

PHYSICIAN PRACTICE OPTIONS™

August 15, 1998

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

CONTENTS

Features

Opinion

Prescription for a
Workable PPMC Model 3

Case Study

Urology Group
Embraces Managed Care 8

Interview

Is It Possible to Build
a Kinder, Gentler
PPMC Structure
With Hospitals? 10

Departments

Editorial

Here's What Helps
Groups Get Along 2

Health Care Law

HCFA Issues PSO
Waiver, Solvency
Rules 13

Capital Ideas

Sources of Capital
for Physicians 15

News & Commentary 16

Consultant Offers Unusual Advice on How to Thrive Under Managed Care Although Some Disagree With His Controversial Ideas, Participating Physicians Report Positive Results

On a hot summer morning in a hotel conference room in Deerfield Beach, Fla., 40 physicians and practice managers are sweating through lectures by Greg Korneluk. These high-salaried professionals have traveled from as far as California, have paid \$900 each, and will lose two days of work to hear unconventional ways to succeed in managed care. Then they'll return to their practices and teach what they have learned to others.

"We are the Home Depot of the physician consulting business," Korneluk says of the International Council for Quality Care, in Boca Raton, Fla. Korneluk is the founder and CEO. "We don't do the work. We train others to do the work."

More than a thousand professionals graduate annually from Korneluk's seminars and physician strategy course—a sort of rigorous fitness program for practices. The hundreds of ideas that result from their participation in Korneluk's program lead to increased referrals, satisfied patients, and more efficient and profitable practices, say physicians who have participated in previous Korneluk seminars.

Competitors dispute some of Korneluk's teachings but can't argue with his results. "I've talked to clients who've said he's done a nice job for them," says Michael Parshall, vice president of The Health Care Group, practice management consultants in

Plymouth Meeting, Pa.

Some in Korneluk's Deerfield Beach audience are repeat clients who swear by his philosophies. Family practitioner Mary Welp, MD, from Carrollton, Tex., says that after she started heeding Korneluk's advice last year, she achieved such efficiency that she now ends her workday at 7 p.m. rather than 11 p.m.

"I had a problem delegating responsibility, specifically phone management," says Welp. "Now, in between patients, I hand charts to a nurse and tell her what to say on callbacks. I also handle all prescription refills by fax, cutting the number of my phone calls in half. Now, I have a lot less stress in my life."

Another repeat attendee is Leonard Makerewich, MD, who says income from his ENT practice in Niagara Falls, N.Y., has tripled since he began working with Korneluk in 1982. What's more, he's home by 6 each night with no charts to complete or calls to return.

"Korneluk took me from seeing 14 patients a day to seeing 65," Makerewich says. "He showed me how to remove the nonessential activities, like writing out blood reports and taking a history. He trained me to work at a level at which I'm using only my diagnostic and treatment skills—the things I was trained to do."

Those meeting Korneluk for the first time

(Continued on page 4)

Here's What Helps Groups Get Along

Recently, the leader of a South Florida medical group that was considering whether to merge with two other physician groups asked me why some groups succeed and others do not. "Share with us your experience on helping groups to get along with each other," he requested. The invitation addressed a fundamental dilemma. Group formation is rising in the United States, but physicians who are part of these merging groups are confronting numerous and divisive difficulties in creating larger, harmonious, and efficient group practices capable of assuming managed care risk.

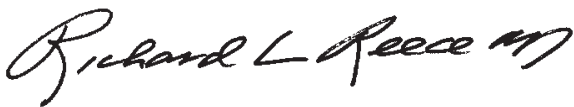
Among the problems groups face when they merge with other groups are these:

- Meshing cultures and practice styles
- Deciding which employees to keep
- Choosing physician leaders
- Minimizing income differences among merging physicians and producing an acceptable compensation formula
- Resolving conflicts between primary care and specialty physicians
- Reversing loss of morale and faith if revenue falls
- Resolving investment decisions, such as which information system to use and how much to spend on information system improvements

Despite these problems, surveys by the AMA show that from 1991 to 1996 the number of physicians per group grew from 9.6 to 14.5, a 51% increase, and the percentage of physicians in practices with 20 or more rose to 10.1% from 6.7% of all physicians. Driving these trends is the knowledge that larger groups win more managed care contracts; solo physicians or physicians in small groups aggregate to prevent being denied these contracts. According to recent data from the AMA, 18% of all solo practitioners have been denied managed care contracts. But among groups of 25 or more, only 3% have been denied managed care contracts.

After years of watching groups operate, I have found that successful groups have several characteristics in common and that groups get along when their physician members see a reasonable path toward stable or rising incomes. Arriving at this healthy financial state may take two to three years to achieve and almost certainly will follow the adoption of a well-crafted strategic business plan. In addition, it will require good management, adequate capitalization for growth, and the recruitment of new physicians. It is also likely that a successful practice will need to add sophisticated information systems. Among the most important characteristics of a successful practice are leaders whom all physician members trust. Managed care markets demand fast decisions by a strong central management team, decisions that can't wait to be voted on democratically or debated by every physician in the group.

Daniel Zismer, a consultant with Towers Perrin in Minneapolis, summarizes why some groups get along well: "Physicians are getting smarter. When they aggregate into larger group practices, their business opportunities expand exponentially." In other words, merging out of desperation breeds divisiveness, but merging to expand contracting and business opportunities fosters togetherness.



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Prescription for a Workable PPMC Model

By Bill Freeman

Physicians have been warned about the pitfalls involved in affiliating with a physician practice management company (PPMC). Some observers have told them their chances of avoiding these pitfalls improve if they identify the value such an affiliation brings to their practices by examining the PPMC for four key elements: a focused market strategy, managed care expertise, strong management skills, and the ability to execute its business plan. Presumably, physicians could safely affiliate with the "perfect" PPMC that contains these elements.

In the perfect PPMC world, physicians have absolute local autonomy and their every capital need is met. What's more, they are entrusted with majority ownership and controlling governance of the PPMC enterprise. There are no risks, only rewards.

Unfortunately, this perfect PPMC world cannot exist in part because the federal Securities and Exchange Commission and Wall Street investors do not allow a public company to operate without risk arrangements involving all participants, including physicians, management, and investors.

To compete effectively, physicians are organizing themselves into various legal and operational structures. One of these structures is a PPMC that positions physicians to compete. While there is no perfect—that is, risk-free—PPMC model, one particular model may be workable in today's health care market.

This workable PPMC model is committed to quality, brings value to the community, and offers high accessibility through primary care sites located close to patients' homes and businesses. It is an integrated health care delivery system that requires physician leadership, and uses a unified patient data system and various financing arrangements and partnerships. Most important, the system is capable of managing medical costs without cost shifting.

Bill Freeman is vice president, operations, of MD Alliance Corp., a physician practice management company in Atlanta.

The model is basically a merger of physicians and physician groups who share the same goals and agree on the means to achieve them; it is, in essence, a physician-centric, cooperative organization. Its goals include greater access to capital through a public stock offering, growth for each local group, bargaining power with payers, supplemental income to physicians, and a pooling of intellectual capital and management resources.

This model allows the physician cooperative to retain a great level of national and local autonomy, even in day-to-day practice operations. Decision-making autonomy is directed by the national cooperative

One PPMC model is, in essence, a physician-centric, cooperative organization.

because it is owned by the physicians. Even as a public company, this PPMC is governed by a physician-controlled national board of directors. Physician owners would control a majority of the public stock, unlike public PPMCs in the marketplace today.

This model provides direct access to capital via the decision-making authority of the board, which governs the direction and use of the capital raised by the initial public offering. Access to this capital can be used to fund local and regional management service organizations, acquire state-of-the-art information systems, establish reserves for risk contracts, develop or purchase profitable ancillary services, and fund retirement for physicians.

Growth for each local physician group is directed cooperatively by the physicians and the public company management team. The group's decisions ultimately supplement each physician's income via prudent and profitable utilization of capital resources. The larger the physician cooperative is locally and nationally, the greater the bargaining power it will have in negotiating with managed care organizations.

Because physician owners and members

of the management team face the same restrictions on stock divestiture, physician shareholders have a great incentive to increase the value of the company's stock over the long term.

Under this model, the management fee paid by each physician group to the national cooperative is lower than that currently paid to public PPMCs. The fee covers certain specific base services; additional services, if needed or desired, can be added for an increased fee.

The public offering occurs through a mechanism that provides each physician group a way to sell its practice assets in a tax-deferred transaction. By exchanging

practice assets for company stock, physicians are not hit immediately with a heavy tax burden. Restrictions on the cooperative's stock provide for sale at a time in which gains from the sale of the stock are treated as long-term capital gains and taxed at a lower rate.

This model has potential weaknesses. Since the value of public stocks fluctuates, the value of a physician owner's stock will depend on earnings of the company and market conditions. Also, despite their comparatively increased level of autonomy, physicians will have a reduced level of control to a certain extent due to the requirements of being a public company. Also, this model offers physicians and physician groups no cash upfront for the sale of their practice assets.

The model also has several advantages, however. Among them are capital for growth, profits to replace declining income, stock for value at retirement, the greatest level of local autonomy offered by any national PPMC, and a board of directors and a company majority-owned by physicians. In sum, it provides physicians with a vehicle to control their destinies more effectively. ■

(Continued from page 1)

are often skeptical about his theories. “Will they work in the real world?” asked Gregory Pauly, administrative director for primary care at Massachusetts General Hospital, in Boston. Pauly manages 220 physicians at 16 sites. Interviewed several weeks later, Pauly says he believes Korneluk’s notions did not represent “real life,” and he did not implement any suggestions.

Indeed, Korneluk is a contrarian, one who challenges traditional notions. He does not believe solo practice is dead, for example. He doesn’t accept the idea that grouping physicians necessarily brings economies of scale, or that patients think more of a physician who spends more time with them.

Perhaps the most mainstream of Korneluk’s teachings is his organization’s

“We are the Home Depot of the physician consulting business. We don’t do the work. We train others to do the work.”

— Greg Korneluk, *International Council for Quality Care*

mantra: The most successful physicians improve quality and patient satisfaction while increasing volume and efficiency. To some, this may seem like a contradiction in terms. But Korneluk claims that by eliminating wasted time and making quality improvements, it can be done.

“Money is the result of delivering quality,” he says. “One of the worst things to happen in health care because of managed care is that providers focus on dollars. When doctors focus on economics, dollars go down; when they focus on quality, dollars go up.”

Some of Korneluk’s teachings require remodeling offices to gain efficiency. But physicians can make little enhancements as well. “He takes an industrial engineer’s approach to practice management. I once heard him say you shouldn’t have door-knobs on exam room doors because they slow you down,” says Parshall, of The Health Care Group.

Revolutionary Ideas

Developed over time and collected in a book, *Practice Enhancement, The Physician’s Guide to Success in Private Practice* (MacMillan, 1985), Korneluk’s ideas were

revolutionary even at that time. In fact, he says, the theories were developed for a managed care environment and a majority of the work on the book was done in Minneapolis and California where managed care was born.

Korneluk’s doctrine is backed by 13 years of physician time-and-motion research kept in a proprietary database. “You must have data to support your theories or else they are anecdotal,” he says. Among the more than 5,000 physicians whose data are in his database are physicians from the Mayo and Cleveland clinics, he says.

“He’s trying to differentiate himself in a crowded market of practice management consultants,” Parshall says. Adds medical business professor John D. Blair, “Some of

what he says is politically correct” in that physicians want to shift the focus of managed care from dollars to quality. Blair is director of health care strategies at Texas Tech University, in Lubbock, and coauthor of *Strategic Leadership for Medical Groups* (Jossey-Bass, 1998).

Blair questions the database legitimacy. “The data are only as good as how they were collected and the bias in the samples. We have no idea whether he gathered the data from only his clients,” he says. Korneluk responds that some physician responses have come from clients and some are from clients of other organizations that have purchased the council’s materials. The questionnaire itself was validated by University of Michigan professors of statistics, he says.

To support the numbers in the database, Korneluk shadows some of his physician clients while they work. When completing a questionnaire, a physician can easily say he sees 20 patients a day, Korneluk says, but seeing is believing. With a clipboard and a stopwatch, Korneluk conducts his time-and-motion research by following successful doctors, watching them from the time they rise, what they eat for breakfast, how much

time they spend between patients, and most of all, how much time they waste.

The result is a system of more than 300 criteria for benchmarking physicians and streamlining practices to cut fat. The criteria are encompassed in the acronym, CARES Plus. Within each letter of the acronym are dozens of time management and quality improvement tools.

C stands for care, skill, and judgment.

A is for access in scheduling, patient flow, and time management.

R stands for how physicians represent themselves to patients, referring doctors, and the public.

E is for economics—overhead management, payments, and collections.

S is for developing loyal staff and support.

Plus signals that successful physicians have a clear vision, take responsibility and pride in the profession, and have an action orientation.

“Make every minute count” is Korneluk’s unofficial motto, expressed by Brita Hess, president of the International Council. According to Korneluk, a primary physician’s time is worth about \$3 to \$5 per minute, depending on productivity. Korneluk has determined how that time is used best to achieve quality, income, and success with patients and staff. Each of the following applies to the most successful physicians:

1. They are clinically good doctors.
2. They are time efficient, productive, and responsive.
3. They get good grades on patient satisfaction surveys.
4. They produce enough income to pay good people well.
5. They have stable, happy staffs.
6. They have productive attitudes.

“The difference is attitude,” Korneluk says. “How physicians look at their practice and their lives. They have to have pride in being the best they can be.”

Other contrarian views derived from Korneluk’s research include the following.

Solo practice is not dead. “You should not give up what has worked in medicine,” Korneluk lectures. “Physicians can still practice profitably as soloists as long as they belong to a larger contracting network.” Generally, however, Korneluk does not advocate either solo or group practice. “Physicians feel they have to join a group,”

The Question Persists: Does Group Size Matter?

By Richard L. Reece, editor-in-chief

A contrarian is one who contradicts the prevailing wisdom. He or she is likely to embrace ideas that are currently unpopular, such as the idea that physicians can succeed today in solo or small group practices. Physicians are told such practices don't work because physicians need size, sophistication, and business expertise to compete effectively in markets dominated by managed care.

Yet, in the accompanying article, it is clear that consultant Greg Korneluk, CEO of the International Council for Quality Care, in Boca Raton, Fla., believes that solo practice remains profitable. Physicians in groups of two are most profitable, he says. Three in a group are less successful, four or five are even less successful, and those in groups of six or more do no better. But Korneluk adds three important caveats:

1. You will do well in a solo or small-group practice as long as you belong to a larger contracting network.
2. To succeed, you must re-engineer your practice into care teams and focus exclusively on what you do best: diagnostic and therapeutic decision-making.
3. You must be a clinically good doctor; be time efficient and responsive; get good grades on patient satisfaction

surveys; produce enough income to pay people well; have a stable, happy staff, and have a positive attitude and pride in what you're doing.

John R. Shaw, MD, is an example of a solo practitioner who is succeeding. A primary care physician, Shaw is 57 years old and practices in Riverside, Calif., a market heavily penetrated by HMOs. Among his patients, 50% are capitated. Yet, by delegating responsibilities to 12 of what he calls "cross-trained medical assistants," most of whom are long-time employees of the practice, Shaw can limit his time with each patient. His staff gather historical, clinical, and physical data before he sees patients. Shaw says his practice is thriving and that his income has never been greater. He believes HMOs offer a service by educating patients about illness prevention and disease management. There is more to practicing medicine than simply continuing to grow bigger, he says. There is satisfaction with one's work and life, even in a market dominated by managed care, he adds.

Among the many reimbursement mechanisms that managed care plans use, capitation may be the most challenging for physicians. Indeed, large groups in markets that have a high level of capitation need size and sophistication, accord-

ing to the Medical Group Management Association (MGMA). The MGMA's *Cost Survey: 1997 Report* indicates that physicians may be better off in a large group (of more than 38 physicians) if more than 50% of income comes from capitation. Physician compensation averaged \$227,000 in such groups that had more than 50% of revenue from capitation and \$218,000 in groups of 20 physicians with no revenue from capitation. Therefore, for physicians considering capitation contracts, the message is clear: If you are going to take on a capitation contract, it makes sense to be large enough to generate more than 50% of total practice revenue from capitation. Problems may result in groups of fewer than 34 physicians that generate some capitation revenue, but less than 50% of total revenue from capitation. The lessons from the MGMA report are these:

- If you believe in a capitated future, join a large group of physicians.
- If you're uncertain about capitation, and you're in a group of 20 or more, embrace capitation reluctantly.
- If you're wary of capitation or of joining a larger group, and you're solo or in a small group of 20 or fewer, trust your instincts and maintain the status quo.

but this belief is not necessarily true, he says. Both solo and group practice can thrive if the structure around each physician is in the form of care teams, he explains. "Each team consists of three members: a physician, a receptionist, and a nurse, who are all responsible to each other," he says. Each patient is assigned to a team, and the primary goal of the teams is to meet all patients' needs.

He calls this strategy the "condominium-ization" of health care. "Each care team controls its own schedules and everything is focused on being responsive to the doctor's needs so the physician can serve the patient," Korneluk explains. "The team

members meet with the doctor once a month to talk about improvement and motivation. With teams, clearly you know what each member of the team must do if a problem arises with a patient. Teams clean up communication problems" because lines of communication are clear, he says.

Rarely is there an economy of scale to be achieved by grouping. "Our whole health care system is driven by bigger-is-better, and economies of scale," Hess says. "There's been a mass movement to groups. There's a belief that if I'm not part of a group, I won't succeed. And if you can get a salary, being a physician is perceived to be easier. According to our studies, none of that is

true. You still need the same number of people to run each physician practice. The more people you put in a group, the higher the overhead because you add more infrastructure—managers, manuals, systems." Korneluk adds that several large physician organizations, including MedPartners Inc. and PhyCor Inc., have had financial problems recently, demonstrating that larger is not necessarily better.

"When doctors sell their practices, organizations tell them, 'All you have to do is practice medicine,'" Hess continues. "It sounds too good to be true and it is. Unless doctors feel they're contributing to decision making, it doesn't work."

(Continued on page 6)

(Continued from page 5)

Korneluk believes that to succeed in managed care markets, physicians need to be associated only with large contracting groups. Yet, the idea that physicians can succeed in small groups may be among the most controversial of Korneluk's theories (see sidebar: "The Question Persists: Does Group Size Matter?"). Parshall of The Health Care Group, for example, disagrees: "I would not agree that grouping does not achieve economies of scale," Parshall says. "If you want to be in managed care on a risk basis, you need a big bankroll, which can come only from large groups."

Bigger is not better in terms of numbers of doctors. While employed as the program director in the medical practice division at the American Medical Association, Korneluk conducted studies in the 1970s that showed soloists are profitable, he says; dyads—two doctor practices—are most profitable, three are less successful, four and five even less successful. When you get to six-physician groups, you're as profitable as when you were in one, he says.

"The genesis of this theory sprouted at the AMA but it has been substantiated over time through our own database," Korneluk maintains. "Groups of more than six break down. Six can sit around a table, and you can design a building of one floor with six doctors. More than that and you may need to add floors."

Parshall disagrees. "We've always told doctors that they need to develop large groups to gain market share," he says.

Centralizing billing and collections doesn't improve collections. "Many large consulting firms of a decade ago recommended centralization for group billing, collections, and reception to achieve economies of scale," Hess says. "Costs actually go up when you centralize because you require a highly skilled individual to run the organization. You need computer systems, but only a few people can operate them. There's not enough time to do individual accounts receivables, so there's a decrease in collections. The level of connectivity or commitment goes down, so you have substantial decreases in staff morale. There's an additional barrier of communication when staff don't report to the doctor, and there's an overall lack of accountability and responsibility so the blame thing kicks in. While centralization works well in hos-

At a Glance

A native Canadian, Greg Korneluk says, "Since I was 13, I have been interested in why some people succeed and others lead average lives. I wanted to find out how successful people get to be successful." In college, he wrote a thesis on the most successful traits of doctors and found that he liked physicians.

"They're smart and 98% are patient driven," says Korneluk, 45. "It's a myth that physicians are driven by the dollar. Physicians go into medicine because they like people and they like what they're doing. They lose that along the way. Part of our goal is to reunite them with their early goals."

After graduating from the University of Western Ontario, Korneluk started a Toronto consulting business in physician productivity. To drum up clients, he wrote papers, gave seminars, and worked with the Canadian Medical Association to train new doctors going into practice.

In 1976, the Ontario government hired his company to set up a fully capitated HMO to mimic Kaiser Permanente, the large managed care organization in Oakland, Calif. Two years later, he was conducting research for the AMA. What he found is that if physicians focus on making money, they are never successful. "If they focus on quality and patient satisfaction and believe in being the best at what they do, then they will be successful," he says.

Korneluk never returned to Canada to live. Today, he lives and works in Boca Raton. Even his choice of hometown is the result of research. He hired a researcher who wrote a book on the best places to live in America. It came down to Boca Raton; Scottsdale, Ariz.; and LaJolla, Calif.

The International Council's most recent project is helping Poland develop a viable health care system as a prerequisite for NATO membership. Korneluk says the country has no organized ambulatory health care system and average length of stay is 14 days.

pitals, it doesn't work well in physician practice," Hess continues.

The reason that centralization works in hospitals, Korneluk explains, is that "hospitals essentially follow a manufacturing model in which a patient comes in as raw material and exits as a finished product. A physician practice is more retail-oriented. These are different kinds of businesses. Physician practice is a high-volume, low-margin business."

Centralizing reduces productivity by as much as 20%, and there's a higher level of dissatisfaction among patients and physicians, he says. "To resolve denial of a claim, you need a chart and a physician—both of which aren't in physical proximity of the billing office," Korneluk explains. "Centralization causes duplication and frustration. It will work in 10 years when electronic clinical records are tied to billing records."

Parshall says if properly executed, centralization can be very efficient. "If we don't centralize, then tasks are dispersed," he adds. "There's a huge difference in skill level

and efficiency when one person is doing a task repeatedly and another is doing it occasionally."

Central switchboards in group practices are a mistake. "Every doctor should have his own team phone number so that receptionists answer the phone with the doctor's name," Korneluk says. "I believe patients who call their doctors should get a warm, friendly voice who knows them. Physicians don't usually call in on their main numbers because they can't get through. They call in on the back line. Doctors should call on their main lines to do a quality check to see if their phones are answered appropriately. Doctors also come into their offices through a back door so they don't see what patients see."

Centralized records do not improve efficiency. "In fact, they provide dis-economy of scale," Korneluk says. "The frequency of losing a chart goes up. Efficiency and productivity go way down and group costs go way up. Charts should be closest to the person who needs them; namely, the nurse."

Demand management is a failure. "In

"Korneluk took me from seeing 14 patients a day to seeing 65."

— Leonard Makerewich, MD, an ENT

recent years, many insurers installed demand management hotlines for patients to call for triage," Korneluk says. "Patients don't use them. When you get sick, you're going to call the Dr. Welbys because those are the people with whom you have a relationship."

Parshall counters that anyone's help is appreciated in the middle of the night when you don't feel like disturbing your physician. "We're big on telephone triage," he says.

There is little or no correlation between the time the physician spends with the patient and the quality of the visit. "Physicians who spend eight minutes versus 30 minutes get the same scores on patient satisfaction studies," Korneluk says. "The quality versus quantity issue is true in medicine. Does the patient have your full attention or are you running out of the room to answer phone calls?" he asks.

As expenses are cut, overhead goes up. "In the short range, the practice saves money," Korneluk says. "But as you cut overhead and infrastructure, you also cut productivity. Now you have a highly paid doctor or nurse handling administrative chores."

Pay staff well. "Pay staff peanuts and you get monkeys," he says. He also finds that the most green employee is often asked to answer the phones, the last place that person should be.

Doctors who work faster do not get more done. "What we found is that in order to speed up, doctors need to slow down," Hess says. "If you watch a doctor who has great interpersonal impact, he walks and speaks slowly. The more he hurries, the more frustrated he gets, the more he screws up and the more stress. Just take the wasted time out of the system." In one example, Korneluk suggests physicians install a button to a door chime that rings for a nurse, thereby saving time hunting for a nurse to do a lab test.

Patients are not directed to physicians by insurers alone. "One thing we've really seen this last year is that physicians have bought into this whole idea that third parties will be telling patients where to go when they need health care," Korneluk says. "The reality is that patients are always going to get sick and they're always going to go to a doctor. Patient choice will always be part of the system, no matter what managed care program is in place. Patients are going to say 'I love my doctor and I'm going to refer my doctor to my friends.'"

After hearing all of these ideas, what does a participant do? A week after the Korneluk seminar, one Deerfield Beach participant is enthusiastically making changes. Hector Delgado, MD, a family practitioner in Miami whose practice is owned by PhyMatrix Corp., in West Palm Beach, Fla., returned and told his partner they can improve efficiency.

"Korneluk made me much more aware of the time I spend in wasted activities," Delgado said. "We are now clustering our exam rooms. Instead of both of us running between two halls, we are grouping four exam rooms for each doctor together in the same hall to save time going between rooms. And, we're considering removing the doorknobs."

—Reported and written by Maureen Glabman, in Miami.

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Urology Group Embraces Managed Care

Physician practices that move quickly to accept and prepare for managed care often find their efforts are well rewarded. A good example is Georgia Urology, PA, in Atlanta. Key to the group's success are understanding how its market is changing, developing relationships with health plans, and embracing capitated managed care contracts. Says urologist Jim Libby, MD, a co-leader of the practice, "You have to educate yourself on the direction your particular market is headed and respond appropriately. We learned we could work with HMOs without giving up control of our own destiny by asking what they wanted, building relationships with their medical directors, and forming a network of urologists dedicated to keeping both the HMOs and our patients satisfied."

In just six years, the group has grown from four physicians based in two southern Atlanta offices to 34 physicians in 22 locations throughout the greater metropolitan Atlanta area. Georgia Urology is the nation's largest private practice urological clinic, Libby says.

Required Homework

In the early 1990s, Libby and his co-leader Arnold B. Rubenstein, MD, realized that managed care was beginning to affect the Atlanta marketplace. Their initial wake-up call came in 1992 when United HealthCare and Cigna Health Care, two national managed care companies, issued requests for proposals for capitated contracts in Atlanta for several specialties, including urology. "Back then, with just four urologists in two locations, we knew we weren't big enough to land those contracts," recalls Libby.

Libby and Rubenstein asked United and Cigna which types of medical practices were most attractive to them. "They wanted specialists with a strong reputation, who prac-

ticed efficiently, offered a wide array of services, and covered a broad geographical area," Libby says. "They insisted that their members be within 20 minutes of a urologist no matter where they lived in the greater Atlanta metropolitan area."

Before acting, Libby and Rubenstein did their homework. They knew from reading medical journals that California was one of the most heavily penetrated managed care areas in the country at the time. They flew to southern California to investigate care delivery models that they might transport to Atlanta. They studied, in particular, how California physicians were grappling with capitation. "Our West Coast colleagues convinced us that at least a part of our practice needs to be a predictable revenue stream, which capitation provides," Libby says.

Back in Atlanta, the group hired a practice management consultant to help plan a growth strategy. Libby and Rubenstein also immersed themselves in the learning process. "Capitation was new to our area," says Libby. "So, there were no experts to rely on. The development of our practice was mostly the result of our hard work." Libby stresses the importance of self-reliance. "You have to develop the relationships with the payers and other doctors yourself," he asserts. "You can't rely on anyone else to do that work for you."

Georgia Urology began expanding its practice in 1992 by hiring more physicians. At the same time, it developed affiliations with five other urology practices in the greater Atlanta area and formed a network. But not all urologists in Atlanta were interested in joining the network. "Initially, we encountered a lot of resistance," Libby recalls. "Many local urologists wanted nothing to do with us. They fought to keep managed care out of the area and opposed capitation. One of them told me, 'I don't need this kind of discount medicine.'"

Taking on Capitation

Libby and Rubenstein pressed ahead, convinced that managed care was the wave of the future. Their persistence paid off in 1993 when the group won capitated contracts from United, Cigna, and Prudential Health Care—the three largest payers in Atlanta. Under these contracts, Georgia Urology was the exclusive provider of all urological services to the enrollees of these health plans throughout metropolitan Atlanta. The contracts also shifted many management and administrative functions to the group. Thus, Georgia Urology became responsible for quality management, utilization review, and distributing the capitated dollars to the other urologists in its network.

Libby and Rubenstein realized that in this new capacity, they would be called on to determine whether surgery was needed for some patients, hospitalization for others, and a particular procedure was appropriate for still others. To help make these decisions, Libby, Rubenstein, and the other urologists in their network developed clinical pathways for the diagnosis and treatment of common urological disease processes. By following the pathways, the network of urologists embraced a common approach to practice, providing patients with improved quality of care at a reduced cost. "We were able to cut fat out of the system by eliminating some therapeutic regimens that did not measurably improve care and by reducing overutilization of medical resources," says Libby. By eliminating just one screening test—the prostate ultrasound—from its clinical pathways, Georgia Urology saved United hundreds of thousands of dollars.

Libby and Rubenstein ran into difficulties early on in determining how to pay out the capitated dollars to the network's urologists.

"To take on capitation, you have to develop a system that discourages unnecessary medical services while simultaneously providing the right care for the patient. It's a balancing act."

—Jim Libby, MD, Georgia Urology, PA

“While physicians still have to keep their primary focus on their patients, they must also become much more savvy about who their customers are and where their patients come from.”

—Debi Croes, the Croes Oliva Group

“Initially, we paid everybody on a reduced fee-for-service schedule,” says Libby. “By deeply discounting reimbursements, we figured we had removed the incentive for doing unnecessary procedures. But instead, the urologists simply started ratcheting up services and doing more surgery, so it was very difficult to control utilization. We quickly ran out of money because there was no incentive to be efficient.”

Within a few months, the two partners switched to subcapitation. “We realized that if we were going to be capitated ourselves, we in turn had to capitate each other,” says Libby. Under this reimbursement method, Libby and Rubenstein divide up the dollars based on the number of new patients seen by each physician over the year. Unlike some urology networks, Georgia Urology doesn’t adjust reimbursements for case mix and illness severity. “We wanted to keep it as simple as possible,” Libby says.

To take on capitation, Libby says that “you have to develop a system that discourages unnecessary medical services while simultaneously providing the right care for the patient. It’s a balancing act. This is a sensitive issue for most people. Some think HMOs give inferior care, but I believe it’s better care because patients get the appropriate level of care, nothing more. If one of our doctors wants to operate on a patient, it won’t be for the wrong reason.” The group’s patient satisfaction averages 96%, and most of the urologists receive scores of 98%, according to surveys the group conducts periodically.

Building the Practice

Throughout the mid-1990s, Georgia Urology continued hiring new urologists to meet its expanding patient load. The managed care contracts “were feeding our growth,” says Libby. “We worked closely with the health plans’ network coordinators to make sure we were doing exactly what they wanted. For example, when one HMO coordinator told us that his HMO’s ballooning membership had created a need for

urological coverage in the Atlanta suburb of Marietta, we approached a Marietta urologist about joining our network. When he declined, we opened our own office and hired a urologist to staff it.” Over the last five years, the group has opened 10 offices in the greater metropolitan Atlanta area.

In 1995, Libby and Rubenstein merged one of the network practices into Georgia Urology, bringing the number of urologists in the group to 13. The four remaining practices in the network joined Georgia Urology last year. By bringing these practices under one roof, Libby says that Georgia Urology has saved significantly on lease arrangements, laboratory costs, supplies, and the other expenses of running a private practice.

With 34 urologists supported by more than 100 nonphysician employees, Georgia Urology can provide services in a 100-mile area encompassing greater Atlanta. By expanding its geographical reach, the group has improved access to care because its offices are convenient for patients. For example, the 180,000 to 200,000 United patients covered by the group are within a 10-minute drive of care from a urologist affiliated with Georgia Urology. In addition to the three capitated arrangements that account for roughly 20% of its revenue, the group has noncapitated contracts with all the other managed care plans in the Atlanta region.

Data and Outcomes

Libby and Rubenstein are also measuring clinical outcomes. “Increasingly, employers and health plans are demanding this information,” says Libby. Under an agreement with Physicians’ Data Corp., a medical information company in Norcross, Ga., Libby says, “we can pull virtually any clinical or cost data that we want to see about how we are caring for our patients. For instance, we can determine how many Cigna patients with enlarged prostates we have, how many days patients with a par-

ticular disease stay in the hospital, or how our patient population breaks down by age, location, and the type of health insurance.” To ensure that all of its physicians dictate their clinical notes in a uniform fashion, the group invested in a central dictation system.

Libby advises other medical groups to seek out capitated managed care contracts aggressively because they offer many opportunities, including the potential to increase market share and gain access to new referral sources. The group, for instance, has attracted several clinical research studies from pharmaceutical companies.

Debi Croes, a principal in the Croes Oliva Group, physician practice management consultants in Burlington, Mass., applauds Libby and Rubenstein for tackling managed care actively. “They assessed their market and asked, ‘Is there potential for us to lose market share?’ The answer was yes,” she says. “So they developed a deliberate plan that focused on the target areas they wanted to serve. Atlanta, with its fast-growing population and large corporate presence, is a ripe market for managed care. So it was smart of Georgia Urology to be prepared.”

It is critical that physicians understand that the health care market has changed, Croes says. “While physicians still have to keep their primary focus on their patients, they must also become much more savvy about who their customers are and where their patients come from. Georgia Urology realized that besides the physician-patient relationship, the doctor-insurance company relationship is extremely important.”

Another key “customer” of specialists is primary care physicians, notes Croes, because insurers build specialty panels by asking PCPs which specialists they recommend. Specialists should develop and nurture relationships with PCPs and their staffs, Croes says. “You can help secure your market share by ensuring that your staff is making it easy for PCPs to use you,” she says.

—Reported and written by David L. Coleman, West Hartford, Conn.

Is It Possible to Build a Kinder, Gentler PPMC Structure With Hospitals?



Nathan Kaufman is president of the Kaufman Group, a division of Superior Consultant Co., physician and hospital consultants in San Diego. A nationally renowned expert on managed care and

physician practice issues, Kaufman has held executive positions in joint venture imaging centers and various delivery networks. He also is a member of the editorial Advisory Board of Physician Practice Options and the primary author of Building Business Relationships With Physicians (*American Academy of Family Physicians*, 1995). This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q. Please tell us about Superior Consultant Co. and describe for us the nature of your consulting work.

A. Superior Consultant Co. Inc., one of the largest health care information and management consulting companies in the nation, acquired the Kaufman Group in March 1996. The Kaufman Group practice focuses on managed care organizations and physician groups, including the structuring, restructuring, valuing, buying, selling, and operations improvement of these organizations. We are currently involved in several unwinds of poorly structured physician hospital organizations (PHOs), management services organizations (MSOs), and medical groups. In addition to strategy consulting and presentations, I spend much of my time as an expert witness in arbitration among partners within integrated delivery systems (IDSs).

Q. In your work, what do you see happening with IDSs?

A. Many IDSs are experiencing atrophy, meaning they are unable to attract managed care risk contracts. Most of the IDSs that have received risk contracts are in financial distress because they are unable

to deliver care within their budget. In theory, IDSs were designed to enable physicians and hospitals to work together to manage the care of a population. In practice, however, most providers view the IDS as a vehicle for maintaining, if not enhancing, their personal income. Managing care while maintaining physician income are conflicting objectives. Businesses with conflicting objectives usually fail.

Q. Would you agree that the efficacy and workability of physician practice management companies are also being questioned?

A. PPMCs provide a needed service in the market. The real issue is whether there is sufficient money to be made in these enterprises so that they can remain viable public companies. Our primary concern about PPMCs is that they are in an extremely tough business with very slim margins. That is, after paying the physicians a fair salary and paying for expenses, there is little profit left in most physician groups. For a PPMC to meet Wall Street's expectations, it has to take

ple expect. Therefore, many physicians are finding their compensation is suffering as a result of their PPMC's inability to capture the needed incremental revenue.

Q. To develop ancillary services as a physician group, physicians need capital. What is the most likely source of that capital?

A. The problem with most physician groups is they're not operated as a business. To be a true business, they have to retain earnings and invest to become even better in the future; otherwise, they don't have a business, all they have is a group of doctors sharing expenses. So, one of the critical elements in forming a group is the willingness to retain earnings and fund capital projects, such as ancillaries. There are also outside vendors that are willing to help physicians put in imaging centers or other types of ancillary services.

Q. Do you think most physicians realize that to succeed in the managed care environment they must retain earnings?

A. No, just as most businessmen don't understand clinical issues, most

"PPMCs provide a needed service in the market. The real issue is whether there is sufficient money to be made in these enterprises so that they can remain viable public companies."

money from someone else—either from the physicians' compensation in the form of management fees, or from a local hospital, by capturing the hospital's ancillary services and institutional risk-pool dollars. This is proving difficult.

Q. Has capturing the ancillaries worked?

A. Yes, in select cases. In fee-for-service markets—that is, the few fee-for-service markets that are left—adding ancillaries, such as lab and x-ray services, to a large medical group can enhance the group's revenue, but usually not to the extent that peo-

physicians don't have an appreciation for all of the business issues involved in successfully running a group. By definition, businesses need to retain earnings to maintain a state-of-the-art organization. That's hard for physician groups, especially now. First, the managed care market reduces their reimbursement, and then the physicians are supposed to take some of what's left and set it aside to re-invest in their organization? That's a tough sell.

Q. An article in *The Wall Street Journal* on PhyCor's difficulty discussed Fort Smith, Ark., a town of 80,000 in which

PhyCor had a 100-physician clinic. The article pointed out that there is only a limited amount of revenue to be had from ancillary services in a town that size.

A: That's correct. The standard PPMC model is to start physicians off with at least 15% less compensation than they previously made; then, by adding ancillaries and reducing expenses, the PPMC is supposed to make that money back for the physicians. In our experience, we've seen that PPMCs succeed at this only about one-third of the time. If PPMCs are unable to enhance physicians' income, they end up with unhappy physician partners.

Q: Is there a workable model for hospitals and physicians?

A: Without aligned economic incentives, hospitals lose about \$100,000 per physician, especially if they simply put physicians on salary and insulate them from their practice expenses and revenues. The physicians will benefit in the short term, but in the long run they will not. The hospitals will end up terminating the physician employment agreement, and the physicians will find themselves out in the community having to start over.

There are more than 50 PPMCs, and virtually all of them use the same economic model for compensating physicians. That is, they pay their physicians a percentage of the net revenue that is left after expenses. This strategy aligns incentives of both the physicians and the PPMC in terms of reducing expenses and increasing revenue because if revenue increases and expenses decline, both the PPMC and the physicians benefit.

We try to structure a "kinder, gentler," PPMC model for physicians with hospitals. For example, the hospital may take only 5% of the physicians' compensation (not 15% as is typical when physicians affiliate with PPMCs) and rather than require physicians to stay in the deal for 40 years, we may give them some ability to get out earlier if they're unhappy.

Q: I've heard you say that "contractual integration" is the model for the future. Could you explain what you mean by that and why you think that strategy will work in these turbulent times?

"When physicians and hospitals work together because they want to, not because they have to, the managed care delivery systems operate more like a business and are more effective."

Q: One-size-fits-all integration doesn't work. Most PHOs are designed so that you have to use all the PHO's participating physicians—consisting of the hospital's medical staff—for every contract. Some inefficient providers should be excluded from risk contracts, but there isn't a mechanism within most PHOs for excluding physicians based on the contract terms. Patients, physicians, and hospitals will be better off under free-market conditions whereby the providers negotiate with each other to design a delivery system to service specific contracts. Each provider is evaluated based on the value (meaning the benefits versus the costs) that they will bring to the delivery system. Now, if somebody else comes in and offers a contract with different terms, this same delivery system may not be appropriate; a different delivery system would have to be designed for that situation and the providers could do so, unencumbered by the politics usually found in PHOs.

Q: Do you find that the relationships between physicians and hospitals are better after the two parties contractually integrate, as opposed to the previous forced integration?

A: When physicians and hospitals work together because they want to, not because they have to, the managed care delivery systems operate more like a business, and thus, are more effective, and the traditional hospital-physician relationship

is preserved. Many times when hospitals and physicians are forced to work together, they find themselves in arbitration and a hostile relationship develops between the parties.

Q: Why do you prefer the term "contractual integration" to "virtual integration"? Is there a difference between the two?

A: To me, "virtual integration" makes the process sound too easy. When we're talking about contractual integration, we're talking about very tough contractual negotiations with potential business partners that are independent of each other. Our goal in contractual integration is to integrate around specific contracts with payers, not to create a "virtually integrated delivery system" for all contracts.

Q: Under contractual integration, is the motivation for the physician group to provide the best care, the best outcomes, and the best geographic distribution in order to make itself attractive in the market?

A: Physicians who believe that contractual integration is the wave of the future, which is what we believe, need to look at their business line and ask, "How can we become the most attractive provider to the various contracting parties in this market such that they will want to contract with us and pay us more than a commodity rate for our services?" Doing this involves such things as providing better patient care, better outcomes, broad geographic coverage, extended hours, and so on.

Q: Why is there so much turbulence in the market right now?

A: In the early 1990s, the market began to shift toward managed care and

(Continued on page 12)

(Continued from page 11)

entrepreneurs started creating new delivery mechanisms to prepare for the new managed care environment. In theory, these delivery mechanisms—whether they are PPMCs, IPAs, MSOs, PHOs, or whatever—sound really good, and from a theoretical standpoint, they should work. In many, if not most, cases, the actual performance of

research, it will be tougher to sell a premium in the market without your group because people will demand that you be included in the delivery system. So, all providers need to examine their market and make sure that they are as attractive as possible. Geographic coverage is usually a factor to consider.

have told me that now they would prefer to negotiate their rates directly with the payer, rather than with their affiliated physicians in the IDS.) These rate negotiations reach a point when the competing hospitals realize that only by merging can they gain leverage in their negotiations with payers and physicians. Then the hospitals merge, they negotiate better rates, the risk-pool surpluses diminish, and the California models experience financial distress.

“Hospitals that want to become PSOs should take a cue from the hospitals that have been in, and are seeking to get out of, the HMO business.”

these enterprises does not match up with the theoretical models.

Q. Do you see any gain from all this turbulence?

A. Yes. The gain we see is that the providers are going back to basics. Hospitals are now realizing, and we are advising them, that they need to earn the right to be part of the delivery system. To do so, they have to become cost effective and physician friendly. They have to provide excellent patient care. They also have to merge and consolidate into regional delivery systems. If they do all this, they're likely to get contracts at favorable rates and physicians will want to partner with these systems. Physicians also need to go back to basics. They need to look at their business and ask, “How can we become more attractive to patients, payers, and other contracting parties in the market?” And then design their practice to be recognized as the best in the market. Then payers and hospitals will want to work with them.

Q. So, are you saying that physicians have to consolidate into groups that cross geographic boundaries and serve an entire region?

A. The question that everybody in health care needs to ask is, “Will it be easy in this market to sell premiums if I'm not a participating provider?” If you're in a three-person oncology group in San Diego, it's no problem to sell premiums without you; you either accept the payer contract or you're not included in the network and no one will miss you. If you're in a 30-physician oncology group providing broad geographic coverage with the “clinical stars” that are doing state-of-the-art

Q. In other words, physicians have to create an organization that the market cannot do without?

A. That's the concept. Also known as American free enterprise. Providers of any goods or services that are perceived as offering the greatest value win.

Q. Certain groups are likely to pull that off very well, but do the physicians have to be in an organization or can they remain solo or in small groups or work within an IPA type of arrangement?

A. We think that physicians have to be in a fully integrated group to do this successfully because just forming a network doesn't generate the buy-in from the member physicians, which is needed to standardize clinical practice. Also belonging to a partially integrated group doesn't give physicians the negotiating clout they need. Belonging to a fully integrated group provides negotiating clout and allows physicians to develop their own ancillary services, which can provide incremental income.

Q. Do you think that the so-called California model—that is, the large primary-care-dominated groups structured to receive and profit from capitation—is the wave of the future?

A. There is some question as to whether the California model is sustainable. The primary source of profits for the model is institutional risk-pool surpluses. The medical group plays one hospital against the other in order to get the lowest rates. This assures that the medical group will receive a surplus payment from the institutional risk pools. (In fact, many California hospital administrators

Q. Do you find that many medical groups have exhausted their credit worthiness or are on the verge of being forced to sell?

A. Yes. Many groups that have needed capital to grow have borrowed the funds rather than tax physician compensation, with the hope that things will get better and they can then repay the notes. Unfortunately, this is not usually the case and the physicians are forced, under duress, to find a capital partner, which is not a good negotiating position to be in.

Q. Last question: What is the future of HMOs?

A. Right now, we have two opposite trends occurring with hospital-affiliated HMOs. The first trend is that hospitals are in a feverish state of wanting to become provider-sponsored organizations (PSOs) so that they can become an HMO and contract directly with Medicare patients. At the same time, many hospitals that have been in the HMO business want to sell or divest their HMOs because they're finding that it is not their core competency, it is jeopardizing their physician-hospital relationships, and it is creating significant deficits. Hospitals that want to become PSOs should take a cue from the hospitals that have been in, and are seeking to get out of, the HMO business.

The second trend we're seeing is HMOs are merging and consolidating, creating a handful of dominant payers in each market. These are not benevolent organizations. Their goal is to gain leverage over local providers. What we've learned is that those that do best are those that do what they do best. There are few get-rich-quick schemes in health care. The folks that are selling PSOs today were selling PHOs yesterday. The message in all this is, “Buyer beware. Stick to the basics and become the best at what you do.” ■

HCFA Issues PSO Waiver, Solvency Rules

By Edward B. Hirshfeld, JD

The Balanced Budget Act of 1997 (BBA) created provider-sponsored organizations (PSOs) as part of a new program called the Medicare+Choice program. PSOs are health plans that are controlled and operated by physicians and other providers. The Medicare+Choice program allows Medicare patients to select from a wide variety of health plans as an alternative to the traditional Medicare fee-for-service plan, including PSOs, preferred provider organizations, medical savings account plans, and private fee-for-service plans. Before Congress passed the BBA, Medicare patients in most markets were limited to selecting an HMO. The incentive for patients to select a health plan instead of the traditional program is a richer benefits package. Open enrollment for Medicare+Choice plans begins this fall, and coverage starts on Jan. 1.

On May 7, the Health Care Financing Administration (HCFA), the federal agency that administers the Medicare program, issued a regulation that sets forth requirements for PSOs to obtain waivers from state licensure and solvency standards for PSOs. In addition, on June 26, 1998, HCFA issued a substantial set of regulations setting forth criteria that must be met by all Medicare+Choice health plans, including PSOs. Those regulations will be discussed in a subsequent issue of *Physician Practice Options*.

Waiver Requirements

Any Medicare+Choice plan must be licensed by each state in which it operates. To facilitate PSO formation, the BBA allows qualifying PSOs to obtain a waiver from state licensure. If eligible for a waiver, the PSO must apply for certification by HCFA to obtain a contract to be a Medicare+Choice plan that may be selected by Medicare patients. To become certified, the PSO must meet solvency standards developed by HCFA. PSOs that obtain a

waiver and certification must comply with all state consumer protection statutes other than the state solvency standards and related licensure requirements.

PSOs must file an application for a waiver by Nov. 1, 2002. No applications will be accepted after that date unless Congress authorizes an extension. HCFA must act on a completed application for a waiver within 60 days. Waivers will last only 36 months, unless that period expires during a Medicare+Choice contract year, in which case the waiver will last until the end of the contract year. After the waiver expires, the PSO must obtain a state license. Waivers begin to run at the time a Medicare+Choice contract is awarded to a PSO, not at the time the application for a waiver is granted.

To qualify for a waiver, the PSO must have applied for, and have been denied, a

applied by the state to substantially similar health plans, or (b) a requirement that the PSO offer a product or plan other than a Medicare+Choice plan.

- The state denied the PSO a license because it did not meet state solvency standards that are different from the federal standards. Both the state and federal solvency standards give the regulator discretion over certain items. Even where state and federal standards are identical, a PSO may assert that a state regulator exercised discretion differently than a federal regulator would have acted over the same type of requirement, and therefore that the state standards are different.
- The state refused to accept the PSO's application.

A PSO must apply for a license covering

PSOs that obtain a waiver and certification must comply with all state consumer protection statutes other than the state solvency standards and related licensure requirements.

state license for one of the following reasons:

- The state failed to act on a substantially complete license application within 90 days. A license is deemed by HCFA to be substantially complete if (a) the state has notified the PSO in writing that it is complete, (b) the state has failed to respond to the license application within 60 days, in which case the license is deemed substantially complete as of the date of submission, or (c) the state has not responded within 30 days to a supplementary submission of information by the PSO in response to a notification of deficiency, in which case the application is deemed complete as of the date of submission.
- The state denied the PSO a license based on discriminatory treatment, including (a) material requirements, procedures, or standards other than solvency requirements generally not

the type of entity that most closely approximates a PSO. Some states offer PSO licenses. In states that do not, an HMO license is the one most likely to approximate a PSO. HCFA will not consider licenses for indemnity plans or preferred provider organizations to approximate PSOs, and denial of such a license will not be grounds for a waiver. PSOs must make a good-faith attempt to obtain a state license. A PSO may not, for example, submit to a state an application that omits information about its finances that would enable it to get a license, a denial, or a waiver, and then submit an application for certification to HCFA with complete information.

Solvency Requirements

The BBA required HHS to convene a negotiated rule-making committee to make recommendations for federal solvency standards. The committee consisted of repre-

(Continued on page 14)

Edward B. Hirshfeld, JD, is the AMA's vice president, Health Law.

(Continued from page 13)

sentatives from provider associations, including the American Medical Association (AMA), payer associations, patient advocacy groups, and government regulators. The rule-making process required that the committee members unanimously agree on a recommendation that all members could "live with," even if not to their complete satisfaction. The committee made its recommendations on March 5, 1998. The recommendations were adopted by HCFA without change in the regulation published on May 7, 1998.

New PSOs that have not yet broken even must prefund losses up to the projected break-even point. If uncovered costs exceed 10% of all expenditures, then a deposit in the amount of 120% of the PSO's outstanding liability for uncovered expenditures must be made.

At the time a PSO applies for certification, it must have a minimum net worth of \$1.5 million. That may be reduced to \$1 million if the PSO contracts with a parent company or a vendor to supply administrative and managerial services instead of investing in the infrastructure necessary to handle those functions itself. The PSO must have sufficient cash to meet obligations as they come due, and \$750,000 of the net worth amount must be in cash or cash equivalents. The PSO must file financial projections showing when the PSO will break even or show a profit for 12 consecutive months. The first six months of any projected operating losses must be prefunded with cash or cash equivalents, and there must be adequate security, such as a parental guarantee or a letter of credit, to cover the balance of the losses to break even. The PSO must deposit \$100,000 with HHS, which may be counted toward net worth.

Tangible health care delivery assets (HCDAs) may be counted toward net worth calculations at 100% of their value under generally accepted accounting principles (GAAP) of the Financial Accounting Standards Board (FASB). Twenty percent of the net worth amount

may consist of goodwill recognized by GAAP if the PSO has at least \$1 million in cash, but no more than 10% may consist of goodwill if the PSO has a minimum net worth of less than \$1.5 million or less than \$1 million in cash.

After certification has been granted, the minimum ongoing net worth is calculated according to one of four tests. The PSO must have a net worth that is the greater of: (1) \$1 million, or (2) 2% of annual premium revenue on the first \$150 million of premium, and 1% of premium in excess of

\$150 million, or (3) an amount equal to three months of uncovered expenditures, or (4) an amount equal to: 8% of health care expenses paid to nonaffiliated providers on a noncapitated basis, plus 4% of health care expenditures paid to nonaffiliated providers on a capitated basis and paid to affiliated providers on a noncapitated basis, plus 0% of health care expenditures paid to affiliated providers paid on a capitated basis. The greater of \$750,000 or 40% of minimum net worth requirements must be in cash, and there must be sufficient cash to meet obligations as they come due.

Tangible HCDAs are included in the same way as at application for certification. Goodwill is limited to 20% of net worth requirements provided that the PSO has the greater of at least \$1 million or 67% of the ongoing net worth requirement in cash. If not, then goodwill is limited to 10% of the requirement. Deferred acquisition costs may not be admitted as assets.

New PSOs that have not yet broken even must prefund losses up to the projected break-even point. Guarantees may be used as security for prefunding. The guarantor must commit that during the first year of operations, at the beginning of each quarter, it will provide enough cash to the PSO so

that it has projected losses covered for two quarters ahead throughout the first year of operations (one quarter ahead at the beginning of the third quarter). If the guarantor has met these obligations for a year, it may notify HHS that it intends to reduce the period of funding projected losses, and HHS must respond within 60 days if this intention is deemed not acceptable. A PSO may use lines of credit from regulated financial institutions, legally binding agreements for capital contributions, or other legally binding contracts of a similar level of reliability to fund projected losses after the first year.

If, at any time, uncovered expenditures exceed 10% of all expenditures, then a deposit of 120% of the PSO's outstanding liability for uncovered expenditures must be met. It can be withdrawn once the uncovered expenditures fall below 10%.

Federal Versus State

If the federal standards are less onerous than the standards of a state, providers considering the formation of a Medicare+Choice plan may want to form a PSO. If the standards are more onerous than those of a state, such providers may choose another type of health plan, such as an HMO. In this regard, it may be difficult to ascertain the standards of a state because most states give the insurance commissioner discretion to add to or to waive statutory net worth requirements. In recent years, many state commissioners have added requirements to reflect the large investments necessary to create a successful new health plan. Most statutory state solvency standards have not been changed in many years, and do not reflect the current amount of investment necessary. It appears that the PSO solvency standards are at about the midpoint of state standards—meaning that they are less rigorous than the standards in about half of the states. ■

Editor's Note: Waiver applications may be found at the HCFA site on the World Wide Web, which is at www.hcfa.gov/medicare/mplusc.htm. In addition, the AMA has a summary of the solvency standards and a state-by-state comparison. For a copy, readers may call the author at 312/464-4640.

Sources of Capital for Physicians

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

In the past, we have presented the opinion that physicians need to compete based on their ability to deliver quality care rather than on price in order to succeed in the changing health care system. To demonstrate quality, physicians need to invest in information systems and management expertise. These initiatives require capital.

The prospects of achieving new means of demonstrating quality have caused many

physician practices to partner with physician practice management companies (PPMCs). However, the downturn in the market for PPMC stocks and the major management and operational upheavals at some PPMCs have caused physicians to analyze alternative sources of capital. The accompanying table lists some of these sources, as well as the benefits and considerations associated with each one.

Increasingly, access to capital is a

strategic weapon for clinics. It allows them to enter new markets, develop integrated delivery systems, invest in technology and infrastructure, and acquire other clinics. These activities allow clinics to develop competitive advantages in their markets so that the clinics will be sought after by physicians, patients, and managed care payers, which will help clinic physicians maintain their compensation levels and job security. ■

Considerations Regarding Capital Sources

The following are some considerations related to various sources of capital.

Source or type of capital	Considerations
Senior bank debt	<ul style="list-style-type: none"> • Cost of capital is relatively low; borrowing rate depends on credit quality of the group • Typically requires pledging assets and/or personal guarantees of physician partners • Can have restrictive covenants that limit capital expenditures, acquisitions, or physician compensation • Must be paid back
Variable rate notes	<ul style="list-style-type: none"> • Relatively low borrowing rate compared with that of bank debt • Requires sinking-fund contributions • Can have restrictive covenants that limit capital expenditures, acquisitions, or physician compensation • Refinancing required at maturity
Strategic partner debt	<ul style="list-style-type: none"> • Favorable and flexible borrowing terms possible • Ability to gain additional resources from strategic partner • Depending on the nature of the strategic partner, potential conflicts and control issues could limit attractiveness
Sale and lease-back with a real estate investment trust	<ul style="list-style-type: none"> • Immediately reduces debt on balance sheet; has potential to increase borrowing capacity • Increased lease expense may exceed amount of interest, and depreciation eliminated as part of the transaction • Potential tax consequences will be associated with a gain on sale of the real estate

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 Advisory Board of Physician Practice Options. *Jill S. Frew* is managing director of Townsend Frew & Co.

HCFA Struggles to Issue New Regulations

The federal Health Care Financing Administration (HCFA), which operates Medicare, is struggling to make changes in its systems required to accommodate the Balanced Budget Act of 1997 (BBA). As a result, HCFA may ask Congress to delay payment increases to physicians and hospitals, and it may seek to postpone new reimbursement schedules for home care and outpatient providers, according to an internal HCFA memo that was reported in *The Wall Street Journal*. Delaying increases to physicians and hospitals breaks a promise made during BBA negotiations last year, said a congressional spokesperson. In addition to complying with the BBA, HCFA has been working to make certain that its computers are in compliance with year-2000 requirements, a Medicare spokesperson said.

HCFA officials also have been struggling with a requirement of the BBA that many home care agencies complained was too onerous. After the complaints, HCFA agreed to drop the requirement that by July 31 they had to have posted surety bonds of \$50,000 or 15% of annual billings, whichever was greater. The BBA requirement was an attempt to prevent unscrupulous agencies from participating in the home care program.

Comment: *In yet another problem, focus groups have found HCFA's publication explaining the BBA to beneficiaries to be confusing. Originally, HCFA planned to send the handbook to all 38 million Medicare beneficiaries. Instead, a rewritten publication, 1999 Medicare Handbook: Balanced Budget Act of 1997, will be sent to only 5.5 million beneficiaries in Arizona, Florida, Ohio, Oregon, and Washington State.*

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