

PHYSICIAN PRACTICE OPTIONS™

September 15, 1998

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Falling Stock Prices Signal a Restructuring Among PPMCs

Several publicly traded physician practice management companies (PPMCs) have struggled in recent months as stock prices of these companies have fallen precipitously. As a result, many of the 40,000 physicians who have affiliated with PPMCs to acquire investment capital and to increase their income are concerned about the value of their practices and future revenue.

"This industry has grown very fast," says Nathan Kaufman, senior vice president of Superior Consultant Co. Inc., health care management consultants in San Diego. "There was bound to be a market correction as weaker players shake out. That should be a matter of concern to physicians who sold

to PPMCs." (See table.)

In addition to the money and the PPMC stock a medical group's owners receive to make a deal, physicians sell their practices to PPMCs to raise revenue through increased market share and so that they can manage their practices more effectively, says Albert Barnett, MD, a health care consultant in La Habra Heights, Calif. "Physicians expect their PPMC to bring in capital," says Barnett, "and they expect the PPMC to have the management expertise necessary to add value to their practice. These two issues are related. PPMCs are expected to be stable enough to continue to provide investment capital over the life

(Continued on page 6)

Highs and Lows

Stock prices for the top five physician practice management companies by 1997 revenue (in millions)

Company	Specialty	Net revenue	52-week high	52-week low
MedPartners Inc. Birmingham, Ala.	Multispecialty	\$6,331	28 %	3 1/2
PhyCor Inc. Nashville	Multispecialty	\$2,171	33 1/4	7 3/8
FPA Medical Management Inc. San Diego	Primary care	\$1,166	40	1/2
Physicians Resource Group Inc. Dallas	Ophthalmology	\$474	11 1/16	2 3/16
Coastal Physician Group Inc. Durham, N.C.	Emergency departments	\$425	2 3/4	3/32

Source: Townsend Frew & Co., Durham, N.C. Stock price information from *The Wall Street Journal*, August 7, 1998.

A Simple Approach to Information Systems

Physicians struggling to comply with managed care requirements and government rules and regulations are investing in information systems. In doing so, they may forget that the best practices may be the simplest.

Bruce Landes, MD, has found that relying on a pen, paper, a phone, and a fax machine can be easier, quicker, cheaper, and better than using a sophisticated computer to store and communicate patient information. A 40-year-old internist in Dallas, Landes is a member of a 1,000-physician IPA and practices in the Secure Horizon's Medicare-risk program run by PacifiCare Health System, a large managed care organization based in Santa Ana, Calif.

Landes has developed a summarized version of the patient's chart, which he calls "the gold sheet"; officially it's known as Essential Medical Information Sheet, or EMIS. It consists of a single sheet of heavy yellow paper. The color helps it to stand out.

The gold sheet is a collection of information on a particular patient that tells the patient's physician and any other doctor the basics of what they need to know to treat the patient. Included are demographic information, current diagnoses, health risks, allergies, medications, family medical risks, recent consultations, major tests completed, screening information, and immunizations.

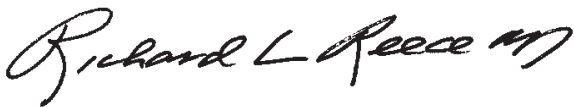
At a glance, emergency room physicians or a specialty physician treating one of Landes' patients on a referral can glance at the gold sheet and get all the information needed to begin a thorough patient exam. When one of Landes' patients presents at the emergency room or is referred to a specialist, Landes simply faxes the gold sheet, which, he says, helps to identify risk factors, avoid unnecessary prescriptions, and eliminate repeat tests.

Landes credits EMIS with helping him to keep the rate of hospitalization among his patients at 300 bed days per thousand patients versus a national average among HMOs of more than 1,000 bed days per thousand.

Landes' approach is simple and underscores a basic fundamental of developing a practice management information system: You can lay much of the groundwork without spending a penny or going near a computer. All you have to do is ask the right questions. Landes, for instance, asked: "What do I, ER physicians, and consulting physicians need to know about my patient to minimize utilization of resources and to achieve speedy, convenient, and effective resolution of the patient's problems?"

Like the simple, straightforward information Landes' gold sheets provide, the answers to simple, straightforward questions will help physicians decide what they need from an information system. Jerome Carter, MD, director of informatics at the University of Alabama in Birmingham, suggests that physicians begin their search for an information system by asking such basic questions as: What percentage of my patient volume is covered by managed care? What percentage by Medicare and Medicaid? What are my referral patterns? Which HMOs are the most—and least—rewarding to deal with? Armed with answers to such questions, physicians can begin to shop for an information system that meets their needs.

The gold sheets that Landes has developed will not substitute for a comprehensive information system, and even Landes is working on an electronic version of his gold sheet, which he promises to keep simple.



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Pediatricians Seek Strength in Single-specialty Groups and Educational Initiatives

Pediatricians face the economic pressures of both generalists and specialists. They often lose market share to less expensive generalists, such as family practitioners, while watching health plans limit reimbursements for specialized services, such as immunizations and well-child visits.

"Pediatrics is different from adult primary care in many ways," says Skip Creasey, president of Kelson Pediatric Partners Inc., a pediatric physician practice management company (PPMC) in Hartford, Conn. "Pediatricians have to rely on office visits as their primary source of revenue, without the use of the expensive procedures and the extensive use of ancillary services that come with treating older, frequently sicker, populations. Therefore, they function in settings of very low profit margins and are very sensitive to small changes in overhead and patient volume."

Cost Control

Pediatric subspecialists, such as pediatric rheumatologists and pediatric cardiologists, have been hit particularly hard by managed care's emphasis on cost control. "Managed care companies think about money and how much a doctor visit costs," says Ronald J. Glasser, MD, a pediatric nephrologist and rheumatologist in Minneapolis. "They would rather a patient see an internist or a nonspecialty pediatrician, who charges less than a subspecialist. They'd rather a patient see a family practitioner than a pediatrician, a nurse practitioner than a family doctor, and a nursing coordinator than a nurse practitioner. Pediatric subspecialists are being squeezed out of the business."

Pediatricians and pediatric subspecialists seeking solutions to these problems are forming or joining larger groups, such as single-specialty pediatric medical groups, or gaining managed care expertise by affiliating with networks of physicians and with PPMCs that serve pediatricians only. These practice options currently are finding favor among pediatricians worried about their

financial future.

What's more, pediatricians are organizing educational initiatives directed at the public and at politicians to emphasize the importance of fostering access to pediatric care. "I spend a lot of time talking with patients worried whether their health plans will pay for our services," says Joseph Bogdan, MD, a pediatrician in Neptune, N.J. "And our committee spends a lot of time issuing pamphlets and articles and publishing books teaching pediatricians about how to deal with managed care." Bogdan is a member of the Child Health

21% of primary care physicians (PCPs), according to the AAP. The average salary for pediatricians in 1996 was \$123,247, up 1.2% from \$121,776 in 1995, according to *1997 Environmental Assessment: Redesigning Health Care for the Millennium*, a report by Deloitte & Touche, CPAs and health care consultants in Detroit. The report states that 1,593 medical school graduates entered pediatric residencies in 1996, an increase of about 21% over the 1,316 students who entered residencies in 1991.

Many pediatricians join medical groups following their residencies, and many join

"Pediatricians function in settings of very low profit margins and are very sensitive to small changes in overhead and patient volume."

—Skip Creasey, Kelson Pediatric Partners

Care Financing Committee of the American Academy of Pediatrics (AAP) in Elk Grove Village, Ill. (See sidebar, "Academy Provides Education Needed to Sustain Market Share.")

Strength in Groups

The number of practicing pediatricians is increasing, and so are their incomes. But some health care professionals express concern that if the number of pediatricians continues to increase, incomes could fall. Too many pediatricians in individual and small-group pediatric practices negotiating separate contracts, coupled with the prevalence of other generalists, could give managed care companies the ability to negotiate lower paying contracts. "More pediatricians are joining the field every day," says Bogdan, "while managed care keeps making it more difficult to survive for each of us." One way to protect income is to negotiate as a group, and some health care authorities say the bigger the group, the better.

The nation's 50,000 pediatricians represent about 7% of all physicians and about

multispecialty groups, according to a 1996 study by the American Medical Association in Chicago, *Medical Groups in the United States: A Survey of Practice Characteristics*. About 28% of the nation's nearly 5,000 multispecialty groups employ about 5,700 pediatricians. A greater number of pediatricians are in single-specialty groups. About 1,400 of the nation's 13,684 single-specialty groups are pediatric groups, employing more than 7,000 pediatricians, according to the AMA. The pediatricians in these single-specialty medical groups are beginning to appreciate the economic clout they could have if they were to deal more effectively with managed care plans, a power not realized in multispecialty settings, says Kelson's Creasey.

Kelson offered PPMC services to multispecialty groups when it started in 1994, but in 1996 the company began marketing solely to single-specialty pediatric groups. "Pediatricians are not well served in multispecialty groups because of the nature of the pediatricians' high-volume, office-based practices," Creasey says. "Other

(Continued on page 4)

Academy Provides Education Needed to Sustain Market Share

Providing pediatricians with the information needed to sustain, or increase, market share is one of the primary missions of the American Academy of Pediatrics, says Joseph Bogdan, a pediatrician in Neptune, N.J., who is a member of the AAP's Child Health Care Financing Committee. "We are working very hard to educate people about the proper role pediatricians should play in patients' health care needs," he says. "Pediatricians should be the PCPs for children because they are often better trained and more experienced in meeting the needs of children than are internists and family practitioners." Some managed care plans treat pediatricians as specialists, requiring a referral from another PCP, he adds.

If consumers view pediatricians as their child's PCP, then so will managed care companies, according to the AAP. In policy papers published recently that address the issue of pediatricians and managed care, the AAP says that "pediatricians are the most qualified to meet the health needs of children, and should therefore be identified as primary care providers" to all children covered by a managed care plan.

Concern for the welfare of their patients is what should, and does, drive pediatricians as they seek effective practice options, Bogdan says. He serves as co-chairman of the AAP New Jersey chapter's Practice Management Committee. That committee is currently examining the practices, including child health treatment denial patterns and appeals processes, among New Jersey HMOs. The committee plans to make its investigations public and to report patterns that adversely affect children's health to the state legislature.

"The key to surviving managed care is to be aggressive about the quality of the medicine we are allowed to deliver," Bogdan says. "In the end, the ability to deliver quality medicine comes down to us."

(Continued from page 3)

group members are not necessarily as concerned about these fluctuations as are the pediatricians because PCPs treating adults often rely heavily on Medicare reimbursements for specialized services for their income. Therefore, pediatricians have problems demonstrating their value to these groups. In addition, in multispecialty settings, family practitioners and internists can compete with pediatricians for patients, which further diminishes perceived value."

In addition, pediatricians in single-specialty groups have a stronger negotiating position with managed care organizations (MCOs) than they have in multispecialty groups, Creasey says. "Single-specialty affiliation provides an economic advantage to pediatricians, who we believe do not get proper value for their service within a market in multispecialty groups," Creasey explains. "People more often choose their

health plans based on whether their children's doctors, rather than their own doctors, are in the plan. HMOs know this, and they know that without an affiliation with regional pediatricians they can't do business. In multispecialty groups, pediatricians lose that negotiating clout."

Health plans also are beginning to realize that having a high volume of younger patients helps them to manage financial risk. "Many MCOs are anxious to develop relationships with pediatric groups because it means a younger, healthier population," Creasey says. "Pediatricians in large multispecialty groups lose that market advantage because the volume of young patients is, by definition, proportionally smaller in multispecialty groups than in single-specialty groups."

The ability to service a defined, comparatively healthy population is particularly advantageous in managed care negotiations,

says F. Lane France, MD, a pediatrician who is CEO of Pediatric Healthcare Alliance (PHCA) in Tampa. The group's 32 pediatricians and seven nurse practitioners serve patients in 11 offices in the Tampa area, and include more than a fourth of the region's approximately 125 pediatricians. "Nearly all the health plans that want to do business in this area have to deal with us," France says. "It gives us negotiating strength."

Growth Through Merger

In January 1997, France's group was formed through a merger of six group practices, representing a total of 24 pediatricians. Since then, PHCA has been seeking additional members through mergers with other groups. "When we formed, we realized that size gave us several advantages," France says. "To begin with, it gave us economy of scale. The cost of supplies and malpractice insurance for individual members fell significantly after we got together. In addition, forming a large, single-specialty group increased our operational efficiency. For example, we have central billing now and managed care negotiations are conducted for all of us by one or two individuals."

Revenue and profit in the first quarter of this year were 24% higher than they were in the first quarter of last year, says France, although he declined to offer specific revenue and profit numbers. "Revenues are up not only because we've increased our patient volume, but because of cost savings we realized as we learned how to be more efficient," he says.

The founding members of PHCA began their merger discussions with an understanding that they could not deal successfully with MCOs without an adequate information system, and that such systems were expensive. MCOs often compensate physicians on a prepaid basis, meaning that payment is determined by the number of patients enrolled in a plan, not by the number or type of services rendered. Physicians without adequate historical data on how much care a population may require are at a disadvantage when negotiating managed care contracts.

"As individual physicians, it was almost impossible to afford the information systems we needed to deal successfully with managed care contracting," France says. "We

realized the only way we could afford an adequate system was to join together.”

In addition to a more powerful information system, France and his colleagues realized in July 1997 that they needed more business expertise as well. The pediatricians joined with three local investors to form a management services organization (MSO) to provide all support services. The MSO was created by, and is now owned jointly by, the investors and the medical group. It employs all of the group's nonmedical personnel, and handles all billing, scheduling, and managed care negotiations.

“We don't work for our investors because we own half of the MSO,” says France. “Our group is entirely physician run and physician driven. We have the autonomy we feel we need to maintain clinical independence, something that was important to all of us when we decided to merge.” The investors receive half of the profit from the MSO, and several serve as administrators.

Network Affiliation

While PHCA has found success through mergers, some pediatricians in Dallas pursued the less formal strategy of network affiliation. Pediatric Subspecialty Network (PSN), an independent practice association in Dallas, includes 75 subspecialists. The network differs from an organization formed as a result of a merger in that participants maintain their own taxpayer identification numbers and separate billing, scheduling, and claims-processing operations. Yet, since PSN is an IPA, the organization handles contracting for its member physicians.

“This structure provides much better negotiating leverage than would be the case if these doctors had to negotiate on their own,” says Nita Pickett, executive director. “We are able to negotiate a much better reimbursement schedule with managed care plans.”

PSN was formed as a professional association in November 1995. The original six subspecialists began discussions on forming a group practice in response to “a recognition that medical care in the Dallas area is driven by managed care, and none of the local IPAs included a comprehensive grouping of pediatric subspecialists. In fact, PSN has been successful because it is a very

marketable commodity,” says Deborah Nelson, a health care consultant in Dallas who was the network's original executive director.

Originally, the six subspecialists had planned to form an integrated group practice, but later decided doing so was “too elaborate and too costly,” Nelson says. Instead, the physicians formed a network that that could represent them as a group in dealing with MCOs, while maintaining separate practices. “A key element in bringing the network together was recognizing that physicians don't cooperate very well most of the time,” says Nelson.

“Pediatric subspecialists are being squeezed out of the business.”

—Ronald J. Glasser, MD

“So, we needed a very narrow goal that did not interfere in any material way with anyone's practice.” Because affiliation was simple, and participants could leave the network at any time, “formation moved quickly and easily,” she says. “The main issue for us was dealing successfully with managed care.”

Affiliating With a PPMC

Negotiating successfully with MCOs is one reason pediatricians are affiliating with PPMCs, says Creasey of Kelson Pediatric Partners. Kelson, and other pediatric PPMCs, such as Pediatric Physician Alliance of Atlanta, form partnerships with pediatric groups in which the PPMCs may purchase a group's accounts receivable or other assets, such as real estate and equipment. Then, the PPMC manages and markets the practice, including negotiating with MCOs. In exchange, the PPMC receives a percentage of the group's revenues, generally 15% to 20% after expenses, for a specified period, usually 40 years. In addition, the PPMC may offer stock options, cash payments, or profit-sharing to the pediatricians who own the group.

Nonmedical personnel become employees of the PPMC, but “the doctors continue to own and control the practice,” says Creasey. “Kelson simply

becomes their partner.” Since remaining independent is important to the physicians, such a structure “works best for the future profitability of the medical group because the physicians remain productive,” Creasey explains.

Pediatricians who choose to affiliate with a PPMC rarely do so for the initial cash for receivables and other assets, says Creasey. “They usually are seeking the capital necessary to continue to practice medicine successfully,” he says. PPMCs often invest in equipment and information systems, and may make other capital improvements for affiliated medical groups. Kelson has invest-

ed more than \$5 million in the 27 pediatric groups it has affiliated with in the last two years, Creasey says. Those 27 practices represent a total of 131 physicians. “Taking on managed care contracts, accepting risk, managing a growing practice, expanding personnel. All these things take money,” Creasey says. “And we prefer to deal with practices that want to grow. We want to make them more profitable. In addition, most of the pediatricians we affiliate with become Kelson shareholders. We become stronger together.”

Kelson manages groups in Connecticut, Florida, Massachusetts, New Jersey, New York, and Utah. Pediatric Physician Alliance has affiliations in California, Florida, Georgia, Illinois, Maryland, Massachusetts, New Jersey, New York, North Carolina, Ohio, and Virginia.

Whether they join or form single-specialty groups or affiliate with PPMCs, pediatricians are capable of exercising market clout as specialists capable of providing primary care, Creasey says. “Pediatricians are beginning to become knowledgeable about their market value and the importance of working with organizations that can provide the capital they need to increase that market value,” Creasey explains.

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

Glossary of Investment Terms

The following are definitions of some of the most common terms investors in publicly traded physician practice management companies use when discussing the value of a company.

Current assets—Value of cash, accounts receivable, inventories, marketable securities, and other assets that could be converted to cash in less than one year.

Current liabilities—Amount owed for salaries, interest, accounts payable, and other debts due within one year.

Current ratio—Indicator of short-term debt-paying ability. Determined by dividing current assets by current liabilities. The higher the ratio, the more liquid the company.

Debt-equity ratio—Indicator of financial leverage. Compares assets provided by creditors to assets provided by shareholders. Determined by dividing long-term debt by common stockholders' equity.

Depreciation—A noncash expense that provides a source of free cash flow. Amount allocated during the period to amortize the cost of acquiring long-term assets over the useful life of the assets.

Dividend—Distribution of a portion of a company's earnings, cash flow, or capital to shareholders, in cash or additional stock.

Earnings—Net income for the company during the period.

Earnings per share (EPS)—Also referred to as primary earnings per share. Net

income for the past 12 months divided by the number of common shares outstanding, as reported by a company. A company also may use a weighted average of shares outstanding over reporting term.

Earnings yield—The ratio of earnings per share to the current share price after allowing for tax and interest payments on fixed-interest debt. The earnings yield is the inverse of the price-earnings ratio and is the total of 12 months of earnings divided by the number of outstanding shares, divided by the recent price, multiplied by 100. The end result is shown as a percentage.

Equity—The value of the common stockholders' investment in a company as listed on the balance sheet.

52-week high—The highest price the stock reached over the last 52 weeks.

52-week low—The lowest price the stock reached over the last 52 weeks.

Initial public offering (IPO)—A company's first sale of stock to the public. Securities offered in an IPO are often, but not always, those of young, small companies seeking outside equity capital and a public market for stock. Investors purchasing stock in IPOs generally must be prepared to accept large risks for the possibility of large gains.

Prices—Price of a share of common stock on the date shown. Highs and lows are based on the highest and lowest intra-

day trading price.

Price-earnings (P/E) ratio—Shows the "multiple" of earnings at which a stock sells. Determined by dividing current price by current earnings per share (adjusted for stock splits). Earnings per share for the P/E ratio is determined by dividing earnings for past 12 months by the number of common shares outstanding. A higher "multiple" means investors have higher expectations for future growth, and have bid up the stock's price.

P/E ratio equation—Assume stock in XYZ Co. sells for \$25 per share and has earned \$1.25 per share this year. Since \$25 equals 20 times \$1.25, XYZ stock sells for 20 times earnings.

Revenue—Includes all net sales of the corporation plus any other revenue associated with the main operations of the business (or those labeled as operating revenue) as indicated on 10-K or 10-Q filings with the federal Securities and Exchange Commission. It does not include dividends, interest income, or nonoperating income.

10-K—Annual report required by the SEC. Provides a comprehensive overview of a company's state of business. Must be filed within 90 days of the end of the fiscal year. A 10-Q report is filed quarterly.

Yield—The percentage rate of return paid on a stock in the form of dividends, or the rate of interest paid on a bond or note.

Source: *Glossary of Investment Terms*, Fuhrman-Matt Securities Inc., Philadelphia.

(Continued from page 1)
of the relationship."

PPMCs pay physicians in cash and stock when they purchase a practice. In exchange, the PPMC is paid a management fee of 15% to 20% of a practice's income, after expenses, generally for 30 to 40 years. A drop in stock value means that some PPMCs may have trouble providing investment capital as part of their management service. And it means a drop in the value of the stock the physicians received to make the initial deal.

Analysts say some PPMCs have grown too fast, taking on too much debt too fast through the acquisition of practices, and

that is a major reason their market value has fallen recently. At the end of 1996, there were 30 publicly traded PPMCs, with revenues of about \$12 billion, according to Peter S. Stamos, director of Stanford University's Comparative Health Research Center in San Francisco. Just 16 months later, there were 45 publicly traded PPMCs, with revenue estimated at more than \$20 billion, and about 150 privately held, smaller companies. Stamos predicts that by 2002, PPMCs could be making \$70 billion to \$100 billion in annual revenues.

Wall Street investors fostered this growth in PPMCs. By mid-1997, the stock value of

some larger PPMCs rose 200% and more, in just six months, as the companies acquired more practices and as a result of support from investors. But the love affair between the market and PPMCs began to fade on Jan. 8, 1998, the day MedPartners in Birmingham, Ala, and PhyCor in Nashville—the two biggest and most successful PPMCs—called off a proposed \$1.8 billion merger. By the end of May, investors viewed PPMCs so skeptically that some PPMC stock values fell to an eighth of their market highs.

"Businesses, including PPMCs, generally source capital in two ways," says W.L. Douglas Townsend Jr., managing director and CEO of

"This industry has grown very fast. That should be a matter of concern to physicians who sold to PPMCs."

— Nathan Kaufman, Superior Consultant Co.

Townsend Frew & Co., health care investment bankers in Durham, N.C. "They borrow funds through traditional commercial banking facilities or they sell equity to third parties, such as shareholders. The ability of young, upstart PPMCs to continue to raise public equity capital depends largely on the investors' perception of sustainable growth in future earnings per share. PhyCor and MedPartners' news cast significant question on such earnings growth, which has been reflected in the significant drop in per share stock prices."

This summer, both PhyCor and MedPartners cut their earnings targets for this year and next year. On the news, PhyCor's stock price dropped 38%, and MedPartners' stock dropped 12.5%. In July, FPA Medical Management Inc., a primary care PPMC in San Diego, filed for protection under the U.S. Bankruptcy Code. Last year, FPA had revenue of more than \$1 billion and its stock was trading at about \$40 per share. At the time of its bankruptcy filing, its stock had fallen to 25 cents per share.

Caution Advised

Analysts say it is too early to tell whether falling earnings will hurt PPMCs so badly for so long that physicians should avoid relationships with these companies. Physicians' lack of confidence in PPMCs, can, in fact, create a self-fulfilling prophecy: "A multispecialty clinic's ability to grow or sustain its market share depends largely on the acquisition and recruitment of new physicians, especially lower revenue-generating primary care physicians," says Townsend. "This growth is capital intensive and generally cannot be carried out without a capital partner. These transactions are a mistake for physicians, no matter what the up-front dollars, if their capital needs in the future cannot be supported."

Some analysts say physicians should be careful in choosing a PPMC, but not lose confidence in the PPMC practice option. Courtney LeClercq, a health care analyst with Johnson Rice & Co., investment bankers in New Orleans, believes that the upheaval caused by the failed MedPartners-PhyCor deal will fade and that companies will rid themselves of less profitable medical practices and reduce their overall debt. At that time, the PPMC industry will begin to consolidate and investor enthusiasm will be rekindled.

Townsend agrees. The strongest PPMCs are those that bring the greatest value to the practices they acquire through management expertise and by increasing the market share of affiliated practices. These PPMCs will do well in the future, Townsend says. PPMCs appeal to what Townsend calls "momentum investors" who follow trends in specific industries and watch earnings growth carefully. "Momentum investors will continue to watch current earnings performance, and the PPMCs that demonstrate operational value will ultimately be rewarded with price-to-earnings ratios the sector enjoyed 12 to 18 months ago," he says.

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

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Firm Says: Manage Care or Be Managed

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

Depending on their market and their particular career goals, many physicians today need to consider committing to being part of a strong, cohesive group, according to some advisers. The choice today is "manage or be managed, own or be owned," says one such adviser, Jack Weiss, MD, MBA, an otolaryngologist who is president of Integrated Medical Dynamics (IMD), a consulting group in Paradise Valley, Ariz.

The physicians who founded IMD chose to manage. The lessons they learned while forming their independent practice association can benefit physicians who are assessing their organization's strengths and weaknesses, or contemplating joining a group or starting from scratch. The physician consultants at IMD, who are now in the business of helping colleagues build organized systems of care, say collaboration between primary care physicians (PCPs) and specialists is critical to a group's success.

Forming an IPA

IMD's genesis began four years ago with five physicians in Scottsdale, Ariz. They were concerned about what managed care was doing to doctors and were convinced that integrating the clinical and business aspects of their practices would be beneficial. They wanted their organization to be a multispecialty group encompassing PCPs, specialists, and a hospital partner, if possible. In a matter of months, a like-minded cadre of PCPs was identified, and an IPA known as Scottsdale Integrated Management Inc. (SIMI) was born.

Then began the hard work of outlining SIMI's structure and the steps necessary to achieve clinical and business integration. "It became apparent that we needed a consulting group that shared our vision of medicine and had experience in putting together a group like the one we envisioned," says Robert Flores, MD, a family practice physician in Scottsdale who is the president and medical director of SIMI. HealthQuest Affiliates, managed care consultants in Tucson, Ariz., was selected to help define SIMI's direction, develop the group's infrastructure, and educate its physicians, PCPs

and specialists alike. Ultimately, SIMI evolved into a physician-driven organization with a strong partnership between PCPs and specialists, including a governing board with representation from both groups. But the partnership was not easily achieved.

Stumbling Blocks

Before the IPA was formed, SIMI's PCPs had worked together as a unit doing managed care for several years, but because many of the specialists had not previously worked with PCPs in a physician group, the learning curve for them was steep. "Some of our specialists have not embraced managed

when the group began to establish contractual relationships with health plans. "We thought that if we put together the 'cream of the crop' of PCPs and specialists, we would automatically have an inroad into health plan contracts," says Flores. That turned out not to be true. Health plans in Scottsdale, a community with one hospital system, were reluctant to contract exclusively with SIMI. Consequently, in order to gain access to health plan contracts, SIMI had to work with the hospital through the Scottsdale Memorial physician-hospital organization. "Although our physician-hospital organization made great strides, it was not as ready as

"Each practice will need to evolve into a superior-performing business."

—Daniel K. Zismer, Towers Perrin

care and our ideas of capitation, and they have rebelled against them," says Flores. "From the outset, we envisioned a strong partnership between PCPs and specialists, but a lot of dust has had to settle to get to the folks who are truly interested in making that happen. As we projected, we've had a certain amount of attrition among specialists." In general, PCPs stayed with the IPA, but SIMI's primary care base faced formidable competition from the local hospital system, which embarked on an aggressive practice-purchasing program.

Clinically integrating PCPs and specialists was further slowed by battles related to SIMI's financial stability and the process of developing the organization's infrastructure. "We're not as far along as we felt we should be in that respect," says Flores. "We're looking at the process of the continuum of care for a patient, whether it's outpatient or inpatient, who does it best, and under whose direction it should occur." SIMI's goal is to develop true clinical guidelines and an integration process that delineates patient care through a coordinated effort to improve outcomes.

Unexpected hurdles were encountered

when we were to take on risk," says Flores. "So we were delayed in our plans to effectively manage contracts and take full risk."

The Evolution of IMD

Convinced by the lessons learned during SIMI's formation that many of the pitfalls that had befallen the IPA could have been avoided or minimized with a more systematic approach to developing an IPA, Weiss founded IMD in December. IMD's vice president of development, Aubrey Kesterson, MBA, also was a veteran of the SIMI experience, having previously worked for HealthQuest. Together with experts in finance, physician education, and relations between medical staffs and hospitals, Weiss and Kesterson have developed a continuum of services for physician groups, targeting four specific areas:

1. Managed care readiness
2. Compliance with federal rules and regulations
3. Organized systems
4. Medical staff organization

In addition to SIMI, the IMD approach has been tested at Virginia Integrated Physicians (VIP), in Arlington, Va., another

"Some of our specialists have not embraced managed care and our ideas of capitation, and they have rebelled against them."

— Robert Flores, MD, Scottsdale Integrated Management Inc.

er IPA. Founded in 1996 by five physicians, VIP currently has 120 physicians and does risk contracting. "Without the mentorship we received, it is hard to imagine how, as a group of busy practitioners, we would have organized," says Barry Byer, MD, a family practitioner and medical director of VIP. "We needed expert consultation to reach our goals."

Managed care readiness. The IMD process starts with a two-day on-site analysis of clinical infrastructure and readiness to function in a managed care environment. IMD team members conduct interviews, collect data, and observe group dynamics. Next, they compile a report detailing the group's evolution and current position in the market and listing the steps needed to excel in both the short and long term to ensure growth and survival. The group's response to this analysis is critical; the physicians must be receptive to change.

"A failure to properly align the incentives of PCPs, specialists, and hospitals will result in a failed organization, some sooner, but all eventually," says Kesterson. "Here in Phoenix, two PHOs have collapsed in the last three months. It is absolutely imperative that an integrated, data-driven unit, with an infrastructure designed to reinforce coordinated, outcomes-oriented care, emerge in our communities. Unquestionably, this is a physician-driven phenomenon."

A similar trend nationwide is predicted by Daniel K. Zismer, national practice leader, health systems consulting, in the Minneapolis office of Towers Perrin, health care consultants. "Medical groups will go through substantial cultural change, shifting from a collection of individuals," Zismer says. "Each practice will need to evolve into a superior-performing business. If a practice does not change in this way, the goal of being physician-owned and physician-led will be threatened, and the practice will be forced to consider other options, such as selling out to a hospital system or to a physician practice management company," says Zismer. "However, when the practice does sell out,

the new owner will not tolerate poor business performance. In either case, the practice will not be able to continue with poor business performance, whether it's physician-owned or owned by somebody else."

Compliance. Complying with federal regulations is at the heart of survival for physician groups and physicians in private practice. The federal government estimates that health care fraud accounted for losses of \$29 billion for 1997 and \$6 billion of that amount is believed to be the result of fraud by physicians. Whether that fraud is due to incorrect billing resulting from fraudulent intent or inadvertent error, physicians remain at risk. "If someone comes knocking at their door, physicians had better be armed with a plan that demonstrates compliance," says Kesterson. "For example, they must be able to show that they document their coding and billing practices, that they are conducting background checks on potential employees, and that their employees are aware of their responsibilities."

Organized systems. In addition to counseling physicians on partnership formation and compliance issues, IMD conducts an on-site analysis of a group's governance, management, and financial effectiveness. In many cases, the structures taken for granted in other business endeavors are lacking. Items such as a mission statement, business plan, strategic action plan, cost accounting, and business valuation often do not exist.

When it evaluates financial effectiveness, IMD reviews a group's ability to manage premium income, its cash and capital positions, any internal risk-sharing incentives among providers, and the business' financial indices and ratios. Corrective actions fall into two broad categories: financial or debt restructuring, and strategic restructuring. Strategic restructuring includes adding revenue sources such as clinical product lines (senior care, women's health, or workers' compensation) whenever possible. Economies of scale are considered, such as common billing and collection, employee leasing, pooled purchasing of insurance and supplies, and con-

solidation of office sites.

"Once restructuring strategies are in place, it is our belief at IMD that independent financial institutions will look more favorably on such groups as they try to access additional capital," says Weiss. "For example, a Southern California primary care group without walls recently received a \$6 million infusion of venture capital merely by consolidating sites and instituting centralized billing and collecting. Sound business practices and investment in infrastructure signal to financial institutions that such groups are serious."

Medical staff organization. Another aspect of the IMD review involves an on-site analysis of the medical staff's effectiveness. When medical staffs and hospital management are working in collaboration, the medical staff itself must be an effective and efficient organization. IMD examines the medical staff bylaws to ensure compliance with case law, statutory law, and regulations, and evaluates the credentialing, peer review, and due process provisions. The development of physician leadership also is important, and IMD facilitates this process as well, through individual training and educational sessions involving groups of physicians and administrators.

"An efficient medical staff organization provides a viable partner for any collaborative relationship between physicians and the hospital," says Howard L. Lang, MD. An obstetrician-gynecologist and vice president of medical affairs at IMD, Lang is a past chairman of the American Medical Association's Hospital Medical Staff Section.

Conclusion

Preserving the private practice of medicine and keeping clinical decision-making in physicians' hands are IMD's goals. Its advice to groups in formation or transition can be summed up in one sentence: Harness the collective intellect and problem-solving ability of your physicians through dialogue, collaboration, and strong business principles.

—Additional reporting and writing by Danae A. Manus, in San Francisco.

Wharton Professor Believes Physicians Need Business Skills to Reassert Themselves



Lawton Robert Burns, MD, PhD, is professor of health care systems at the University of Pennsylvania's Wharton School and director of research for the Leonard Davis Institute of Health Economics at the university. He teaches undergraduate, MBA, and PhD courses in strategy and health care management, focusing on integrated delivery systems. Burns received a PhD and an MBA in health administration from the University of Chicago. This interview was conducted by Richard L. Reece, editor-in-chief.

Q: Dr. Burns, please tell us briefly about how you earned your degrees.

A: I got my MBA after my PhD, which is the opposite of how most people earn their degrees. After I had the PhD and had started teaching courses in health care at the University of Chicago's Graduate School of Business, I realized that I didn't know as much about the business of health care as my students did. To teach in the business school, I felt that I needed to know more about the operational side of health care, so I got a fellowship from the Kaiser Family Foundation, in Menlo Park, Calif., to go to the business school at the same time I was teaching in it. As it turned out, I was a professor during the day and a student at night, and my students were my classmates. It was an odd situation.

Q: How long have you been teaching in the MBA program at Wharton?

A: I've been at Wharton for four years, but I've been teaching since 1980. I've also been teaching seminars for physicians around the country since 1993.

Q: How do you view the current state of mind of physicians in their career development in the business world?

A: Physicians have a significant interest in getting graduate training in business management. In fact, there's a huge

boom market now in the executive education of physicians, and many universities—not just business schools—are setting up executive physician management programs. The Advisory Board Co., in Washington, D.C., and the American College of Physician Executives, in Tampa, Fla., have set up physician executive training programs. They're all developed to meet demand on the physician side. Physicians want the training.

Q: Tell us about the program offered at Wharton.

A: We have three options. One is a full-time daytime MBA program, and a large number of physicians apply to it. In fact, we could fill up our entire MBA program with qualified physicians who want to get MBAs. For diversity purposes, however, we admit only nine or 10 physicians a year out of a class of about 45. The second option is our executive weekend MBA program. The third option is a range of executive education programs, such as the medical management program.

whereby teams of MBA students do consulting for firms on a low-cost or no-cost basis. The article says that these teams do just as good a job as the major consulting firms and cost nothing or only a fraction of what the consulting firms charge. Essentially, this program offers a firsthand experience in a consulting engagement. It involves a team that you didn't put together, people you have to get along with, and a client with an unstructured problem that has to be solved in a short period of time.

Q: Is it a fair assessment to say that you believe physicians have a bright future as leaders in the medical industrial complex?

A: Yes. I've been studying physicians since 1984. Back then, my business school classmates never got a good introduction into what it means to be a physician and the instruction never prepared us for what it means to work with physicians. I've oriented much of my research toward that gap. In time, physicians will reassert their dominance in the health care system. But they need the business skills to do that.

"The studies we've done show that the relationship between physicians and hospitals is clearly not as tight as administrators either think it is or would like it to be."

Q: Tell us about the Wharton MBA curriculum and how physicians fit into it.

A: It's the standard MBA curriculum, with the addition of four or five courses from the health care curriculum. Our health care students have two required courses: one is an overview of the major providers, payers, and suppliers in the health care system; the second is a field application project. Interestingly, the May 4 issue of *Forbes* featured field application projects. The thrust of the article was that the top-flight MBA programs around the country have field application projects

Q: Over the last decade, you've conducted surveys on physicians in large physician organizations at the county, state, and national levels. Based on that research, can you say what the second or third generation physician-hospital organizations will be like?

A: It is hard to generalize from one market to the next, but we found that in one advanced managed care market during the mid-1980s and early 1990s the relationships between physicians and hospitals were deteriorating for several reasons. Managed care was one. Diagnosis-related groups was another. Also, because hospitals were ven-

turing into ambulatory care and physicians were venturing out of hospital specialty services, they were beginning to encroach on each other's turf. So, the studies we've done show that the relationship between the two is clearly not as tight as administrators either think it is or would like it to be. In fact, it is stretching a point to call these "integrated systems" because, although they may be integrated in the sense that a deal has pulled these entities together and put them under one roof, either in an ownership model or a contractual model, the integration ends there. The operational alignment of the components within these systems is weak.

Q. *Would you agree that the practice of hospitals acquiring doctors as salaried employees hasn't worked well?*

A. It has met with mixed success. The published evidence says that it costs hospitals between \$25,000 and \$100,000 per primary care physician per year, depending on the system. In other words, they are losing that amount of money each year per physician. Those studies typically don't take into account whether there are offsets in terms of increased referrals to the inpatient facility.

There are two responses to that. One is that the systems don't want to even touch that information because it would seem like they were trying to buy referrals and they don't want to be accused of that. The other reason they don't mention it is that some systems have figured out that there is no increment in referrals, therefore it is essentially a net loss of \$25,000 to \$100,000 per physician. So, the acquisition of primary care physicians has not been a financially winning strategy in the short term. Whether it pays off in the long term with respect to winning managed care contracts because of the in-house primary care component remains to be seen. The initial evidence suggests it doesn't help a whole lot.

Q. *Some physicians dream of "being back in control" of the health system. Under what conditions is that likely to occur?*

A. Eventually, physicians will rise to the top, but first they need to be much more savvy about developing alliances and partnerships with other providers, including

health care I find debatable, if only because it represents a continued fragmentation of the health care system, which is the whole reason why there's integrated health care in

"It's not clear that the incentives of Wall Street, hospitals, physicians, and insurers will ever be fully aligned. We will always be talking about aligning the incentives among them."

their colleagues. That's something physicians historically have not been very good at, except for those in the large multispecialty groups. Figuring out how to manage risk under capitation is another skill they need to develop; as is disciplining their own membership. These are some of the critical infrastructure elements that any physician organization will need. Over time, if they develop those kinds of skills, they'll do well.

Q. *I have heard it argued that the wave of the future will be "contractual integration," in which physicians and hospitals are best operated as separate entities with contractual relationships. Do you agree with that?*

A. Yes, overall I would agree with that assessment, but it will vary from one market to the next because you can't generalize across markets, although you can make some broad generalizations that apply to a lot of markets.

Q. *Regina E. Herzlinger, a professor at the Harvard Business School, has written a book, Market-Driven Health Care (Addison-Wesley, 1997), in which she talks about focused factories. You have stated that you both share some views but differ on others. Could you share with us those views?*

A. We have a common interest in what she calls focused factories, which are single-specialty networks or single-disease models that focus on a small number of interrelated patient conditions or diseases or specialties that need to be managed together. To say, however, that this approach is and should be the future of

the first place. Our current formulations of integrated health care have not necessarily worked, but I'm not advocating a focused factory approach where each part of a patient's care is carved out as a single entity. I also take issue with how well these single-specialty networks work. A handful seem to work fairly well, but the vast majority have merely been interested in aggregating and consolidating physicians under one roof and not necessarily in improving the practice and organization of their medicine.

Q. *What is your perception of physician practice management companies (PPMCs) and the likelihood of their success?*

A. It's cloudy at best. The fact that PhyCor and MedPartners, the two leading firms in this industry, have difficulty pulling off a merger suggests that neither of them really understands fully what they're about or the problems of this physician integration model. PhyCor and MedPartners are light-years ahead of their industry counterparts in trying to integrate physicians, but even they are having problems. For example, physicians are questioning whether PPMCs are serving them or the investors. In the short term, they're serving the investors.

Q. *Many people think that there's a contest going on for the allegiance of physicians between hospital-based systems and the Wall Street-based systems, such as PPMCs. And many feel that this is a contest for the soul of medicine between the nonprofit community models and the for-profit commercial models of*

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Wall Street. Would you comment on this?

A. The Wall Street firms are interested in just capturing the dollar flow and carving out their portion of it. The hospitals have had a much longer historical relationship with physicians and are obviously much more oriented than the Wall Street firms toward quality of care, access to care, charitable care, and so on. So, the hospitals at least are operating on some of the same turf as physicians are in terms of these kinds of interests. But it's not clear that the incentives of Wall Street, hospitals, physicians, and insurers will ever be fully aligned. We

work, reimbursements, and negotiations in contractual relationships with third parties. It's a growth industry, but not necessarily in the areas that positively affect physician incomes.

Q. *So, what is happening to doctors' incomes in the face of rising overhead costs?*

A. Their net incomes haven't necessarily been falling, but they haven't been rising that quickly either. It's clear that there will be tighter reimbursement checks, and with rising overhead costs, physicians are being forced to be much more efficient

"Since the country as a whole will not bite the bullet of national health reform, providers will be forced to figure out how to ration health care in terms of balancing cost, quality, and access."

will always be talking about aligning the incentives among them.

Q. *You've studied a lot of physician groups. What market forces are having an effect on group practices, and how are they reacting?*

A. The rise in the number of group practices and of large groups has created a growing competition among group practices. This poses a competitive threat to the smaller groups in terms of visibility, prestige, and the ability to win capitated contracts and managed care contracts. This competition among groups is one of the single biggest market forces affecting physicians. Another market force that is affecting group practices is, obviously, managed care and the need to do utilization review or quality assessment and assurance, and efficient screening of physicians who will belong to the group or the networks that you're putting together. The administrative hassle of medicine and having to deal with all the payers and paperwork are forcing groups to increase the nonclinical side of their practice in a way that's threatening their viability. A statistic I ran across recently showed that one of the biggest growth areas in employment is in the health care sector in physicians' offices, suggesting that physicians have to take on not only more medical staff, but nonmedical staff as well just to handle such things as paper-

practice managers. Although I can't prove it, I sense that physicians are probably the best ones to figure out how to manage their offices efficiently because all of this comes right out of their pocket, therefore they have the greatest incentive to manage their practices efficiently. A hospital or a PPMC doesn't know as much about physicians' practices as do the physicians. Most of the physician groups I've consulted with are parsimonious in how they utilize additional personnel and additional office space because they have to justify to the partners with whom they're splitting revenue the added expense of any administrative item.

Q. *Isn't that one of the major drawbacks that occurs when PPMCs tell physician groups that they will cut their overhead through consolidation; that is, that there isn't much to cut anyway?*

A. There's a limited amount that can be cut to achieve the efficiency that they're claiming is achievable. Reducing overhead by 5% is about the limit. To achieve savings beyond that, changes will have to come on the clinical side, and PPMCs aren't geared up for that.

Q. *What do you see as the role of the companies on the supply side in all of this, meaning the companies in medically related industries, such as pharmaceutical companies and distributors and medical device manufacturers?*

A. They are part of what we call supply chain management, which is part of the value chain of health care production, and involves all the suppliers and distributors that manufacture and distribute products to hospitals, physician offices, and nursing homes. These organizations will play an increasingly important role in the health care system because, like everybody in the system, they're consolidating and trying to do cost containment to achieve more efficient supply chain management. They are trying to be more efficient in managing the interface between the suppliers, the distributors, and the providers. Achieving such efficiency involves activities such as aggregating purchase orders to get lower prices, making partners out of suppliers, and assuming risk with suppliers in terms of efficient delivery.

Q. *What is your concept of a winning relationship between physicians and other health care players? Are we engaged in a vast experiment to find out what the best system is?*

A. Exactly. And to me there's no clear winner. You have to tailor solutions, not only to the local markets, but also to the needs and interests of the specific providers you're dealing with.

Q. *You're preparing tomorrow's physician leaders to work in business and health care. What will this new breed of physicians be like?*

A. We need to train physicians in the business side because the way our health care reform efforts work is we pass the buck down to the local provider level in terms of how health care is rationed. Since the country as a whole will not bite the bullet of national health reform, providers will be forced to figure out how to ration health care in terms of balancing cost, quality, and access. Because we don't have the national will or resolve to go with national health insurance, we control health care costs by limiting the amounts of money hospitals and physicians get. It's up to them to figure out how to best deliver health care at this rationed price. We need physicians who are astute not only on the clinical side but on the management side as well and who understand the cost and quality tradeoffs. The next wave of physicians will be adept at these kinds of deliberations at the micro-level when they're treating a population of patients for whom they're at risk. ■

Electronic Claims Filing Offers Benefits

By Kathy M. Ross

For physicians seeking to get insurers to pay claims faster, filing claims electronically may be a successful approach. Aetna U.S. Healthcare, for example, announced in June that it would pay physicians who filed claims electronically within 15 business days.

Over the past few years, electronic processing of claims information has begun to be adopted widely, especially among large managed care organizations.

But not all physicians may find it easy to file electronically; some may have few payers that allow electronic claims processing, still requiring that hard-copy claims be submitted instead. Surgical practices, too, may find that they have so many exceptions to the electronic processes, such as the need to include operative notes for procedures, that the opportunities to make the most of the processes are reduced.

Physicians who cannot yet file claims electronically may find it best to ensure that any new systems added to the practice have such capability, since electronic filing is likely to be useful in the near future. In fact, electronic claims processing has evolved to the point where all providers should consider its value in their continued efforts to maximize receivables and improve the overall business management of practices.

Physicians trying to determine the appropriateness and value of filing claims electronically will need to understand the systems that receive and process such information and what procedures they would need in their offices to accommodate electronic filing. As with all information systems, electronic claims processing is only as good as its design and maintenance and the individuals who support that processing.

Assessing Value

The greatest value of electronic claims processing is that it increases a payer's ability to

review, reject, and pay claims promptly. In addition, payments to providers can be remitted electronically, saving time and reducing administrative chores. Claims processing and remittance can be totally paperless processes that usually produce few errors and result in more rapid follow-up on claims that must be rebilled. Ultimately, the processes may result in lower practice overhead.

Fewer administrative personnel may be needed in the provider's billing area to manage the processes to support these functions. However, before making any staffing changes, the physician group should wait several months after installing the systems and testing the processes that support filing claims and receiving remittances electronically before conducting a careful review of personnel needs. Staff will still be needed to maintain and manage the billing process to

so, additional software and communications equipment must be purchased, adding needlessly to the cost of the system. In addition, electronic claims processing should be a seamless process for the physician group using the system. Additional manipulation or duplicate entry of data wastes time and energy.

When considering how to make electronic claims filing work effectively in a practice management system, physicians should carefully assess the payer's requirements and the group's ability to respond to those requirements. Practice management systems vendors typically have standard approaches to responding to individual payer requirements for electronic claims processing. If a group cannot accommodate these standard approaches, it may be time to get a new, more flexible system. For this reason, a physician group assessing a prac-

In their efforts to maximize receivables and improve the overall business management of practices, all physicians should consider the value of electronic claims processing.

ensure that the electronic procedures comply with the payer's requirements and to follow up on submitted claims. A senior staff member may be needed to establish the appropriate procedures, for example, to ensure that remitted payments are processed appropriately. The group should ensure that the remittance system applies the correct payment to the correct account, an operation that is critical to managing accounts receivable successfully regardless of whether the process is done electronically.

Typically, practice management systems can accommodate electronic filing of claims. If a practice management system cannot do

practice management system should determine how effective the system will be in responding to payers' ever-changing requirements. For example, most systems allow physicians to differentiate between payers whose claims can be submitted electronically from those that accept only paper claims. Also, most practice management systems provide an override capability to ensure that a specific claim can be submitted on paper, if necessary, even though the payer is designated to receive electronic claims.

The system should be able to accommodate all procedure codes, documentation requirements, and any unique billing requirements. The procedure code itself may be set specifically for paper submission or a specific charge may be sent on paper, depending on the payer's requirements. Rebilled charges may require that a physician group submit a paper copy of the claim and of notes on a test

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interpretation, for example. Systems that are inflexible regarding charge information and the requirements of various insurers simply may not be desirable.

To determine if a system can support such a wide range of functions, the physician group may want to speak with other customers of the systems vendor before committing to a purchase. The physician group should ask the vendor for the names of several clients, and while it is not necessary to speak to all of them, it would be prudent to contact the client groups that have similar operations.

Accommodating a Clearinghouse

Many insurers process claims from physicians through a claims clearinghouse that edits the claims before forwarding the information to the payer. These clearinghouses frequently require physicians to use individual submitter designations or identification numbers, which are distributed only after a physician group completes an application process. Usually, practice management systems vendors help their customers complete such an application and help ensure the timeliness of a response from the clearinghouse. The vendor may then need to program the system to include the appropriate identification numbers for each payer and for each clearinghouse. Since the clearing-

house has a roster of payers that accept electronic claims, and that roster can change regularly, the systems vendor will review and implement changes as needed. If a payer requires additional information to be submitted electronically, the electronic forms will need to be revised, or a payer will simply change clearinghouses, meaning a different provider designation will be needed.

Some practice management systems offer their own clearinghouse functions. Under such an arrangement, claims are submitted to the vendor's clearinghouse, where additional edits are made. Claims are then forwarded electronically to the payer for review and payment. Claims submitted to payers that do not accept electronic claims are identified by the vendor's clearinghouse, printed on paper, and forwarded for processing.

Testing Required

Testing of the electronic claims formats prior to using the system in a so-called live setting is time well spent. Regardless of how ready-made the processes may appear to function, a testing period to ensure that all communication systems are fully operational is critical. Test data should reflect a variety of charges and insurance information. In the test, a physician group has an opportunity to review the system design and its own corresponding office procedures.

Once testing has been completed, the physician group should get documentation directly from the clearinghouse or payer that claims can be submitted electronically. The physician group also should get documentation whenever the clearinghouse, the practice management systems vendor, or the payer makes any changes in billing requirements that affect claims submission.

Some practice management systems vendors recommend that physician groups keep a paper copy of all reports or logs filed electronically, especially during the first few months of running a new system. During these first months, it is particularly useful to call the payer's help-desk staff to verify that each claim or batch of claims has been received electronically. Although infrequent, electronic claims can be lost, just as paper claims get lost.

A major value of an efficient and well-designed electronic claims processing system is the use of edit capabilities to verify claims information logic or identify missing data prior to submitting claims to a payer or clearinghouse. Typically, a run of electronic claims goes through a first-pass edit in which those that do not meet predefined standards for completeness or information logic are identified. For example, breast exams should be charged only for female patients. The physician group then reviews any charges that are questioned, determines the steps needed to permit the claim to be submitted electronically, and continues the electronic submission or identifies the claim as one for review and submission later.

Some practice management systems include an interactive editing capability, which can be modified as needed. Other systems come with standard edits, which usually are based on demographic and insurance requirements or procedure and diagnosis logic. Regardless of how the system's editing capabilities are established in the practice management system, the use of such a function is critical. A claims clearinghouse performs the same editing review on submitted data as was performed by the physician group.

While the initial steps required to implement an electronic claims filing system may be time-consuming and painstaking, the end result offers significant advantages for physician groups. ■

Aetna Proposes Faster Claims Payment

Aetna U.S. Healthcare, the large managed care organization in Hartford, Conn., announced in June that it wants physicians to file health claims and referrals electronically and that it will pay physicians within 15 business days when they submit HMO referrals and claims electronically. Aetna expects the program, called E-Pay, to enhance service to physicians and members, while allowing Aetna to take a leadership role in making rapid payments to physicians.

"We believe E-Pay will improve HMO claim turnaround time, leading to more predictable cash flows for physician practices and therefore to higher satisfaction levels among our participating physicians," says Michael J. Cardillo, president of Aetna U.S. Healthcare.

Initially, the program will be available to physicians in Northern New Jersey and New York. By the end of next year, it will be available nationwide, Aetna says. Nationally, only 38% of physicians are submitting claims electronically.

Participating physicians will have several options for electronic connectivity, including voice response units, swipe card boxes for eligibility checks, desktop systems with claims filing software, and training on each option. The necessary software will be free to Aetna U.S. Healthcare participating physicians.

Evaluating PPMCs Requires Due Diligence

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

Since early this year, physician practice management companies (PPMCs) have faced widely reported operational difficulties. Despite this turmoil, many physician groups are considering partnering with one of these companies. As a result of the troubles PPMCs have confronted, it is more important than ever for physicians to determine a potential partner's ability to deliver both operational value for the clinic and the capital to carry out a strategic plan.

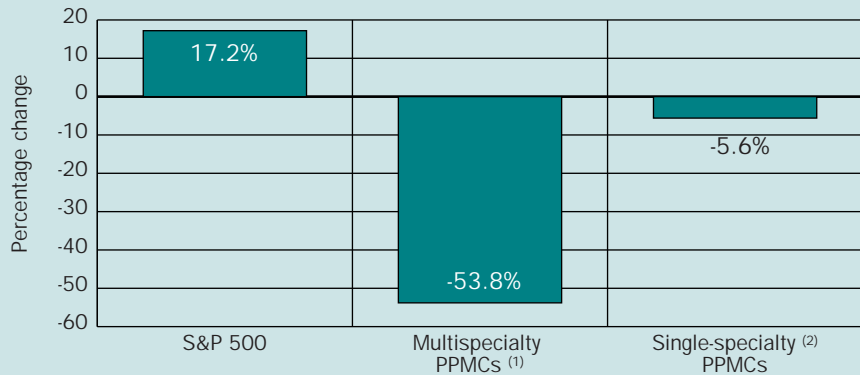
Since most affiliation agreements between physicians and PPMCs run for 40 years, the selection of a viable partner for the clinic is critical. Therefore, before a clinic can determine which partner would be the best fit, it must determine its own strategic direction and what it needs from a potential partner. During the due diligence process that occurs before a transaction closes, physicians should seek to discover a potential partner's strengths and weaknesses. Listed below are criteria physicians should consider in a partner.

Before making a deal with any PPMC, physicians should determine that:

- The physicians will have a significant role in driving local market growth.
- The PPMC's senior management has been stable.
- The PPMC has demonstrated growth in affiliated clinics. Some PPMCs have started to disclose revenue growth from affiliated clinics that have been with the PPMC for at least one year.
- The PPMC is equally committed to operations and acquisitions.
- The PPMC has taken relatively few restructuring charges; its financial statements are clean and easy to understand.
- The PPMC has a productive relationship with its affiliated physicians.
- The PPMC has access to capital to meet its affiliated clinics' needs.
- The management fee the PPMC will charge is fair and reasonable in relation

Stock Price Changes

Percentage change in stock prices of PPMCs versus S&P 500, Jan. 2, 1998 to June 30, 1998.



(1) Multispecialty PPMC Index includes: Complete Management, FPA Medical Management, MedPartners, PhyCor, PhyMatrix, and ProMedCo Management Co.

(2) Single-specialty PPMC index includes: American Oncology Resources, MedCath, Omega Health Systems, Orthodontic Centers of America, Physician Reliance Network, Physicians Resource Group, Physicians' Specialty Corp., Response Oncology, Specialty Care Network, and Vision Twenty-One.

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

to the purchase price it is willing to pay.

- The PPMC can demonstrate an ability to secure managed care contracts and purchasing discounts for the clinic.
- The PPMC has a plan for helping its affiliated clinics enhance their competitive position.
- The PPMC will help stabilize physicians' income to predeal levels.
- The PPMC's strategic direction meshes with that of the clinic.

History Lesson

PPMCs have always had a volatile relationship with investors on Wall Street, and some have faltered in recent months. Most grew quickly by taking on debt and acquiring physician practices voraciously. In some cases, investor support had helped push up the stock value of some larger PPMCs by 200% and more.

But in January, investors began to question the ability of PPMCs to sustain growth. At that time, MedPartners, the largest PPMC, and PhyCor, the second largest player in the field, announced that

their proposed \$1.8 billion merger was being called off. In the next few months, investors became increasingly skeptical about the value of PPMC stock. Also, other PPMCs began to report financial difficulties.

Some analysts believe PPMC stocks have reached their lowest point and that they will begin to turn around. These analysts cite two reasons for this prediction:

1. PPMCs are beginning to take steps to improve their operating performance.
2. The largest PPMCs have already announced bad news.

Other analysts question the continued viability of the industry.

The point is that many companies in the PPMC industry are undergoing a major transformation as they move from being simply companies that acquire physician practices to being operators of physician practices. Some companies will successfully negotiate this change in direction, while others will fail. To ensure that they affiliate successfully, clinics must be thorough in investigating potential partners. ■

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FPA, the Third Largest PPMC, Files for Bankruptcy

Amid continuing difficulty for physician practice management companies (PPMCs), FPA Medical Management Inc., the nation's third largest PPMC, has filed for bankruptcy protection. Signs that the company was experiencing financial problems had been seen since late last year, according to *The Wall Street Journal*. Based in San Diego, FPA has networks of 7,900 physicians in 29 states. Company executives blamed the company's fast growth over the past two years for the filing and said a number of acquisitions did not perform as expected.

Other PPMC's have reported financial difficulties as well. In July, PhyCor Inc., in Nashville, cut its earnings targets for this year and next year. In August, MedPartners also lowered its earnings targets for 1998 and 1999.

Regarding FPA, physicians have been perturbed by the slow payments, the journal said. Chronic delays were reported in payments to physicians, and at least one physician filed a complaint last year with the California Department of Corporations, which regulates HMOs.

In May of this year, the company reported that it had almost run out of cash. The filing under Chapter 11 of the U.S. Bankruptcy Code eliminates any equity shareholders may have had in the company and leaves many physicians with unpaid bills, the journal reported. In California alone, FPA owes physicians some \$60 million, according to preliminary estimates prepared by the California Medical Association.

Comment: *Despite signs of financial trouble last year, the company had a stock market value of \$1 billion last fall when its stock was trading at about \$40. After the filing, its stock was trading at less than \$1.*

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