

PHYSICIAN PRACTICE OPTIONS™

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A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

CONTENTS

Features

Strategy
Solo Practitioners
Buck the Trend 4

Interview
Mayo Clinic Executive
Says Federal Fraud
Investigation Is Unfair,
Fragmented 8

Departments

Editorial
Resources for Physicians
Interested in MBAs 2

Commentary
HHS Says PPMC Fees
May Be Illegal 3

Health Care Law
Exploring the Tax
Deductibility of Incurred
But Not Reported
Expenses for IPAs 11

Capital Ideas
A Look at Venture
Capital Activity 13

Information Systems
Software Evolves as
Managed Care Spreads 14

Negotiating With PPMCs Requires Communication, Preparation, Due Diligence In a Quest for Financial Gain, Physicians Could Lose Their Clinical Autonomy

Physicians struggling to sustain their income and autonomy under managed care systems are seeking assistance from physician practice management companies (PPMCs) in an effort to gain market share. By promising 15% to 20% of their annual income for as long as 40 years in exchange for immediate cash and stock in the PPMC, the physicians gain access to long-term capital and management expertise.

Despite the advantages for both sides, physician relationships with PPMCs can founder because the two sides may not communicate effectively, especially during negotiations, and because the business orientation of a PPMC may clash with a medical group's clinical philosophy. Therefore, physicians need to consider carefully the ramifications of signing a contract with a PPMC, or the deal can result in the loss of clinical autonomy in exchange for an apparent financial gain.

"It is critical that physicians do not engage in PPMC transactions solely out of fear of the financial consequences of remaining independent, or allow themselves to be distracted by an attractive buy-out price," says Albert Barnett, MD, a health care consultant in La Habra Heights, Calif., and former CEO of the Friendly Hills HealthCare Network, an integrated health system in La Habra, Calif. Physicians also must consider the effect a PPMC will have on the quality of their professional lives, Barnett says. "Physicians should not neces-

sarily sell themselves to the highest bidder. They should do a comprehensive investigation concerning their practice's autonomy and the PPMC's corporate culture."

Obviously, physicians enter into relationships with PPMCs to gain financial security, but that security can have a significant effect on clinical care, agrees Lloyd M. Krieger, MD, a physician with the UCLA Medical Center who has written about PPMCs for *JAMA*. "The link between financial and clinical affairs can be subtle," says Krieger. "For example, a PPMC may have trouble negotiating managed care contracts with favorable capitation rates because a given practice has a high rate of hospitalization or specialist referrals. In that case, the style of medical practice could affect the PPMC's ability to survive as a business. In addition, the PPMC may be compelled to intervene by bringing pressure on physicians to lower utilization rates, just as managed care does. But, unlike managed care, the pressure is now within the practice."

Inherent Disparity

"The PPMC might attempt to decrease physician compensation or pressure the group to replace the most profligate physicians," Krieger continues. "At the cost of increasing efficiency, the PPMC's utilization review may lower medical quality."

Disparity between what may be in a practice's best financial interests and what

(Continued on page 6)

Resources for Physicians Interested in MBAs

After we published our cover story in April, "Seeking Job Alternatives and More Income, Physicians Pursue Advanced Degrees," we received many phone calls from interested readers. One caller, a 46-year-old orthopedic surgeon from Dallas, had been taking an MBA course offered by Johns Hopkins University in Baltimore. Using satellite video technology and interactive software, the physician, Bruce Preger, MD, has been attending classes in a Dallas conference room. He learned about the course from the American College of Physician Executives and said he found such distance-learning extremely useful.

Chiefly, however, callers wanted to know where they could get more information on advanced degrees or other managed care educational opportunities. A 30-year-old part-time faculty member, Pseti Markova, MD, in a family medicine program in Pontiac, Mich., sought the name of a university within 100 miles of her home. She wanted a part-time MBA course so she could continue in her current job and still care for her two young children. A 46-year-old otolaryngologist in Georgia reported that he was "close to burnout" from heavy competition in his market. Seeking other career options, he inquired about the possibility of taking an MBA course part-time in Atlanta.

To answer these and other questions, we suggest readers seek information from the following sources:

- The Official MBA Guide (www.mba.us.com/guide/program) lists 986 MBA programs offered nationwide. The site lists program by region and by those that have a concentration in health care services. The site also gives characteristics of the schools, costs, curriculum, and ranks the schools. The Screen + Rank Engine helps physicians find schools that meet specific criteria.
- The Graduate Management Admission Council, MBA Explorer (www.gmat.org) contains information on how to prepare for the GMAT, the books and software required, schools and programs available, financing an MBA, and other resources.
- The American College of Physician Executives (www.acpe.org) offers information on a graduate program in medical management at Tulane University or Carnegie Mellon, both of which lead to a Masters of Medical Management. Readers are invited to write to ACPE, 4890 East Kennedy Blvd., Suite 200, Tampa, Fla., 33609-2757, or call 800/562-8088, or 813/287-2000.

Readers seeking information on managed care educational opportunities and managed care curriculum, not necessarily leading to formal business degrees, may wish to call the following individuals who direct programs at "managed care universities," the generic name for courses developed by various health systems and health care organizations for educating physicians about managed care: Christine Micklitsch, director, physician education and services, at the Fallon Healthcare System in Worcester, Mass., at 508/799-2100, ext. 69836; Duane Davis, MD, senior vice president and medical director, Penn State Geisinger Health Plan, Danville, Pa., at 717/271-6487; Maria Cardenas-Anson, manager of provider education, Group Health Cooperative, Seattle, at 206/326-3441; and Deborah Cunningham, managing director, health care member services, The Advisory Board Company Inc., Washington, D.C., at 202/672-5653. Cunningham has information on all the current managed care education programs for physicians and welcomes calls.



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HHS Says PPMC Fees May Be Illegal

By Richard L. Reece, Editor-in-Chief

Management fees for marketing and billing paid to a physician practice management company (PPMC) and based on a percentage of a physician practice's revenue could violate the federal anti-kickback law, according to an opinion issued by a federal agency.

Issued by the federal Department of Health and Human Services Office of Inspector General (OIG), the opinion also says a PPMC that requires affiliated physicians to make referrals to physician networks managed by the PPMC could violate the anti-kickback law.

"The opinion takes the broadest possible interpretation of the anti-kickback statute, and indicates that, under certain circumstances, a percentage-based management fee coupled with marketing activities may be a violation," says Michael Blau, an attorney who is chairman of the Physician Practice Management Company Group of McDermott, Will & Emery, a law firm in Boston.

The opinion resulted from an inquiry to the OIG by an unnamed primary care physician. The physician planned to contract with a PPMC for management services, including negotiation and oversight of health care contracts, in exchange for a percentage of his income.

Under common contractual relationships between physician groups and PPMCs, groups pay 15% to 20% of their annual income each year when they affiliate with PPMCs. Sometimes, PPMCs also establish their own provider networks, which could include the physician. In such cases, the physician could be contractually required to make referrals to the PPMC's affiliated specialist networks.

OIG advisory opinions offer advice. They are not legally binding, reflect only the circumstances described by inquiring parties, and do not reflect independent government investigation. The opinion, No. 98-4, was issued on April 15. It states that the fee arrangement described by the inquiring physician is problematic under a section of the Social Security Act known as the anti-kickback statute. The statute "prohibits payments made to purposely induce referrals of business payable by a federal health care pro-

gram," and allows for prosecution of both sides in a kickback transaction, the opinion states. The anti-kickback provisions of the federal Social Security Act is Section 1128B(b). Violation constitutes a felony punishable by a fine of as much as \$25,000, imprisonment for as long as five years, or both. Conviction automatically leads to exclusion from federal health care programs, including Medicare and Medicaid.

The opinion lists three reasons why the physician's percentage-based fee arrangement with the PPMC is possibly illegal:

1. It would include financial incentives to increase patient referrals.
2. It contains no safeguards against overutilization.
3. The arrangement would include financial incentives that increase the risk of abusive billing practices.

"Risk can be minimized if both parties document their lack of intent to violate the law."

— Michael Blau, McDermott, Will & Emery

The OIG "has a longstanding concern that percentage billing arrangements may increase the risk of upcoding and similar abusive billing practices," the opinion states. Upcoding is the illegal practice of billing payers at the highest possible diagnostic reimbursement code for a medical condition, regardless of the level of service performed.

Within the context of the opinion, the words "marketing" and "referral" are used synonymously, Blau says. The opinion appears to find problems with a PPMC marketing a particular practice to perform specific Medicare and Medicaid services for distinct populations, such as radio ads encouraging diabetics to receive blood tests from a specific physician, Blau says. "It should not be read to prohibit all general advertising of a practice, such as hours of operation or convenience of location," he says. "Violation of the anti-kickback statute requires the intent to generate inappropriate referrals, resulting in illegal income, and the opinion refers to activities that may put

a physician and PPMC at risk of violation, but do not necessarily violate the statute."

Physicians can take several steps to minimize the risk of appearing to intend to do wrong, Blau says. One step is not to create contract arrangements that require referrals to a closed network of providers managed by the PPMC.

PPMCs and medical group practices also can take the following steps to minimize the risk of violating the anti-kickback provision and demonstrate a lack of intent to circumvent federal regulations:

- Practices should implement a Medicare compliance program, including periodic audits of coding and billing practices. These programs should be designed to demonstrate a willingness to avoid overutilization, upcoding, and improper referrals. "Risk of appearing to intend to

defraud or commit abuse under the anti-kickback statute can be minimized, especially if both parties document their lack of intent to violate the law," says Blau.

- PPMCs can eliminate percentage-based marketing fees by paying for marketing services on a fixed-fee or other basis that does not vary with practice revenue.
- PPMCs and practices can hire consultants to determine a fair market value for marketing services, a value independent of the number of referrals. "This will negate an inference of improper intent because it will demonstrate a proper intent to pay only a fair market value for a business service actually rendered by the PPMC," Blau says.
- Practices can write a contract that includes a disclaimer of any intent to induce referrals for specific services.

Editor's note: Advisory Opinion No. 98-4, issued April 15, 1998, by D. McCarty Thornton, is available on the Internet at www.hhs.gov/progorg/oig/advopn/advopn.html.

Solo Practitioners Buck the Trend

The conventional wisdom holds that solo practitioners cannot survive in markets dominated by managed care. Indeed, the number of solo practitioners is shrinking, from about 255,000 in 1983 to 183,500 in 1997, according to the AMA's 1997 Socioeconomic Monitoring System survey.

"They are kind of a dying breed," consultant Robert Bohlman says of solo practitioners. "Their practice options are increasingly limited. It's difficult for them to get good contracts with managed health plans when they negotiate as individuals, or to afford the infrastructure necessary to comply with the many regulations imposed by payers, including Medicare. Many solo practitioners feel they cannot compete in today's market." Bohlman consults with the Medical Group Management Association in Englewood, Colo.

Regardless of economic pressures, some solo physicians say they wouldn't practice medicine any other way.

"I'm too young to believe in conventional wisdom," says William Andereck, MD, age 48. An internist in San Francisco and chairman of the 15,000-member California Medical Association's Solo and Small Group Practice Forum, Andereck says solo practitioners and small groups of four or fewer physicians can survive if they emphasize a personal relationship with patients. "Physicians are over-reacting, panicking over changes in health care they feel they can't control," Andereck says. "But the biggest problem for health care that's occurred in the last 10 years is that too many physicians in large, impersonal group settings no longer have enough time to spend with their patients. Solo practitioners can thrive by providing personalized, quality care."

While Andereck may be optimistic, some physicians are finding the problems associated with managing a solo practice today are overwhelming. Edward Waechter, MD, is an obstetrician in Omaha, Neb., whose income has declined by nearly 50% over the past two years, primarily because of the increasing influence of managed care in his market. "It is becoming increasingly difficult to get referrals because these plans

allow referrals only to physicians in their networks," says Waechter, age 47.

Waechter was part of a 10-member medical group several years ago, and left that group to practice on his own. "I wanted to be independent, and I thought I could practice better medicine that way," he says. "But being independent requires more overhead than I can afford, and managed care wants to cut deals with physicians in large groups who share expenses and can afford capitation. Now, even if I wanted to, I can't get into these networks. They're filled."

As Waechter found, solo practitioners may need to work more hours than their counterparts with managed care contracts.

Surviving on Fee for Service

Andereck's optimism for the survival of solo practices is based on a belief that a backlash is occurring among patients who believe managed care's emphasis on cost contain-

ment and the growing dominance of managed care. The number of medical groups is increasing sharply, up about 50% between 1990 and 1996, to 5,000 multispecialty and about 14,000 single-specialty groups, AMA records show. The proportion of physicians employed by a hospital, health plan, or other physicians also is increasing, from 24% in 1983 to 38% in 1996.

Survival Strategies

Andereck and other physicians say options exist for physicians who do not wish to be part of a large medical group or who dislike working under the precertification and utilization review requirements of managed care. The CMA created the Solo and Small Group Practice Forum in 1994 to offer programs to solo practitioners and groups of four or fewer physicians struggling to survive the consolidation that is rampant in health care.

"The only way a practice, or anyone, becomes successful is by choosing to be, by working at it."

— John McDaniel, Physician Management Group Inc.

ment and precertification results in inadequate health care.

Since he is not part of any managed care plan, Andereck's practice is entirely fee-for-service. Managed care is creating impersonal medicine, he says, adding that patients willingly pay directly for treatment by a practitioner who "sustains a personal relationship with his patients."

"I don't have to wait for an insurance company to pay me because my patients pay me," Andereck says. "They are then reimbursed by the insurer. They are willing to pay out of their own pockets because they know that I offer personalized medicine. I always return their phone calls, and when they come to my office, they will see me, not another doctor they do not know."

Andereck knows that as a solo practitioner he is bucking a trend. Record numbers of physicians are consolidating into large groups, according to the AMA, moti-

The forum educates members on cost-containment strategies and has formed a buyers' club that provides discounts on office supplies, medical equipment, drugs, and vaccines. It also provides centralized administrative support for photocopying and securing part-time employees.

CMA President Jack Lewin, MD, says that by working together through organizations such as the forum, solo practitioners and small group practices can thrive by offering a quality of medicine that encourages patients to seek them out regardless of whether the practitioner is part of their managed health plan. "Few forecasters predict an increasing influence for solo practice," Lewin says. "But the ideal for medicine, whether it be through managed care or traditional fee for service, is for doctors to work to improve the quality of care and patient satisfaction. Physicians who promote professional integrity and preserve the

The Five Levers of Profitability for Physician Practices

Careful planning, with an understanding of basic medical reimbursement principles, is required for solo practitioners and small groups to survive, says John W. McDaniel, founder and CEO of Physician Management Group Inc. in New Orleans. PMG advises solo practitioners, and medical groups of all sizes, on how to maintain profitability by examining how they control the money they earn.

"In any business, the three ways to improve profitability are increase revenue, decrease expenses, or increase volume," McDaniel says. "However, in health care, volume increases do not necessarily equate to increased profitability because of the impact of many government programs and managed care programs."

When advising a practitioner on how to sustain or improve profitability, PMG examines the five areas that a physician can control about his or her income, what PMG calls the five levers of profitability.

PMG's "five levers of profitability" are:

Reimbursement systems. The first item a physician should examine to increase profitability is patient coding. "Too often, these codes do not adequately reflect the services being provided," McDaniel says. Because many practices repeatedly provide the same services, physicians and their staffs become accustomed to using a limited number of codes. PMG advises physicians to conduct a chart audit to update

codes. "We have found that corrected coding has the largest and quickest impact on profitability," McDaniel says. "About 70% of the physicians we audit are undercoding. By correcting this problem, a physician can increase income immediately by 10% or more."

Billing and collection processes. Many physicians do not bill in a timely manner, McDaniel says, and as a result suffer a significant reduction in cash flow. PMG advises physicians to set up precise billing and collection protocols, carefully monitor collections in the office and the initial billing to third-party payers, rebill payers who fail to respond in a timely manner, and follow up on claims denials. "Too many doctors allow these procedures, which are critical to cash flow, to fall behind, and the longer that happens, the more difficult it is to get back on track," McDaniel says.

Accounts receivable management. Accounts receivable are the single biggest asset of most medical practices, McDaniel says. "It's not so much that most accounts receivable are mismanaged, as they are unmanaged," he says. PMG recommends that a procedure be implemented that lists all patients and segregates their accounts based on each payer and on the length of time reimbursement has been outstanding. Some 80% of past due accounts generally are from about 20% of payers, McDaniel

says. Office staff members should develop relationships with the accounts payable departments of all major payers, and be familiar with the specific documentation required by each payer. Accounts receivable should represent no more than two or three times a practice's monthly billings, says McDaniel.

Expense and operations management. Many solo practices could centralize expenses by sharing the cost of basic office operations, such as the purchase of supplies and photocopying, with other solo practitioners. "Most physicians do a good job of controlling expenses in their private lives, but many fail to apply the same discipline to their professional lives," McDaniel says.

Patient volume and patient mix. PMG recommends that physicians conduct "patient origin studies" that involve examining where patients live and, for specialists, where referrals originate. Such a study can help physicians relocate for the convenience of patients or identify the ideal place for satellite offices. Primary care physicians also should develop a reminder system that notifies patients when they are due for annual physicals and other procedures, such as vaccinations.

"If a physician is providing good patient care, he or she will have enough repeat business to never have to worry about increasing his patient base," says McDaniel.

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doctor-patient relationship thrive regardless of the practice setting."

Success Is a Choice

Although solo practice may bring physicians closer relationships with patients and increased professional satisfaction, surviving requires hard work and careful planning, says John McDaniel, president of Physician Management Group Inc., a practice management company in New Orleans. "The only way a practice, or anyone, becomes successful is by choosing to be, and by working at it," says McDaniel. "And it takes a lot of work."

Health care is unusual among businesses because revenue is derived primarily from

third-party payers, McDaniel says. That makes bookkeeping particularly complicated, and requires careful control of billing and management of accounts receivable. "There are only five ways to make money in any health care enterprise," he says. "We call these the five levers of profitability." The five levers are:

- Reimbursement systems
- Billing and collection processes
- Accounts receivable management
- Expense and operations management
- Patient volume and patient mix

These five methods are the only ways money comes into a practice, and can be controlled and optimized through planning, McDaniel says. They apply to any medical practice, but are especially important to

solo practitioners and small group practices, which often survive on a comparatively small profit margin. (See "The Five Levers of Profitability for Physician Practices.")

Solo practitioners seeking to prosper should carefully assess their business operations, develop a business plan, and hire a good office manager, McDaniel says. "For any practitioner, in any setting, there are four core personal and professional issues: independence, control, time, and money. How to retain all of those and still deal with the complexity of today's market is a problem. It requires a professional commitment, and a willingness to plan carefully," he says.

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

(Continued from page 1)

member physicians view as quality care is often inherent in PPMC relationships, Barnett says, and must be addressed from the outset. "Because of the length of these relationships, generations of physicians connected to a practice will have to live with the affiliation decision," he explains. "A well-crafted relationship can offer financial protection, but if goals, philosophies, and vision are not aligned, the affiliation will eventually fail to meet both parties' expectations."

In most PPMC relationships, a practice sells its assets, including accounts receivable, real estate, and equipment, to a PPMC. The participating physicians may then form a separate professional corporation, becoming both owners and employees of the corporation. The physician corpora-

tion signs a service contract with the PPMC, usually for 30 to 40 years, under which the PPMC manages the medical practice (see "Typical PPMC Services").

The PPMC often provides capital to the practice by investing in new equipment and information technology. Also, the PPMC becomes the employer of all non-medical personnel, negotiates managed care contracts, buys supplies and malpractice insurance, and often recruits new physicians. These arrangements are fairly standard, Krieger says. But in contract negotiations, terms are often used that may mean different things to the physicians in a group practice than they do to the business professionals who run PPMCs.

Communicating Effectively

While trying to talk physicians into making a deal, PPMC executives use words such as "growth," "capital," and "management," all of which imply that the corporation will bring value to the practice. But once a contract is signed, a relationship can become dangerously problematic without a mutual understanding of what is meant by each of these words.

"The vocabulary is ambiguous," Barnett says. "Not only do physicians and PPMCs have differing interpretations of common terminology, but their priorities may be in conflict." (See "Steps to Take Before Affiliating With a PPMC.")

Even the nomenclature of the deal itself can be confusing: Health care analysts and consultants refer to the PPMC's "purchase" of a medical group, and talk about a PPMC "owning" the group. But many PPMCs refer to their relationships as "partnerships," and talk about physician autonomy.

"Our affiliated physicians continue to own and control the practice," says Skip Creasey, president of Kelson Pediatric Partners Inc., a pediatric PPMC in Hartford, Conn. "Kelson just becomes their partner."

Regardless whether they see themselves as employees or partners, physicians can become resentful after a contract is signed if they discover that their would-be savior has an unanticipated agenda. A PPMC may use the word "growth," for example, to mean an increase in its national market share. Such an increase would be measured in the number of physician practices it has under con-

tract and a related increase in revenue and stock value, Barnett says. But to physicians, the word "growth" means increased market share in their own service area, "which is far more significant to them than growth at the national PPMC level, even if they own some stock," Barnett says.

When PPMC officials talk about enhancing "capital," they are referring to increasing the value of their publicly traded stock by acquiring physician practices, Barnett says. "Physicians, however, believe that capital is cash that will be readily available for use in their own practice," he explains. "Physicians should therefore take the time to establish a mutually agreed upon business plan with the PPMC, with specific timetables, that address their specific capital needs prior to signing a contract."

How capital is invested under the business plan is crucial if a relationship is to succeed, says Michael Blau, an attorney who is chairman of the Physician Practice Management Company Group of McDermott, Will & Emory, a law firm in Boston. "How much money a PPMC will put into a practice and how much that investment will cost a practice are major points physicians should consider at the beginning of negotiations, not after a contract has been signed," he says.

Management Expertise

The word that can lead to the most serious complications is "management," says Barnett, because it affects two issues involving a practice's future: the quality of medical care and the role of senior physicians. "Perhaps the most formidable negotiating issue of all is exactly what will be managed by the PPMC," says Barnett. "What constitutes 'management' and therefore will be under the control of the PPMC, and what constitutes 'medical' and will remain under the control of the doctors? Defining what is meant by 'medical' and what is meant by 'management' must be thoroughly explored up front." And explained precisely.

The success or failure of any PPMC relationship depends on the patient-physician relationship, Barnett explains. "For an arrangement to have any chance of long-term success, it requires the support and acceptance of patients. For that to occur, physicians must retain control of their prac-

Typical PPMC Services

PPMCs provide management services to medical groups and purchase some of the assets of the physician group, such as real estate and equipment, with cash and stock. In return for providing management services, the PPMC collects 15% to 20% of the group's income.

Townsend Frew & Co., investment bankers in Durham, N.C., that specialize in advising physicians on affiliating with PPMCs, has outlined the basic management services a group can expect from a PPMC. Those services are:

- Maintaining equipment and facilities
- Managing operations, including billing, scheduling, staffing, and paperwork
- Educating physicians
- Providing capital
- Providing information systems
- Developing managed care relationships, including contract negotiations
- Recruiting additional physicians
- Developing clinical networks
- Doing local marketing, budgeting, purchasing
- Providing accounting, legal, and actuarial services

Steps to Take Before Affiliating With a PPMC

Relationships with physician practice management companies (PPMCs) can enhance the market position and future growth of a medical practice, or go sour quickly because of failed expectations, says Jane E. Jordan, a health care attorney with Kilpatrick Stockton LLP, a law firm in Atlanta. Physicians should take several steps before agreeing to an arrangement that will bind them to a long-term commitment with a PPMC partner, Jordan says. Practices should:

- Have a business plan in mind. Set business goals prior to discussing an arrangement with a PPMC, asking what kind of practice it envisions in five or 10 years.
- Know what strengths can be used as leverage in negotiations, such as a strong patient base or existing managed care contracts, and what administrative weaknesses a PPMC can help correct.
- Be prepared for a brief marriage if differences arise with a PPMC partner. Such differences may include a major change in the company's strategy, a merger with another entity, or the sale of the practice to another organization.
- Be prepared to repurchase the practice

from the PPMC if necessary. Could the practice obtain capital, managed care expertise, or other administrative support independently without the PPMC?

- Know the deal breakers. At the outset, physicians should identify issues over which they are unwilling to compromise. Such issues may include autonomy over clinical and other operational issues, a change in ownership of the PPMC, the PPMC's commitment to a long-term business plan for the practice, specific capital requirements, the ability of the medical practice to leave the arrangement, and the financial stability of the PPMC itself.
- Analyze the tax effect of the sale on the practice. Even the most basic transaction between a medical practice and a PPMC can involve numerous and complicated tax issues. Sometimes the desired structure and allocation of the purchase price can be accomplished only by assuming a certain degree of tax risk. Before deciding on the structure of any PPMC transaction, physicians should evaluate the tax effect of the transaction, and negotiate

the appropriate form of payment (cash, stock, or a combination of the two).

- Know the potential partner. What is the corporate philosophy of the PPMC, for example, and is it compatible with a practice's treatment principles? What are the backgrounds of the top executives, and do they have experience in running medical practices? Has the PPMC entered into arrangements with other physicians, and are those physicians satisfied?
- Discover whether the company has been profitable in its core services. Has the PPMC enhanced the profitability of other practices it manages? Will it tailor its terms to fit current needs?
- Assess the "trust" factor. Trust in any business arrangement is crucial and cannot be documented. Not every concern, contingency, or potential dispute can be addressed in writing. "PPMC transactions involve a long-term commitment, and a large part of the success or failure of these arrangements hinge on the level of trust between the practice and the PPMC," Jordan says.

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tics in critical areas of management. There is no other way to avoid compromising their vital role as patient advocate."

Physicians should remember that a PPMC's agenda is national, but their concerns are usually local, Barnett says. A PPMC may wish to make a deal with a national, for-profit hospital chain to get the lowest possible rates nationwide. But a particular group may wish to maintain a relationship with a local hospital unaffiliated with the national chain because the group may hold staff positions and have privileges it wishes to protect. What's more, the group's patients may prefer the unaffiliated hospital. For the PPMC, such a management decision falls within its control. But to the physicians, it is a medical decision that directly affects the quality of care.

Another management issue is budgeting.

"Under a management agreement, the decision about who will approve financial budgets is critical," Barnett says. "Physicians may feel that budgets developed by PPMCs are inadequate to ensure quality care, but their agreement may not contain a budget approval process. And without such approval, a group will yield significant medical authority."

The loss of the ability to control decisions related to the quality of patient care could be particularly threatening if the group's purpose in affiliating with a PPMC is to allow the group's senior managers to leave medicine with a sum of cash.

"An important consideration is whether present management will be replaced or whether the PPMC will simply advise management and serve as a resource for administrative skills," Barnett says. "Does present

leadership plan to take the money and run? If so, a practice can be left particularly rudderless, lacking the political weight necessary to maintain autonomy in health care decisions."

UCLA's Krieger agrees that PPMCs "control the purse strings, and finances will always affect the style of medical practice. In the near term, a PPMC can probably fulfill its promise of increasing efficiency, sustaining or even boosting income, and relieving physicians' business headaches. But it will be the next generation of physicians that finds out whether a PPMC alliance is a group's salvation or a flawed compromise with a for-profit organization that creates the same profit-driven pressures as managed care."

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

Mayo Clinic Executive Says Federal Fraud Investigation Is Unfair, Fragmented



Robert R. Waller, MD, is president and CEO of the Mayo Foundation, which runs the Mayo Clinic, in Rochester, Minn.; Scottsdale, Ariz.; and Jacksonville, Fla. An ophthalmologist by training, Waller has served on the foundation's Board of Trustees since 1978, and as president and CEO since 1988. He also chaired the foundation's executive committee from 1988 to 1997. Waller is a professor of Ophthalmology and chaired the Department of Ophthalmology from 1974 to 1984. In addition, he has served many professional groups, including the American Board of Ophthalmology, as director from 1982 to 1989, and as chair in 1989. He belongs to the American Medical Association and the Minnesota Medical Society; and is a member of the Board of Trustees and chair-elect of the Healthcare Leadership Council. He also is a member of the Board of Directors of Hormel Foods Corp., the Jackson Hole Group, the Malcolm Baldrige National Quality Award Foundation, and the Institute for Healthcare Improvement.

A graduate of the University of Tennessee, Waller was named distinguished alumnus in 1987. He completed his residency at the Mayo Graduate School of Medicine. In 1992, he received the Medical Executive Award from the American College of Medical Group Administrators and an Honorary Doctorate of Humane Letters from the University of Jacksonville. He received the Yater Award from the American Group Practice Association in 1996 and recently was named an Honorary Fellow of the Royal College of Surgeons, in Ireland. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q. Dr. Waller, please tell us about the scope of Mayo's operations.

A. The Mayo Foundation is a private trust for public purposes. We are governed by a 30-person board of trustees, the majority of whom are members of the public. Our clinical practices are located in

"The medical record is becoming less of a document to support patient care and more of a legal-coding-billing document."

medical centers in Scottsdale, Ariz.; Jacksonville, Fla.; and Rochester, Minn. Each medical center has partnerships with other physicians and hospitals. For several years now, we have been building a system of health care delivery in all three locations. In total, we have about 1,800 staff physicians and medical scientists, and 1,550 residents and students. There are approximately 28,600 people in our organization. Our consolidated assets are \$3.7 billion, and our consolidated annual medical service revenue is about \$2 billion.

In education, Mayo has five major programs: an undergraduate medical school, a graduate school of medicine that provides residency training in all specialties, a graduate school for students seeking advanced degrees in the biomedical sciences, a school for allied health sciences, and continuing medical education. Our expenditures for education are close to \$100 million, and our annual research expenditures are \$175 million.

As an institution, we are dedicated to practice, education, and research. We aspire to provide the highest quality compassionate patient care at a reasonable cost through a physician-led team of diverse people working together within an integrated group practice of medicine in a unified multicampus system that is intimately related to education and research.

Q. Since the collapse of the Clinton plan in 1994, managed care has grown at an unprecedented speed. Has that growth affected Mayo's campuses?

A. Our basic operating strategies are twofold. One is to do our best to remain committed to the principle that the clinical practice of medicine must sustain itself fiscally. With the constant pres-

sure on reimbursement, we must work very hard to keep this commitment. The dollars that used to flow from the practice of medicine to fund education and research no longer do so at the levels they did in the past. Therefore, we must find other ways to fund them because we believe such programs are essential if we are to improve continuously. To sustain those programs, we compete vigorously for extramural grants and contracts, and we are expanding our fund-raising efforts. Mayo Medical Ventures, an entity within Mayo that provides health information for the public, among other activities, generates revenue to help fund research, education, and clinical innovation. We have an office that focuses on forging strategic alliances with industry. Mayo Medical Laboratories generates revenue for our academic missions by providing reference laboratory services to worldwide markets.

So, our first operating strategy is to try to make the practice sustain itself financially as best we can in a world of declining reimbursement. And then we must find alternative sources of revenue to fund the programs in research and education without which we would not be what we want to be.

Our second operating strategy is to support the "mixed model" of medical practice. By that I mean we care for fee-for-service patients, patients who have no sources of income, patients from international locations, and the ones who come to us through our own health plans. We also have a direct contract without an insurance intermediary. In addition, we accept patients sent to us from several hundred managed care plans throughout the country. Caring for patients through whatever mechanisms they may choose to come to

any Mayo practice is what we mean by the mixed model of practice.

Q. *Some argue that Congress, in the Balanced Budget Act of 1997, balanced the budget on the back of Medicare. How are these cuts in Medicare reimbursement affecting Mayo?*

A. To answer, I would mention five major issues, four key messages, and three long-term goals that relate to Medicare. First, although the Medicare program has contributed greatly to our society, the program now has 45,000 pages of regulations and instructions. Compare that with the Internal Revenue Service Code, which has approximately 12,000 such pages. Second, the time that physicians can spend with patients and for scholarship is increasingly compromised because of the complexity of these regulations and because the work necessary to document what physicians do for Medicare patients steals even more time from patient care. The medical record is becoming less of a document to support patient care and more of a legal-coding-billing document. Third, the government is putting an extraordinary effort into investigating fraud, and the dollars realized through the fines and penalties in that effort are in turn used to fuel the investigative process. Fourth, federal enforcement of these regulations is fragmented. The Health Care Financing Administration, the Office of the Inspector General, and the Department of Justice are all involved, and communication among them is not optimal. Fifth, almost every day, we hear news stories about some billions of dollars of fraud in the health care system. Congress and state legislatures are considering numerous anti-managed care bills that will add to the already over-regulated health care environment.

Combined, these five issues undermine public confidence in the health care system, whether it's government or private. The bottom line is that physicians need to be spending more time managing care and less time managing the system. How do you doc-

ument properly? How do you weave your way through 45,000 pages of regulations?

Q. *Those are the five issues. What are the four key messages?*

A. The four key messages actually come out of discussions of the Healthcare Leadership Council, an organization that represents CEOs throughout the health care industry. The first message is that everyone supports a zero tolerance for fraud in the health care industry. But the second message, and this is the key point, is that honest mistakes resulting from confusing and conflicting regulations and instructions—45,000 pages of them—are not fraud. The third message is that the current investigative process is not fair. The fourth is that Congress must help to deal legislatively with the misappli-

No one individual or one group is to blame; we're all responsible and accountable, and somehow we have to turn this around in a positive way.

For us at the Mayo Foundation, cost reduction through improvement is the only plausible strategy. We have to reduce cost, but we have to continue to improve at the same time. Quality improvement is a continuous process because advances in health care are occurring every day. When you make a regulation, you place a stake in the ground. And if you place a stake in the ground on Monday and say "this is quality," you may find on Tuesday that the stake's in the wrong place because quality has moved ahead to a new point. The goal is to constantly improve care, not to achieve or

"The bottom line is that physicians need to be spending more time managing care and less time managing the system."

cation of the False Claims Act.

As for the three long-term goals: First, we have to simplify the regulatory environment. No one is against prudent regulation. But the system we have now is creating, among all physicians who see Medicare patients, a massive paperwork jam that's paralyzing our ability to function efficiently to serve our patients. The second long-term goal is that we have to focus on real fraud, not honest mistakes. The third goal is more privatization: less micromanagement and elimination of price controls.

The overall message in all of this is as follows: We can all take responsibility for the fact that the Medicare program put in place in the 1960s is now enormously complex and unmanageable. This complexity steals time from patient care and scholarship; it dilutes the core purpose and value of the medical record; and it breeds honest mistakes that are not fraud. The complexity and the accusations undermine public trust.

define a regulatory standard.

Q. *Has the purpose of your recent trips to Washington been to help straighten out this Medicare problem?*

A. I'm a member of the Healthcare Leadership Council, which is based in Washington, D.C. The council, a group of 50 CEOs from a cross-section of the health care industry, was formed seven years ago. We try to work in a positive, collaborative manner with members of Congress and members of the Executive Branch to sort out how best to be of service to our patients through the development of sound public policy. The Medicare issues are central, of course, to these efforts.

Q. *Let's speak for a moment about privatization. Mayo has adopted a strategy of forging close relationships with major corporations, such as IBM in Rochester and Motorola in Phoenix. How are such relationships going and what exactly does Mayo do?*

(Continued on page 10)

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INTERVIEW

(Continued from page 9)

A: To answer your question, we must talk about principles. Whether health care is provided through the private sector (such as with IBM or Motorola) or through government programs, the same principles about relationships should apply. Let me mention five key principles.

First, we should have a system that empowers individuals to choose a health plan that best meets their needs. The second involves choice; that is, a market with multiple providers and payers and insurance options. Having a diverse group of providers and payers supports competition, patient empowerment, improvement, and innovation. The third involves competition: Who can provide the best value? We define "value" as encompassing quality and cost, and we define "quality" as improving outcomes and improving service. Fourth is innovation. Research and education are the under-

"Honest mistakes resulting from confusing and conflicting regulations and instructions—45,000 pages of them now—are not fraud."

pinnings of innovation. If we don't continue to support research and education, we won't sustain the innovative environment that patients need and deserve and that allows all of us to improve continuously. The fifth involves the government's role: ensuring fair competition, reforming Medicare with risk adjustment for capitated payments so that all Medicare beneficiaries have access to available plans, and helping to establish a commonality in data collection and reporting that would not only enhance the ability to make informed choices but also reduce costs.

How do we put this together? The basic question for all of us is: Are we going to manage care or are we going to manage the providers who manage care? If we manage care, we'll analyze our practices, we'll be committed to continuous improvement, and we'll be increasingly accountable for outcomes, costs, and patient satisfaction. If we're going to manage providers, which is happening too much today, we'll have more regulations, we'll continue to have price controls, and we'll continue to hire increasingly more workers to oversee the work of others. We need to do more of the former and less of the latter. Nationally, we are out of balance today.

Q: *Mayo is internationally recognized as a world-class referral center, but a lot of people don't know that it is a very efficient organization. Do lower costs give you a competitive advantage in the value equation?*

A: We want to provide the highest outcomes possible at the most reasonable cost. We aspire to provide a very competitive opportunity in our model of delivery in the marketplace. So far, patient demand is significant, and people are coming to our organization through the various mechanisms that I mentioned earlier. So I think the marketplace is telling us that we do offer the care that some patients want. But every day we have to strive to reduce cost and improve quality because that's the long-term objective for us in order to maintain what we want to do. ■

Exploring the Tax Deductibility of Incurred But Not Reported Expenses for IPAs

By Katherine A. Nino, JD

One concern for physicians in IPAs is the tax deductibility of incurred but not reported (IBNR) expenses. Since deducting such expenses could significantly lower an IPA's tax liability for a given year, it is important to understand the different avenues available for deducting IBNR expenses under the federal tax code and which ones are likely to be viewed as appropriate by the IRS.

IBNR Expenses Defined

IBNR expenses include payments that an IPA owes physicians for services delivered during a tax year for which claims have not yet been submitted to the IPA. Typically, such services are rendered during the last quarter of a tax year, and the corresponding claims are not processed until well into the following tax year. To account for this time lag, and to make sure that the IPA has enough money to pay expenses when the claims come due, many IPAs establish reserve accounts to reflect their liability for medical care already delivered but not yet paid for. The amount set aside in such reserve accounts is based on an estimate of what the IPA expects it will owe when the claims are processed.

Because they are contractually bound to pay physicians for services provided through the IPA, many IPA leaders contend that the reserves set aside to pay physicians for services they have already delivered during a tax year are appropriately deductible. Under Section 832 of the tax code, insurance companies can deduct estimates of liabilities for services provided to members prior to the end of the tax year, even when the company has not yet received a claim for such services. In other words, insurers can deduct IBNR reserves. Therefore, if an IPA qualifies as an insurance company under the Internal Revenue Code, it can deduct IBNR reserves.

Katherine A. Nino, JD, is the director of the AMA's Division of Advocacy Issues for Groups and Networks.

Qualifications

The critical question then becomes whether an IPA qualifies as an insurance company for federal tax purposes. Treas. Reg. Section 1.801-3(a)(1) defines an insurance company as "a company whose primary and predominant business activity during the taxable year is the issuing of insurance or annuity contracts or the reinsuring of risks underwritten by insurance companies." Since IPAs neither issue annuity contracts nor reinsure risks underwritten

members satisfy the risk-shifting and risk-distribution requirements for insurance. In contrast, it has ruled that staff-model HMOs do not qualify as insurance companies for federal income tax purposes because the risk assumed by such HMOs is not an insurance risk, but rather a "normal business risk of an organization engaged in furnishing medical services on a fixed-price basis." However, since the IRS has not yet issued guidance for determining when IPAs accepting full risk qualify as insurance companies for tax pur-

Arguably, an IPA that accepts full-risk capitated contracts from an HMO to provide health care services to a large number of plan members should qualify as an insurance company.

by insurers, their qualification as insurance companies depends on whether their predominant business activity during the tax year is the issuing of insurance contracts.

The term "insurance contract" is not defined under the federal tax laws or regulations. Case law, however, has defined the term to mean "a contract whereby, for an adequate consideration, one party undertakes to indemnify another against loss from certain specified contingencies or peril." Case law also has established that risk-shifting and risk-distribution are the fundamental characteristics of a contract of insurance. Moreover, the risk transferred must be an economic loss. Arguably, an IPA that accepts full-risk capitated contracts from an HMO to provide health care services to a large number of plan members should qualify as an insurance company under this definition.

Until now, the IRS has provided limited guidance with respect to whether health care organizations qualify as insurance companies for tax purposes. The IRS has ruled in technical advice that IPA-model HMOs qualify as insurers for federal income tax purposes because their contracts with their

poses, it remains unclear whether IPAs can legally deduct such reserves under Internal Revenue Code Section 832.

Deducting Accrued Expenses

Internal Revenue Code Section 461(1) provides an avenue for organizations to deduct expenses associated with services provided but not yet paid for. Unlike Section 832, which is applicable to insurance companies only, Section 461 allows all organizations that use the accrual method of accounting to deduct expenses associated with services performed in a tax year, as long as the "all events" test is satisfied. Using the accrual method of accounting, organizations account for income and expenses in the period during which the services responsible for bringing in income or generating expenses are performed. This method is in contrast to the cash method of accounting, under which organizations account for income and expenses in the period during which payment actually flows into and out of the organization. Under the all events test, set out in Treas. Reg. Section 1.461-

(Continued on page 12)

(Continued from page 11)

1(a)(1), an accrual-basis taxpayer can deduct a business expense for the tax year in which "all events have occurred which determine the fact of the taxpayer's liability, and in which the amount of that liability can be determined with reasonable accuracy."

In the 1987 Supreme Court case of *United States v. General Dynamics*, Justice Thurgood Marshall stated that it is fundamental to the all events test that, although expenses may be deductible before they become due and payable, liability must first be "firmly established." His opinion went on to hold that the furnishing of medical services to covered individuals was not enough to establish liability on the part of the taxpayer (which, in this case, was a self-insured employer with an employee medical care plan) because the last event necessary to fix liability was the filing of properly documented claims forms.

In addition, Internal Revenue Code Section 461(h) limits the all events test further by stating that "in determining whether an amount has been incurred with respect to any item during any taxable year, the 'all events' test shall not be treated as met any earlier than when economic performance with respect to such item occurs." Although in *General Dynamics* the court did not discuss how the case would be decided under this section, in general, the economic performance requirement postpones deductions until payment is made.

The above discussion suggests that IPAs may not deduct IBNR expenses for services performed in a taxable year before processing and paying the associated claims. An exception in Section 461, known as the "recurring-item" exception, however, provides IPAs on an accrual basis with a way to deduct expenses associated with services performed by physicians in a tax year, even when the physicians providing the services are not actually paid until the following year.

The Recurring-item Exception

The recurring-item exception allows an IPA to deduct amounts based not on an estimate or expectation of liability, but rather on the actual claims processed and paid in the months following the close of the taxable year. Since the filing deadline for tax year organizations that elect the recurring-item exception is not until

September of the following year, IPAs electing to use this exception can look to the claims actually processed and paid several months following the close of the tax year. Because these claims have already been paid, the IPA can demonstrate that the associated expenses were incurred in the tax year and can, therefore, deduct them.

Specifically, the recurring-item exception states that an item is incurred if:

1. The all events test is met in the year. As

IRS officials suggest that it is a misconception that the tax code prohibits IPAs from deducting expenses associated with claims that come into an IPA following the tax year.

explained in the *General Dynamics* case, the all events test is not met simply by estimating the expenses incurred during the tax year. Satisfying the test requires the actual processing and payment of claims. However, because the claims will have been received subsequent to the close of the taxable year, the IPA is no longer merely estimating such expenses, but can show them with certainty.

2. "Economic performance" occurs within the shorter of a reasonable period of time or 8.5 months after the close of the tax year. If the claims associated with services furnished in the tax year are processed and paid within 8.5 months after the close of the year, then economic performance will have occurred and the IPA can deduct the expense.

3. Such item is recurring in nature and the taxpayer consistently treats such items. The items in question involve the physician payments for services rendered during a tax year. Guy Bennett, CPA, a member of the IPA Association of America's CPA Section, suggests that the IRS should consider medical provider claims for services rendered as recurring in nature because the IPA pays claims for the same and similar medical services every month. Moreover, as long as those claims are all charged to a medical expense account of some sort, the IRS should view them as consistently treated.

4. Either such item is not a material item or the accrual of such item provides a more proper match against income than accruing such item in the tax year in which economic performance occurs. Although such expenses would probably not be viewed as immaterial, the IRS would likely agree that the accrual of such expenses allows the IPA to match accurately expenses generated in a tax year against revenue received in the same year.

Guidance Anticipated

To date, there have not been any cases or letter rulings discussing the deductibility of IBNR expenses by IPAs. The IRS has recognized the importance of this issue, however, and plans to issue a paper on the subject this summer. The purpose of the paper will be to provide guidance with respect to what methods are available to IPAs to deduct expenses for medical services rendered in one year when claims associated with such services do not come into the IPA until the following year.

Although the IRS has not released a formal opinion on the tax deductibility of IBNR expenses of IPAs, IRS officials suggest that it is a misconception that the tax code prohibits IPAs from deducting expenses associated with claims that come into an IPA following the tax year. They refer to the recurring-item exception as providing IPAs with an avenue to deduct such expenses when they actually are paid in the 8.5 months after the close of the tax year.

IRS officials also suggest that, while the deduction of estimated IBNR expenses under Section 832 is technically available to insurance companies alone, from a practical standpoint, the IRS is not likely to challenge deductions for IBNR reserves made by IPAs, as long as the estimated IBNR expenses deducted match fairly closely with the expenses that the IPA actually incurred. The accuracy of the deduction, therefore, will be key. ■

A Look at Venture Capital Activity

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

Last year, venture capital companies invested over \$1.1 billion in health care companies, resulting in an average rate of \$4.3 million per deal. At press time, data for the health care services sector as a whole were not yet available for the first quarter of 1998. Some of the recent venture capital transactions are listed below.

In May, Dermatology Partners Inc., in Tampa, a physician practice management company (PPMC) specializing in dermatology, secured \$10 million in equity financing plus a commitment for at least \$10 million more from Charterhouse Group International, in New York. Keith Henthorne, former president of Tenet Health System's Tampa Bay region, founded the company in February 1997. Dermatology Partners reported that it has

completed an affiliation with one six-physician group and is negotiating with 50 other dermatology practices.

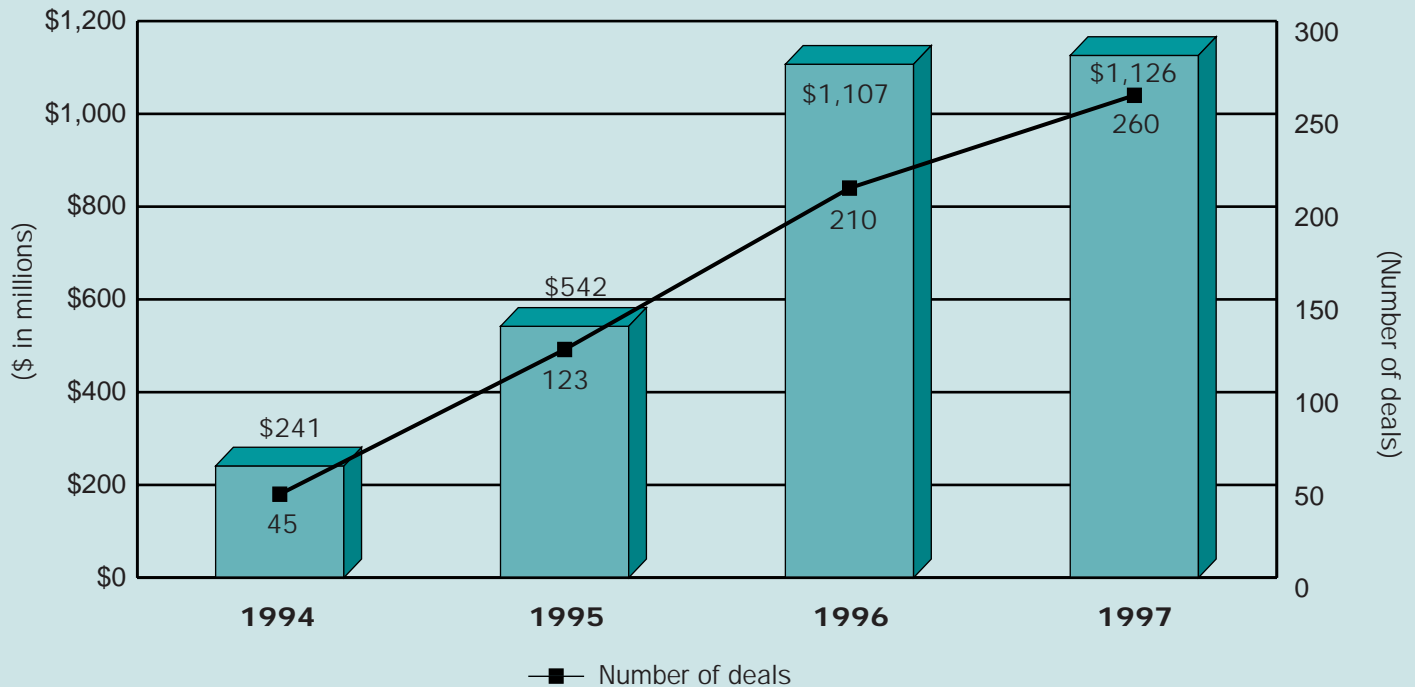
In April, Inpatient Consultants Management Inc. in Burbank, Calif., a provider of hospital-based doctors, received \$2 million from Bessemer Venture Partners, in Wellesley, Mass. Last year, the company got \$2.5 million from Morgenthaler Ventures, in Cleveland, and the Crucible Group, in Sausalito, Calif. Inpatient Consultants employs doctors to oversee the care of hospitalized patients for physician groups, managed care organizations, and hospitals. These physicians (sometimes called hospitalists or inpatient managers) stay in the hospital all day, rather than just stopping by periodically to see patients.

In April, Magella Healthcare Corp., a

perinatology PPMC in Carrollton, Texas, received \$60 million in financing from Welsh, Carson, Anderson & Stowe, in New York. In May, Magella announced that it had closed long-term management contracts with three neonatology groups in Alaska and Texas that included 36 physicians. The company also said it had agreed to acquire three more neonatology groups and one perinatology practice, representing a total of 20 physicians.

Omnia Inc., an IPA management company in Blue Bell, Pa., raised \$12.9 million from a group of venture capital firms led by Behrman Capital, New York, which is contributing \$10 million. The company manages IPAs with 1,300 physicians in Philadelphia, Chicago, Cleveland, and several locations in New Jersey. ■

Health Care Venture Capital Activity



Source: Venture One Corp., San Francisco; and Coopers & Lybrand, New York.

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.

Software Evolves as Managed Care Spreads

By Bruce Orgera

Editor's note: This article on basic managed care software is the first in a series that will focus on information systems for physicians.

The growth of managed care is having a significant effect on all aspects of physicians' practices, and particularly on information systems. The industrywide migration away from small, independent private practices toward larger, integrated delivery systems that offer access to all health-related services means that physicians need to share patient demographic and clinical information with a variety of other health care providers, including other physicians, laboratories and diagnostic services, hospitals, pharmacies, and health insurers. Knowing precisely how patient care is being managed and what that care costs has immense value for physicians, particularly those seeking to enhance their bargaining strength with health plans.

To meet the challenges of new health care delivery models, more sophisticated medical practice software is being developed and marketed by information systems vendors (see "A Variety of Software Tools Are Available for Physician Practices"). Inherent in much of the software available today is the ability to extract meaningful information in the form of targeted reports that can quickly provide data on patient demographics and insurance coverage, service utilization, referral patterns, revenue sources and distribution, and contract profitability.

Seeking Efficiency

As a result of this plethora of new systems, physicians and practice administrators want to know what is the most effective way to sort through all the automated software available. How do they make prudent business decisions about whether they need the software's functionality? What value would

Bruce Orgera is an executive director with Superior Consultant Co. Inc., in Southfield, Mich. Orgera has 15 years of experience in health care and has focused on physician practice management information systems, business office processes, and patient administrative operations.

the software bring to the practice and its patients? What, if any, are the consequences of not acquiring and implementing the software? The answers to these questions are as individual and varied as the software products themselves and the medical practices to which they are being marketed.

Usually, the decision to purchase managed care software is made when the number of managed care patients in a practice has reached a critical mass. A good rule of thumb is when 20% or more of the practice's patients are enrolled in some type of managed care plan or when the practice is taking on risk-bearing managed care contracts that account for 20% or more of the practice's patient revenue.

A group will need to purchase managed care software when at least 20% of its patients are enrolled in some type of managed care plan.

Pressure to reduce the cost of health care delivery without compromising patient care has forced physician groups to seek ways to automate labor-intensive administrative processes. Many physician offices have already automated patient billing by purchasing their own PC-based software or by outsourcing this function to a service bureau. Some physicians also have automated patient appointment scheduling.

Until recently, these processes were the primary focus of automation efforts. But even these automated solutions were primarily stand-alone, meaning they were not integrated with other patient care or business activities, such as those for referring a patient to a specialist or verifying insurance eligibility. As a result, many opportunities for automation are just beginning to be explored.

Functionality

Software designed to meet the demands of managed care systems allows physicians to manage the care-giving process by identifying patients enrolled in various plans and

associated with a particular family physician, provide benefits and co-pay information for a particular patient, help manage referrals to a specialist or diagnostic level of service, and calculate capitation payments for member enrollees.

Some of these functions (or modules for larger systems) automate enrollment, referral management, capitation contract management, and claims.

Enrollment software includes the ability to record, maintain, and report on membership data. These functions are useful for knowing who member patients are, some basic demographic information, whether the patient has selected a PCP, the name of the PCP, how much to collect in copay-

ments and deductibles, eligibility status, and the patient's basic plan coverage. By receiving this information electronically, a physician can save manual recording time and can mail clinical correspondence (such as a patient questionnaire) before the member arrives for the first appointment.

The lack of this software may mean the physician's office staff is spending extra time rekeying information into the system, not collecting the right co-payment amount, and possibly providing services to patients whose insurance has expired.

Referral management software enables a physician's office to record, transmit, manage, and report on referral information, meaning physicians can control the referral process if they are making or receiving a referral. When making a referral, a physician can automatically specify referrals to plan-approved providers for plan-approved services. When receiving a referral, a physician can control the amount and type of service he or she is authorized to perform. This software will enable the physician's office to track the type and amount of

authorized services; actual versus authorized services; authorized providers for specialty, laboratory, radiology, and diagnostic services; and pending referrals for subsequent authorizations. Without this software, a physician's office may not have effective control over the administration of these services, which could lead to a loss of income or to patient dissatisfaction.

Physicians should seek referral management systems that have electronic transmission capabilities because many insurers are requiring paperless referral transmission.

Capitation contract management software gives physicians the ability to record sufficient details about risk-bearing managed care contracts to ensure appropriate management of revenue and to compare patient service budgets with actual performance. For physician practices assuming financial risk under managed care contracts, this software is vital for administering the complex rules of capitation agreements and determining individual contract profitability. Without such software, the practice may rely on the integrity of the managed care insurer's transaction process for this information, and even the best processes are not immune to clerical error.

This software includes the ability to record and analyze capitation rates; process and analyze capitation calculations, including risk pool withholds and stop-loss coverage; post and distribute capitation revenue; and report profit and loss by contract.

Claims management software allows physicians to capture and electronically submit data on patient encounters. The ability to submit an accurate and timely record of patient encounters to managed care organizations is fundamental to managing how much and what types of care are being rendered to a select population. These data are reported to the submitting physician or physician group in the form of individual utilization and group utilization patterns. Mistakes in encounter data can mean distorted utilization measurements and possibly distorted plan profitability conclusions. Electronic submission reduces the possibility of key entry error that can occur if insurers receive claims data entered manually. This software supports proprietary or standard claim formats and coordination of benefits.

(Continued on page 16)

A Variety of Software Tools Are Available for Physician Practices

In addition to basic managed care functionality software, some of the latest trends in software for physicians' practices involve software that will handle:

- Automated electronic medical records
- Electronic data interchange
- Enterprise-wide master person index and appointment scheduling
- System integration via interface engine software
- Internet access
- Security protection.

Automated electronic medical records (EMRs) software allows physicians to record and manage a patient's medical history electronically. Such a system can store all relevant medical information, such as physician and hospital progress notes, allergies, test results, diagnoses, and a complete medical history. In addition, it can supply physicians with supplemental information, such as drug interaction data and disease management guidelines. EMR data can be sent to other physicians or medical facilities quickly and inexpensively if the need arises, thereby reducing the need for redundant testing and treatment.

Electronic data interchange (EDI) software allows physicians to participate in an industry-accepted standard for common transactions, such as insurance claim or eligibility documents. These standard transactions allow for the electronic transmission capabilities necessary to exchange information between health care providers and payers, such as insurers and government agencies.

Enterprise-wide master person index and appointment scheduling software allows physicians to identify an individual patient and to schedule an appointment for that patient directly in any patient information system, within, and ultimately outside, of the health delivery network. Since most medical entities have uniquely identified patients in accordance with their own identification conventions, this tool's value is in the application of algorithms that help identify patients properly. Once the identification process is resolved, other processes such as inter- and intra-entity patient registration and appointment scheduling become possible.

System integration via interface engine software enables disparate information systems to exchange standard and non-standard medical and administrative transactions. The immediate benefit of these programs is the shortening of the timeline for integrating similar functions over different systems.

Internet access software allows physicians to process a clinical or administrative activity, for example, making an appointment or receiving a referral directly from a remote location, such as a patient at home or another physician. To accomplish this goal, large medical office system vendors are developing software that uses the Internet as the communication network. These tools make it possible for physicians to connect to their office information system from a home PC and perform functions such as reviewing a patient's medical history. This technology would also make it possible for a patient to access his or her doctor's office to look up the next appointment or make an appointment from home.

Security protection software allows physicians to help protect the confidentiality of patient information. As the technological barriers to sharing data are being lowered, the concern about protecting that information rises. This concern is especially true in open systems, such as the Internet, which are accessible to the public. Rising to the challenge, software developers are applying health care data encryption techniques once reserved for secret military applications. While still in the experimental stage, these coding schemes are promising new tools for protecting sensitive data in open and closed networks.

—B.O.

Steps to Take When Buying Software

If a physician's practice has made the decision that managed care functionality software is needed and the practice is about to select and implement software, it would be well advised to follow these steps.

Step 1: List all business requirements according to one of four priorities:

- Critical
- Very important
- Would like to have
- Nice feature but not necessary

Step 2: Don't rely exclusively on vendor demonstrations. Before you buy, arrange to see the product perform in an office environment similar to your own.

Step 3: Understand how the software will work with your current software and hardware.

Step 4: Make sure the vendor knows how your office processes work and can match the software to your office processes.

Step 5: Make changes in how your office operates, if necessary, to complement the new functionality.

Step 6: Involve the staff. They know best what is needed.

Step 7: Make sure you get installation and ongoing support from the vendor.

Step 8: Invest in training the staff properly.

Step 9: Thoroughly test the system before using it in your office.

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Richard L. Reece, MD
Editor-in-Chief
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