. “Of necessity, physician-patient communication needs to be focused on improving the patient’s health,” says Gwin, “rather than having them become ‘warm and fuzzy’ friends.

“Falling into stale communication patterns can stifle new, different, or fresh ideas that might be helpful in providing better care,” says Gwin.

If physicians are willing to change ritual communication routines, and encourage patients to share information and ask questions, patients are likely to be more satisfied with the process of care, and they may have improved outcomes as well. Physicians are likely to benefit from having higher patient satisfaction scores, which can mean continued or increased referrals from health plans, other physicians, and patients.

—Reported and written by Laura M. Northup, in Mashpee, Mass.

Experts Offer Best Practices in Communication

Experts suggest that physicians use several behavioral best practices when seeking to develop optimal communication levels with patients. Among the suggestions are the following:

Meet new patients in the office, not the exam room. “A first meeting in the physician’s office allows the patient to be fully clothed; both the physician and the patient to be seated; and provides an opportunity for the patient to share information in an environment where he or she feels less vulnerable,” says Sheila C. Bentley, PhD, principal of Bentley Consulting, in Collierville, Tenn.

Take the patient’s hand in both hands during the handshake. “Research on non-verbal communication has shown that the person with the highest apparent authority in a relationship can affirm and strengthen the esteem of the other person by using extraordinary or acceptable touching behaviors,” says Stanford P. Gwin, PhD, professor of health at the University of Southern Mississippi. Of the factors people use when forming impressions during initial meetings—including attire and personal hygiene—the dominant one is the quality of the handshake.

Ask open-ended questions and encourage patients to talk. “This technique can be especially challenging for physicians because they have a limited amount of time to spend with each patient,” says Bentley, “even though they want to give patients time to complete their responses without making them feel rushed or that their answers aren’t important.”

Interestingly, a study published last year in the *Annals of Internal Medicine* titled, “The Effectiveness of Intensive Training for Residents in Interviewing,” showed that medical residents who were trained to allow patients to talk, pursue psychosocial issues, and build rapport with patients could do so in the same amount of time (less than 15 minutes) as residents in a control group who did not. Further, the study found that these behaviors did not affect the accuracy or efficiency of medical data-gathering during the encounter.

Maintain eye contact when the patient is speaking. “Maintaining eye contact conveys listening,” says Bentley. But doing so is not always easy or comfortable. Gwin suggests this strategy for physicians: Concentrate on one of the patient’s eyes, and then shift to the other once the gaze becomes uncomfortable. “Patients cannot discern the switch, but most will be measurably more comfortable speaking when they believe that they have the physician’s full attention,” he says.

Use positive listening behaviors. In addition to maintaining eye contact, physicians can lean forward, nod, and abstain from other activities while the patient is speaking. These behaviors will be interpreted as active listening. “The more willing you are to listen to the other person, usually the more willing they are to listen to you,” says Bentley. A study published in *JAMA* on Jan. 20, “Soliciting the patient’s agenda: have we improved?” revealed that physicians typically interrupt patients after only 23 seconds, even though patients allowed to complete their statement of concerns used only six seconds more on average than those who were interrupted. “Like interviewing skills, training and practice are necessary to develop effective listening skills,” says Gwin. In fact, in the same study, researchers found that physicians who received such training were twice as likely to allow patients to complete their initial statements.

Probe for unmentioned problems. “Often, patients communicate less significant problems first to gauge the physician’s reaction, and wait to tell physicians about their more serious concerns,” says Bentley. In “Wrapping Things Up: A Qualitative Analysis of the Closing Moments of the Medical Visit,” an article published in the February 1997 issue of the British journal, *Patient Education Counseling*, researchers reported that in 23% of the medical encounters studied, patients revealed new problems during the closing moments of the visit. Therefore, physicians should ask patients if there is anything else they would like to discuss, or if they are experi-

encing any other problems, even after the patient has seemingly disclosed the reason for the visit, Bentley suggests. “When patients feel that the physician is receptive and cares about their concerns, they feel more comfortable talking about problems, especially those that may be embarrassing or very personal,” Bentley says.

Summarize what the patient says. “Paraphrasing, or repeating back what the patients say conveys that the physician not only listened, but understood what they said,” says Bentley. An empathetic tone of voice shows that the physician cares about what patients have said, especially if they express that they are experiencing pain, she adds. “The more feeling a patient conveys, the more important it is to echo the feeling first, and then summarize the information,” she says. Such phrases as, “It sounds like this is causing you a lot of pain,” or “I can see that this is of great concern to you,” express sympathy.

Set expectations about time. “Many patients come to the physician’s office with an expectation that they will find out what is wrong before they leave,” says Bentley. But often, laboratory test results needed to determine a diagnosis may not be available for several days. “A brief explanation of probable timeframes helps patients set realistic expectations,” she says. Also, Bentley strongly recommends against telling patients that they will be notified only if tests reveal a problem. “Patients fear that a lack of notification might be due to an oversight, or results being lost in the mail rather than because nothing is wrong,” Bentley says.

Ask for patients’ cooperation. Rather than assuming that patients will follow the proposed plan of treatment, Gwin suggests that physicians ask for cooperation. Not only can such a request motivate patients, but it also offers an opportunity for patients to voice concerns and ask questions and for physicians to identify and help patients overcome obstacles that might prevent them from complying with the treatment plan.

—LMN

Why Managed Care Is Doomed to Failure

By Richard L. Reece, editor-in-chief

The nation reveres physicians and resents challenges to their autonomy, clinical hegemony, and judgment. Their moral authority—earned through years of training and personal sacrifices that most Americans can comprehend only enough to be awestruck by it—is reinforced by the generally noble portraiture of physicians, warts and all, in generation upon generation of medical television shows. Physicians have an intellectual incumbency that will reign in the end, which stands in sharp relief to the naked ambitions and hollow advertising of MCO marketers.”

So says J.D. Kleinke in his recently published book *Bleeding Edge: The Business of Health Care in the New Century* (Aspen Publishers, Gaithersburg, Md., 1998). Succinctly stated, Kleinke argues that physicians will win the battle with managed care because consumers will follow them.

“That is the central point to my theory,” says Kleinke, chairman of Health Strategies Network, a consulting company in Denver. “That theory is based on empirical evidence that people pick their doctors and then retrofit their health insurance plan choices around those doctors.” The fact that doctors come first in consumers’ health care decisionmaking accounts for the advent of point-of-service plans, which have severely hampered the HMO model, says Kleinke. “The acquiescence of the HMO community to POS plans signals the fact that HMOs are being forced to recognize that people could not care less about which health plan they have,” says Kleinke. “Nor do they care about the supposedly value-added things that HMOs do. What they do value is access to the physicians of their choice.”

All of the corraling of patients that employers do by purchasing managed care insurance plans is a nuisance that people tol-

erate and do everything in their power to circumvent, Kleinke argues. Hence, he says, people are willing to pay extra for out-of-network coverage or to have elements of physician choice built into the plan; they’ll even risk financial liability in an emergency. “HMOs have tried for years, through very expensive marketing and public relations activities, to preach to the community the value that they add to the health care system, but those public relations messages contradict the reality that people see when they try to use the system,” says Kleinke. “Basically, the goal of HMOs is to put obstacles between people and care; as a result, any investment HMOs make in their PR message is lost in the reality of how they do business.”

Contradictory Cultures

Does this mean that managed care organizations are doomed? Kleinke seems to think so. Large health insurance organizations that try to dictate medical practices nationwide from a corporate headquarters in Connecticut, Minnesota, Southern California, or wherever, are doomed to fail because of what he sees as a contradiction in cultures. “Take, for example, what Aetna U.S. Healthcare is trying to become,” Kleinke says. “It wants to be a huge national health insurance organization that has thousands of contracts and processes lots of information. As such, it is an execution-oriented and administratively complex business that doesn’t have a lot of room within the organization or a lot of energy at the end of the day to do the more compelling and difficult task of managing care, which is the other role it wants to assume.”

Managing contracts and medical information on the one hand, and medical care on the other, are two different activities that, Kleinke says, result in two different

business cultures: one culture is execution-oriented, like a Federal Express; the other, which involves what he calls the “development and deployment of medical management intellectual property” relies on innovation and creativity. “No organization that wears both of those hats, while dealing with enormous financial and market pressures and simultaneously trying to integrate five or more acquisitions, can successfully sustain that contradiction over time,” Kleinke argues.

The way managed care organizations contract with providers is another force that will contribute to their demise, says Kleinke. “As they push financial risk for care closer to the actual caregivers through the use of capitation, global package pricing, or other types of risk-sharing arrangements, they are, in effect, giving up their financial control of patients and as a result their control over medical decisionmaking,” he says. “Once that happens and providers are delivering care locally, what basis does the national managed care company have to impose its will on the way care is being managed locally?”

But even if the large managed care organizations give up financial control of patients and their medical decisionmaking authority, they are likely to be tight-fisted when it comes to giving up the 25% of the premium dollar that they garner for administration, handling of the risk machinery, and marketing. So just how long will they be able to hang on to that share of the health care dollar? As long as it takes for providers to develop the market savvy and cultural readiness to accept direct premium risk from consumers, local employers, and the federal government, says Kleinke.

“Basically, it comes down to this: As long as the competition isn’t successful at getting its act together and beating HMOs at their

“The acquiescence of the HMO community to POS plans signals the fact that HMOs are being forced to recognize that people could not care less about which health plan they have. What they do value is access to the physicians of their choice.”

—J.D. Kleinke, Health Strategies Network

own game, HMOs win, if only by bitter default," Kleinke says.

After the game is over and the dust settles, what will the relationship be between the hospitals and the physicians? Who will be captive of whom? "Physicians and hospitals will be captive of each other," Kleinke says. "Frankly, they will strike a truce because they will be mutually dependent on each other and power will shift back and forth between them, depending on the issue. For example, who decides what medical devices or computer system to buy? Though both will have input, the doctors will drive the first decision, and the administrators will drive the second."

Contractual Relationships

Ultimately, physicians and hospitals will be locked together through contractual relationships that will enable them to co-market directly to consumers, employers, and the government, Kleinke predicts. At that point, neither will clearly own or be able to beat up the other, Kleinke says, although he points out that there will be some markets in which one group has advantages in terms of negotiating power that the other group does not have. "In a community with a lot of excess inpatient capacity, for example, physicians can be prima

"As long as the competition isn't successful at getting its act together and beating HMOs at their own game, HMOs win, if only by bitter default."

—J.D. Kleinke, Health Strategies Network

donnas and threaten to move patients from one hospital to another as they choose," he says. "In such cases, physicians tend to have the upper hand and a lot of negotiation goes on about capitation and how to divide the money. Conversely, in markets where a Columbia has come in and aggressively removed or rolled up much of the market's hospital capacity into one corporate group, physicians are at the mercy of the hospital system. Most markets fall right in the middle of these two extremes."

Even with the variations from market to market, what will ultimately force a truce between hospitals and physicians is the mutual recognition that they sink or swim together, Kleinke says. In other words, they will work together when they realize that they cannot go separately to market with a brand and an insurance product to beat HMOs out of that 25% of the health care premium dollar. "Hospitals have to recognize that they couldn't exist without physicians and physicians must recognize that they cannot exist without the infrastructure—particularly the capital and information systems—that hospitals have," he says.

Once they have finally settled their differences, the heavy-lifting of market-driven reform begins: fashioning a health care system out of what has been a fragmented battle of competing interests—a health care system that works for consumers who are becoming ever more informed, more empowered, and more demanding.

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

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(Continued from page 1)

incentives from the patient-care decision-making process,” Weprin says. “The doctors would no longer be paid for doing more procedures. Instead, those who were doing the best job with the most number of patients would get the most money.”

Many ob-gyns were more receptive to the idea when it came from OGM than from an HMO, Weprin says. “Managed care was

most appealing element of prepaid reimbursements to physicians, says Peter Kongstvedt, MD, a health care consultant and partner with Ernst & Young, accountants and health care consultants in Washington, D.C. Kongstvedt also is a member of the editorial Advisory Board of *Physician Practice Options*. About 25% of the nation’s approximately 38,400 ob-gyns

never been late with a payment,” he adds.

Payment predictability notwithstanding, Kongstvedt and others point out that capitation is not without financial risk to ob-gyns and other specialists. “Specialists, particularly those with little or no prior experience with capitation, need to appreciate the risks of these contracts,” says Jeremy N. Miller, a health care attorney and a principal with Miller and Miller, a law firm in Los Angeles. Physicians should examine carefully any capitated contract, no matter who is paying the bill, Miller says. (See “Eight Important Elements to Review When Evaluating Capitated Contracts.”)

OGM’s capitated monthly payments to its members cover all obstetric and gynecological care, including deliveries, but not lab work or mammograms. Weprin will not say exactly what OGM pays its network physicians. But he does say that the national average for ob-gyn payments ranges from \$3.30 per member per month to \$4.50 and that OGM falls within this range. In a recent study, OGM compared capitated payments to claims submitted under fee for service. The results showed that 95% of its members have earned more under capitation than they would have earned if they

“We begin with the assumption that good utilization means providing the right amount of care, and no one knows better than physicians what’s best for their patients.”

—Stuart Weprin, MD, Ob/Gyn Management

already being forced on them,” he says. “They saw their already discounted fee-for-service rates falling. And the fact we’re practicing ob-gyns meant we understood their concerns—autonomy over patient care, appropriate financial rewards for proper care, and steady, predictable monthly payments.”

The predictability of payment is often the

receive capitated reimbursements, according to the AMA. “Contracts that provide a regular revenue stream and the elimination of uncertainty will be worth a measure of peace of mind to most specialists,” Kongstvedt says.

Given that physicians want a regular, predictable stream of revenue, OGM pays its members monthly, says Weprin. “We have

Eight Important Elements to Review When Evaluating Capitated Contracts

Specialists who enter into capitated contracts, either with a managed care organization or with a specialty management company, should be aware of the financial risks inherent in those contracts, says Jeremy N. Miller, a health care attorney and a principal with Miller and Miller, a law firm in Los Angeles.

“Capitation can produce rewards as well as risks for specialists,” says Miller. “But there are steps a specialist can take to reduce the dangers and maximize the benefits, including a careful examination of a proposed contract.” Among the key elements that every physician should review in a typical capitated contract are

1. Definitions
2. Payer’s obligations

3. Specialists’ obligations
4. Compensation
5. Utilization review and quality assurance
6. Exclusivity
7. Term and termination
8. Amendment

Definitions. Many contracts contain a section that defines its key terms. The definition of covered services—those that will have to be provided in exchange for the fixed, capitation payment—is the single most important section in a capitated contract. “Obviously, the fewer services for which the specialists are responsible, the lower the risk,” Miller says. The converse is also true, of course. Which services are covered is often one of the most con-

tentious negotiating issues, say experts in capitation contracting. As a result, any service not listed could be a source of disagreement in the future. What’s more, if a service is not listed and a physician is not paid to provide the service, he or she could lose money later if the payer decides the physician should have been providing the service in question.

Payer’s obligations. The payer’s obligations should include paying the capitation amount each month, verifying eligibility, assisting and supporting the specialists’ office staff, collecting and distributing utilization and other key information, and resolving grievances.

Specialists’ obligations. In addition to providing the covered services for a speci-

were paid under a fee-for-service system.

The reason physicians earn more income under capitation is because the reimbursement system has reduced excess utilization and thus their costs are lower, Weprin explains. "In essence, what we've done is redistribute the money within the system," he says. "The small number of physicians performing the largest percentage of procedures are no longer earning the most money in our networks. The most money goes to the ob-gyn performing the best care in the most efficient way possible." Efficient physicians earn more money because their costs are lower.

The realignment of financial incentives has been effective in controlling utilization, even though preauthorization protocols have been removed, says Weprin. Before joining OGM, the physicians now working with the company had an overall cesarean-section rate of 27.1%, Weprin says. By the end of 1996, that rate had fallen to 18.6%. Between 1995 and 1997, the number of hysterectomies among patients fell 33%, the number of D&C procedures fell 55%, and the number of laparoscopies fell 50%. Surveys conducted by UnitedHealthcare have shown no drop in patient satisfaction,

says Newcomer, United's medical director.

When utilization rates fall and patient satisfaction scores do not decline, managed care organizations begin to notice. OGM's network in Dayton now includes 115 physicians, covering 180,000 UnitedHealthcare lives. The company has also expanded into Southern Florida, where it now has a network of 213 ob-gyns with 260,000 covered lives under a contract with Health Options, an HMO in Jacksonville. In addition, the company is developing a network in Kansas City, Mo.

Growing Quickly

In some markets, OGM contracts with physician organizations, such as large groups or IPAs, and then markets the physicians' services to managed care organizations. In other markets, it contracts with HMOs and develops a network, which can include IPAs, groups, and solo practitioners. "We have to be flexible because each market is different," Weprin says.

To meet the management requirements of these contracts, OGM has developed an extensive information system, which it uses to track surgical rates and subspecialty referrals. "We provide regular feedback to our

members on their practice patterns, which helps them control utilization," says Weprin. The company negotiates managed care contracts for its members, administers care payments, and conducts periodic quality-of-care and patient satisfaction assessments. It also has developed appeals and grievance procedures.

OGM collects 6% of the capitated rate for its services. "That's a low fee for specialty management, particularly compared with other management companies," Weprin says. "We can do it because we have a well-designed and efficient system, and we understand the practice requirements of our specialty."

OGM is a case study in cost-effective specialty care, according to Newcomer of UnitedHealthcare. "Specialty management, particular when it's run by the physicians themselves, works well," he says. "And physicians seem responsive to the idea. Especially in managed care markets, someone has to manage what the group is doing. Capitation requires expertise. That expertise can be particularly valuable when it comes from a peer."

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

fied rate, the specialists likely will have to submit certain encounter data, meet quality standards, agree not to discriminate against capitated patients, collect copayments, follow approval procedures for cross-specialist referrals and hospital admissions, participate in peer review, assist in credentialing, meet insurance requirements, and comply with the payer's administrative procedures.

Compensation. A capitation rate cannot be considered in a vacuum, says Miller. "Its adequacy is inextricably tied to the definition of covered services," he says. Also, there are vast differences in capitation rates depending on the covered population, including the age and sex of the participants, and the particular specialty. For example, some payers have provisions for when there are not enough enrollees in a particular plan to make capitation feasible. "The contract could provide that, until the minimum acceptable

number of lives is reached, the specialists will be paid on a discounted, fee-for-service basis," says Miller. "This is known as a low-enrollment guarantee."

Utilization review and quality assurance. The contract should specify what plans, procedures, and protocols a specialist will be expected to follow for each patient.

Exclusivity. Typically, specialists are not asked to become exclusive providers because the payer cannot offer enough covered lives to make an exclusive arrangement economically viable. Specialists, therefore, should be careful about agreeing to a contract that attempts to limit their ability to enter into contracts with other payers.

Term and termination. Unless the specialists have prior experience with capitation, they probably should not enter into a contract for more than one year, Miller says. They also may want the contract to provide for early termination, with or without cause.

The contract also should discuss posttermination responsibilities. Specialists should try to limit their posttermination obligations to no more than 30 days, and during that time, they should be paid at a previously agreed upon fee-for-service rate. Contracts typically are renegotiated annually, and rates can be adjusted based on the physician's experience during the previous year.

Amendment. The contract should state that it can be amended only with the written approval of both parties. Specialists should look for hidden amendment provisions that allow the payer to change the contract unilaterally by adopting administrative policies and procedures.

"By carefully approaching and handling the contracting process, specialists can reduce the risks of capitation agreements significantly, and increase the likelihood of a successful and rewarding experience," Miller says.

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Health System, Doctors Form New Group

By Thomas M. Gorey, JD

Many physicians are adamant about relying entirely on their own capital and other resources when they set out to form a new group practice. Other physicians look to capital partners to turn the dream of group practice into a reality. One group that was formed as a result of physician-hospital collaboration is the Medical Clinic of North Texas, in Fort Worth.

MCNT was formed on Jan. 1, 1995, following merger discussions that had begun among the physicians at the end of 1993. At that time, managed care was just entering the local market, driven in large part by Harris Methodist Health System (now, Texas Health Resources), a significant presence in the Dallas-Fort Worth market. The physicians were concerned not only that managed care would negatively affect their clinical autonomy, but that it could lead to a loss of access to patients as well.

Managed Care Threatens

The physicians began a series of discussions about how to maintain professional autonomy and keep their practices busy. Initially, the discussions were between Lorimer Clinic, a medical group of six general internists in Fort Worth; and Internal Medicine Associates of Fort Worth, which included five general internists and two endocrinologists. These initial discussions led the physicians to conclude that even if the two groups merged, they would be too small to exert significant influence in the market.

The physicians believed that they would need at least 50 primary care physicians to have enough clout to negotiate effectively with managed care companies. They arrived at this number by assuming that an efficient primary care physician can care for a panel of about 4,000 patients, so a 50-physician group could provide primary care for about 200,000 patients. Based on this conclusion, the physicians began to seek out solo practi-

tioners and small groups that might be interested in participating in a practice merger.

At this time, Harris Methodist Health System in Fort Worth offered to provide financial assistance to help form the medical group, and the physicians accepted the offer. As a result, Harris Methodist became the capital partner in a venture that would involve the mergers of a number of practices into a much larger group.

Under Texas law, only physicians may hold an ownership interest in a professional association. To comply with this law, the physicians established a separate organization, Impel Management Services, to hold

each other well and were familiar with each other's reputations in the community. Also, they shared a common desire to get out of small-group practice. After the initial merger, MCNT quickly started to add more physicians and groups. By late 1996, the group had grown to more than 50 physicians located throughout Dallas-Fort Worth.

Each of the merging practices mailed an announcement about the merger to its patients. Information on the merger also was placed in physicians' offices, and ads and interviews were published in area business journals.

The value of each practice was calculated

When the group was forming, salaries were guaranteed for the first two years of operations, a compensation scheme that led to a decline in physician productivity.

Harris' financial interest. Impel is a management company whose purpose is to provide the infrastructure and services needed to support the medical group's involvement in managed care. In return for its financial investment, Harris Methodist received shares of preferred stock in Impel, while the physicians held all common stock.

Recognizing that they lacked expertise in administration and managed care, the physicians' first major step in the merger process was to hire a chief executive officer. Recruiting a CEO before consummating the merger was possible because of Harris Methodist's willingness to guarantee the CEO's employment contract. Harris agreed that even if the merger fell through, it would honor the CEO's three-year employment contract.

Merging the Groups

The initial merger in January 1995 involved 20 physicians: the six physicians in Lorimer Clinic; the seven physicians in Internal Medicine Associates; two two-physician groups, and three solo practitioners. The physicians involved in this merger knew

on a discounted cash flow basis, and each physician received a common interest in Impel equal to the value of the physician's practice. As part of the merger, the physicians were paid fair market value for the hard assets in their practices; on average, \$20,000 to \$30,000 per practice, depending on the size of the operation. The physicians retained their accounts receivable and were placed on salary beginning with the effective date of the merger.

Each physician involved in the merger signed a 10-year employment agreement.

Editor's note: The Medical Clinic of North Texas 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 associations. 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 medical societies and \$95 for others.

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MCNT believes that a long-term physician employment contract is important to the viability of the group because, if a physician leaves the group, there is an immediate negative effect on revenue. MCNT also believes that the length of the physician employment agreements can affect the valuation of Impel. Finally, it views the 10-year contract as a commitment to MCNT by the physicians.

Administration

Although MCNT has benefited from some administrative standardization involving hiring policies, pay scales, information systems, registration procedures, chart policies, and fee schedules, deciding what processes to standardize has been difficult. Initially, almost all practice management activities were taken away from the practice sites, but the group learned that not only was this strategy inefficient, it also had a negative effect on morale. Consequently, the group has since returned substantial autonomy to individual practice sites.

After attempting to centralize billing and collections, for example, some functions have been shifted back to the practices. A group representative observed that centralized billing and collections resulted in a less direct sense of ownership, and the physicians missed being able to monitor the collection rate on billings.

Continuing to focus on administrative improvements, the group is working to lower overhead by controlling staffing levels. In the past, the group tried hard not to interfere with the physician-nurse relationship or with other office staffing issues. In essence, the physicians could have whatever nursing staff they requested, regardless of cost. Since the compensation plan provided for guaranteed salaries, staffing levels had no effect on physicians' income. MCNT's current compensation plan, however, links physician income to staff expenses. As a result, physicians are much more judicious in their use of support staff. The group has found that physicians make more cost-effective personnel decisions when they have data illustrating the financial effect of those decisions on income and when they have information on the staffing practices of other offices in the group.

Like most medical groups, MCNT has found the compensation issue to be a formidable and continuing challenge. When the

Lessons Learned From Forming a Large Group

Forming a physician organization capable of accepting and managing financial risk taught the Medical Clinic of North Texas (MCNT), in Fort Worth, several important lessons:

Address group culture on a continuing basis. To assume financial risk successfully, it is necessary to have a tightly integrated group. Although it has been difficult for some physicians to work together as a group, MCNT is continuing to build a team by creating an active committee structure and by establishing mentors for newly recruited physicians.

Identify and cultivate physician leaders. As the group faces new challenges, it has learned that it is becoming increasingly important to identify physicians with leadership skills and an interest in medical group governance. Contrary to popular belief, forming a group practice does not free physicians from all business decisionmaking responsibilities. If anything, the size of the group requires that physicians have even more sophisticated leadership and business skills.

Allow adequate time for training and preparations. The months immediately following a merger are always difficult, but they can be even more so if too much change occurs too quickly. It is important to devote time early in the process to ensure a smooth, comfortable transition.

Do not underestimate the cost of running a large organization. MCNT has not seen large economies of scale as a result of its merger; but it has benefited by a gain in administrative sophistication in information systems and data analysis. Improved administration, however, adds significant costs. All physicians considering a merger should recognize that overhead could increase.

Increase production to compensate for increased overhead. If physicians continue at the same production levels as before the merger, less income will be available because of the higher expenses associated with group practice.

Find a capital partner to facilitate success. Forming a new medical group can require a substantial amount of money. Physicians—especially primary care physicians—may not have the capital needed to hire experienced staff, to implement a new information system, and to carry the group through difficult financial times. In such cases, physicians may need a capital partner.

Face tough decisions to make the group stronger. Although MCNT has faced a number of difficult decisions, it believes that doing so—and surviving them—has made the group even stronger and has prepared it for the tough challenges that lie ahead.

—TG

group was forming, physicians wanted strong assurances that they would not be financially harmed by the merger. So, the group guaranteed salaries for the first two years of operations. This compensation scheme, however, led to a decline in physician productivity. After MCNT experienced a loss in its second year, the group modified its compensation plan. Beginning in 1997, the physician compensation formula has been based on productivity, and all physicians share equally the profit from ancillary services.

Productivity also has been an issue for MCNT. Because there is a wide range in annual billings by physicians, the group has

initiated discussions with physicians who have below par productivity levels. It uses data, such as number of patients seen per day, number of hours worked per week, and vacation time taken by each physician, as the basis for such discussions. These physician meetings are designed to be educational and to suggest ways in which physicians can increase productivity.

Looking back, the MCNT physicians have learned important lessons about forming and running a large group practice. One such lesson is that while there are many advantages to having a larger operation, such operations present new, and more formidable, challenges. ■

PPMC Veteran Says All Physician Practice Management Companies Are Not the Same

Richard Adams is former senior vice president of the MED3000 Group Inc., a privately owned physician practice management company in Pittsburgh, and past president of Alliance Ventures, a subsidiary of Blue Cross of Western Pennsylvania, also in Pittsburgh. Most recently, Adams led the establishment of a health care provider consulting and service company, Med Solutions, another Pittsburgh company. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q. Most physician practice management companies have grown by acquiring and purchasing the revenue of physician practices. You contend that all PPMCs are not alike. Tell us more about the types of PPMCs and how they differ.

A. Unfortunately, much of what has been written about PPMCs and their future viability has been stereotyped and identifies them collectively. There is little question that the industry has followed acquisition strategies to expand by using the financial leverage they had in the public stock markets, rather than through operational efficiency. Such acquisitions were performed from a Wall Street perspective rather than from a strategy of spending resources on expansion and management infrastructure. That "Wall Street" acquisition model presented a "get-rich-quick" opportunity for many physicians, who, for the most part, didn't understand how the PPMCs would charge for their services or the risk involved in not building sufficient revenue to cover the newly imposed management fees.

Although many PPMCs continue to purchase the assets and revenue of practices and still create long-term management agreements, other PPMCs have more fully understood the importance of maintaining physician independence and ownership, and have sought to retain incentives for physicians to remain productive in their respective practices.

While many of today's surviving PPMCs are beginning to recognize these facts, other companies have focused on building provider networks that have been characterized by the term "partnership." That is, they create a relationship with physician organizations that involves collaboration to preserve physicians' independence, autonomy, and their role as the principal stakeholder. The partnership concept I am describing allows physicians to continue to function in an entrepreneurial environment while creating a means to meet future managed care expansion and system requirements. In addition, this model can be structured to build wealth through the appreciation of the physicians' assets.

There should be no reason for physicians not to develop mechanisms that will enhance their asset value over time, a common practice that has been followed

ment. At the end of the day, the network, group, or organization will have created an entity that will continually increase the value of its balance sheet and its ability to access less costly capital, avoid personal debt assumption, and provide appreciation of the stakeholders' assets.

Q. Can you describe the partnership model with a PPMC more fully? Does this model affect equality of governance, for example? Does it create a minority voice for physicians, and what are the effects if it does?

A. I recommend that physicians first determine their future course of action by analyzing the market and forming a business plan that outlines potential opportunities by comparing the network's strengths and weaknesses. This comparison must be accomplished before an entity is created or an equity-partner relationship is consummated. If the plan suggests that an equity-partnership model is appropriate for

"Once a significant level of revenue is lost to a PPMC, or the future upside has been minimized, much of the physicians' incentive and independence is lost."

by many professional groups. To establish this process, the group needs only to create a business entity, while avoiding negative tax consequences, that provides a positive cash flow or retained earnings. The entity's value is enhanced by virtue of its earnings and also can be leveraged as new members join or as other investors increase the price they are willing to spend on a piece of the entity's ownership. If the physician network or group joins forces with a private investor, the value of the entity increases as a result of the public offering potential. Thus, the partnership strategy will increase the value of the group whether it is based on increased revenue, expansion, or a private place-

the network, and the physician organization has created its own management entity, then the physicians may decide to give up ownership in order to have an equity partnership.

Often, the group may consider the positive features of an earlier relationship with a PPMC that will afford it the services required for business planning, managed care contracting, and systems management, and for accessing the necessary capital to build and expand its infrastructure. In any case, the group must evaluate the amount of governance it is giving up, the access to capital that the PPMC brings to the partnership, and how much capital will cost in terms of future revenue. I do

not advocate that any network maintain less than an equal voice in governance and in equity ownership.

Q. *Don't all PPMCs say that they have a partnership with physicians? If so, what then is the principal difference between the partnerships you describe and all the others?*

A. The key to the variation is simply allowing physicians to remain independent. When a group is acquired under the traditional models, a larger percentage of its future revenue will flow to the acquiring PPMC than under the partnership model. In the partnership model, the majority of the revenue continues to flow to the physicians, thus permitting the productivity and ownership incentives to remain intact. Once a significant level of revenue is lost to a PPMC, or the future upside has been minimized, much of the physicians' incentive and independence is lost. By maintaining the entrepreneurial mentality of the group, the revenue should increase and provide the physicians with an increased level of compensation and the PPMC partner with an equitable return.

Q. *Many of the partnership PPMCs that you discuss focus on three areas when they enter into a relationship with a physician group or an IPA: practice improvement, information design, and implementation and managed care contracting. Let's discuss each of these, beginning with practice improvement.*

A. Because the roots of many partnership-focused companies lie in providing basic nuts-and-bolts services to physicians, they seem to have realized the critical importance of maintaining physician ownership and independence in their structural models and have thus been able to expand their core capabilities easily, successfully, and in a cost-effective manner. For example, the practice improvement steps necessary to prepare physicians for managed care contracting require an understanding of what comprises best-practice processes. Those who have performed this function for physicians and

provider organizations in the past seem to be able to relate, and consequently effect, more change within the practices. The

thorough analysis of the specific market. It is essential to set priorities for what must be learned about the market, its managed

"The capabilities to provide real-time data to the delivery site have not been available to physicians in the past, but will be the single most important ingredient for their survival in the future."

fact that understanding and expertise may be more pronounced in these companies makes a transition to broaden their scope and depth much easier to accomplish.

Q. *How about information system design and implementation?*

A. The most important lynchpin in practice management involves the capability of technology and systems to provide physicians with the support they need in terms of managed care functions, such as referral and adjudication, negotiation and contracting, and billing and accounts receivable. These systems are critical to integrate the clinical side with the business side of management effectively because when these two sides are linked they provide the physician group with the ability to chart its course in relation to future contract negotiations.

The capabilities to provide real-time data to the delivery site have not been available to physicians in the past, but will be the single most important ingredient for their survival in the future. Thus, the experience discussed above in terms of practice management may also be a distinguishing capability of PPMCs that have focused on system design and implementation. They have been able to link the practice management and information systems with the third component, managed care contracting and health plan management. The systems component encompasses many different functions for the group, and the most important of these is the

care maturation level, and the potential for gaining future contracts.

As data become available, only then should the negotiations be initiated with the payers. In most markets it is becoming less difficult to secure risk contracts. What physicians should guard against is allowing the group or network to secure managed care contracts until the system capability is developed and functioning because you can't manage what you are not able to measure. Many partnership PPMCs have realized through joint governance and past experiences that there is much system development to be completed before success can be assured.

Q. *Many physicians have become suspicious of PPMCs because of their inability to deliver on their promises to increase income, enhance practice revenue, provide ancillary services, and expand managed care contracting. Why should physicians trust any PPMC?*

A. Until recently, PPMCs were in a period of robust economic expansion. They were growing for the sake of growing mainly due to shareholders' expectations and the arbitrage that was available to PPMCs to purchase practices at a lower price than what they could publicly trade for. The PPMCs had the mandate, if not the self-imposed will, to use their capital for acquisition rather than for infrastructure. As stated earlier, many PPMCs that came out of the practice management service industry, unlike their market-oriented competitors, focused on using

(Continued on page 14)

(Continued from page 13)

capital in the three vital areas to provide the group or network with the functions they would need to survive in the future. Such a strategy provides the infrastructure that will invariably allow the PPMCs to meet the expectations of the physicians and keep the promises they made.

Conversely, a strategy that involves entering a market that is already inflated due to the physician "arms race" among hospitals, insurers, and PPMCs—and adding to this a 15% to 20% management fee—sets up a situation that is bound to fail. This is so because little or no capital remains to meet the group's expectations relative to compensation, contracting effectiveness, system and infrastructure development, and expansion. That formula simply can't provide the capital that groups require to be successful in the short and long term while simultaneously meeting the public market's return expectations.

Q. *Have any groups broken off their deals with the PPMCs that you have been involved with?*

A. To my knowledge, no. Some attrition of physicians has occurred for various reasons, usually due to difficulties encountered in developing a "group think" mentality. This attrition should be anticipated in any emerging organization, since many physicians are unable to shake the old habits of the competitive cottage industry. An important legal issue when forming the organization is usually not the number of physicians in a particular market but rather the physicians' distrust of each other. Therefore, it's important to work hard to form organizations that emphasize the mutual trust of its members.

Q. *In what areas do you believe a group's support functions should focus?*

A. To answer that question, let's first discuss "levers of profitability," which are the core ingredients for a successful practice irrespective of its size and composition. These include coding, billing, and collections; accounts receivable management; operational management; productivity improvement; and enhancement of patient volume or mix. These practice management functions are combined with the need to complete effective and timely business plans; to have access as well as the

"What physicians should guard against is allowing the group or network to secure managed care contracts until the system capability is developed and functioning because you can't manage what you are not able to measure."

ability to allocate capital as required to fulfill the plans and ensure systems connectivity; and to secure assistance in negotiating and servicing contracts.

Combined, these support functions position the physician network to expand, create leverage in population access, and prepare to accept contracts that provide a larger piece of the health care premium. Only then will the providers be successfully reimbursed and rewarded for improved outcomes and payers will be able to control ever-increasing health care expenses.

Q. *When you pierce through the rhetorical fog, success in most markets comes down to a couple of fundamental factors: One is growth of the physician organization and two is growth of the physician income. Do you believe that partnership PPMCs have been successful on these fronts? Are physicians happy with their economic circumstances?*

A. Physicians in most of the networks that I have witnessed have been satisfied with the improved abilities of management to let them care for patients. In situations where risk contracting was an objective, it has taken some time to prepare the networks to accept risk. No one should encourage these networks to rush into risk assumption, even partial risk assumption. The preparation for these types of payer contracts must first involve developing the infrastructure to provide medical and disease management, risk-awareness programs, and effective demand management and patient education services. After a network has been equipped with the proper systems of management, it can successfully negotiate contracts that have a significant ability to increase compensation and the total revenue of the group. Also, physicians in such partnership arrangements have been able to realize additional income through the management entity they have created; that is, through additional income

as well as retained earnings, which also directly increases the value of their assets.

Q. *In the past five years, integrated hospital-based delivery systems haven't done well. Do you expect these relationships to succeed in the future?*

A. Your question poses a difficult problem, which many have addressed in the past year. The fact is that integrated delivery systems, whether hospital- or physician-owned and dominated, face the same issues that insurers do: trying to avoid adverse selectivity and risk-assumption issues by spreading risk to the extent possible. At the same time, they also face the rising cost of technology, competitive employee benefit packages, increased HMO preventive and regulatory requirements, pharmaceutical costs, and our insatiable desire for access to care.

Integrated delivery systems and insurers face the same issues and are under similar constraints. When you have hospitals ratcheting down revenue through aggressive managed care activities while at the same time providing physicians with the incentive to take these savings, all sorts of difficulties come into play. It's very difficult being the provider and the payer. Many hospitals are beginning to realize that physician leadership in their managed care strategies may be the only means to adequately address this dilemma. Thus, it has become more evident that success in the managed care market requires collaboration mixed with compromise and understanding. It simply won't be a win-win situation for anyone, but rather one involving the proper structural and functional arrangements to minimize the loss of revenue and independence. The solutions aren't alike in any two cases and must be evaluated and strategically addressed accordingly.

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

When and Why to Consider a Partnership

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

Readers sometimes ask us for advice on issues related to capital needs and practice options. Often, the questions we are asked concern physicians in similar situations. Two such questions recently posed to us concern physician practice management companies. One physician was considering whether to join a PPMC; the other was wondering if he should get out of one.

A 57-year-old obstetrician-gynecologist asked the first question. He is a solo practitioner in a suburb of a large southwestern city who had been invited to form a partnership with a PPMC. "I've been in practice for almost 20 years and have a successful practice with a stable and expanding income," he wrote. "I've been approached by a start-up ob-gyn PPMC, which has offered to acquire my practice at six times my annual earnings, and offered a five-year employment contract and a 25% annual management fee. The company hopes to gather 30 ob-gyns like myself and then file for an initial public offering next year. I'm skeptical about this offer, since my practice at present is largely unaffected by managed care pressures. What would you advise?"

In general, we tell our physician clients that there are two basic reasons to consider a partnership: economics and strategic need. In responding to this question, we make two assumptions. The first: You will practice medicine for only five more years; that is, until you reach age 62. The second: During this five-year period, managed care will not materially affect your level of reimbursement or your volume of patients. Only you can respond to the first assumption, and the second one will be determined by the marketplace. Depending on how the market in your area develops, you will need to be comfortable that you can get out before managed care becomes such a dominating force that you may be uncomfortable continuing to practice medicine as you have.

With these assumptions in mind, your

decision about whether to partner with a start-up PPMC will be based almost totally on economics. Within the economic framework, two major questions must be considered:

1. What will they pay me?
2. With what will they pay me?

To determine what you are being offered as a purchase price, you first must ask the PPMC how it is applying the "six multiple." Normally, it is a percentage of your pretax, take-home income, which is the amount of money your practice generates after you pay all office and employee expenses.

Despite the upside potential if the PPMC goes public, such organizations are not currently favored on Wall Street and the actual IPO could be many months, if not years, away.

For example, if you take home \$300,000 per year, the PPMC will be asking for a percentage of this income, say 18% for the sake of illustration. Assuming your take-home income has been the same year after year, you would enter into a management services agreement to pay the PPMC \$54,000 (which is 18% of \$300,000) per year. This amount would be a direct hit to your annual income.

Given that you have only five years left to work (and thus would pay \$54,000 five times), and the PPMC is offering what is essentially six years of \$54,000, this deal could be an attractive economic transaction for you, depending on what it pays you *with*. If the PPMC is offering to pay you with 100% cash upfront, continue to move forward with your investigation of the relationship.

If the PPMC is offering to pay you with shares of private common stock that have no market and therefore no liquidity, the

purchase price for your deal is not necessarily \$324,000 because you cannot spend the consideration immediately. If realizing your purchase price is predicated on a public offering of a PPMC, a rather healthy discount should be applied to the \$324,000 cash purchase price because there have been virtually no PPMC IPOs over the past 12 months. Despite the upside potential if the PPMC goes public, such entities are not currently favored on Wall Street and the actual IPO could be many months, if not years, away. We believe PPMCs ultimately will be of significant value to physicians;

until then, you would be giving up \$54,000 in cash compensation each year.

Watchful Waiting

The second question came from one of the 10,000 physicians affiliated with MedPartners. "Medpartners has been very much in the news lately," wrote this physician from a practice in Southern California. "On March 11, it announced it would sell its biggest unit, the Kelsey-Seybold Medical Group in Houston, for \$61 million to St. Luke's Episcopal Health System and Methodist Health Care System. On March 12, its stock fell 17% when California regulators seized control of its California health plan and sought bankruptcy for the unit. Also on March 12, it closed its sale of its Team Health hospital-based physician business to an investor group for \$335 million. The AMA has applauded the quick and decisive seizure by the state of California for 'a financially unstable health provider.' What are my

(Continued on page 16)

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CAPITAL IDEAS

The noncompete provisions in your contract could restrict your ability to leave the group and continue to practice where you live. If you are willing to move out of your restricted area, you may have more options.

(Continued from page 15)

options at this point? Do I wait this thing out? Do I seek other employment?"

We believe your options are driven by what your agreement with MedPartners states, especially in its noncompete provisions regarding your rights to practice in your market. Such provisions could restrict your ability to leave the group and continue to practice where you live. If you are willing to move out of your restricted area, you may have more options.

As for the recent seizure and bankruptcy filing by California regulators: We cannot foresee that such activity bodes well for any company that is seized because it could have an adverse effect on the company's ability to sustain productive relationships with its clients, which are paying its bills. To assume that constriction of your network might occur is reasonable, especially if regulators seek to have these enrolled lives transferred to other financially healthy, risk-bearing physician networks. Word generally travels fast if loss of employment is coming. The best counsel is to keep your ears open.

In any event, you would be well advised to seek the counsel of qualified professionals who have a more detailed understanding of the facts and circumstances of your particular situation. ■

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Richard L. Reece, MD
Editor-in-Chief
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