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INSIDE

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MedPartners collapse leaves a lesson: Keep your hands on the reins

Go slowly, don't make rash decisions, and your practice can survive

When MedPartners decided in November 1998 to get out of the practice management business, it was just the latest in a long line of disappointments in the practice management industry. MedPartners' decision, the bankruptcy of Coastal Physician Services in Durham, NC, and the financial collapse of San Diego-based FPA have left hundreds of practices in the lurch.

"My first reaction was, 'So what else is new?'" says **Stephen Hochschuler**, MD, president of the Texas Back Institute in Plano, a 27-physician MedPartners practice. "I really think they lost their focus, that they had too many balls in the air at one time. Focusing on disease management and the pharmaceutical side makes sense. It's a lot easier than running a bunch of practices."

If Hochschuler sounds blasé about the situation, it's because he isn't letting fear guide his decision making. "This just won't impact us at all," he says. "They haven't hurt our skills or our attitude one bit. We have a big name in the spinal business. We are well-positioned. And if they never delivered on things I was counting on, I also never considered them the Messiah. I never took my hands off the reins."

Indeed, when a decision to centralize billing left his 15-year billing veteran without a job, he simply kept her on as a consultant. Now she's doing the billing again. That's what may separate the Texas Back Institute from other MedPartners clients. The practice never abdicated

KEY POINTS

PPMCs are failing and pulling out of markets, leaving many of their affiliated practices wondering how to get on with business. Part of the problem is that practices abdicated responsibility for their business when they outsourced to those companies.

There is salvation for practices, however. Among the choices are: Go it alone, merge or form a loose affiliation with another practice, or try another PPMC. Don t make the same mistake twice. Make sure the choice you make meets the needs of the physicians and the practice in the long term.

responsibility to others, and Hochschuler has always been as interested in running a tight business as a quality practice.

Steve Messinger, a director with ZA Consulting of Washington, DC, says one mistake many practices made with MedPartners was losing sight of their raison d'être. "These deals were never about being able to practice high-quality medicine better," he says. "They were never about the objectives of the group or of the physicians. It was all about income and upside. The fit of the parties or whether they could live with shared governance wasn't considered. They figured it was MedPartners' problem to meet payroll, to do the billing, and to pick up the gum wrappers in the waiting room."

Now that MedPartners is leaving the scene, many are stuck, not knowing where [those practices'] business stands, still needing the same capitalization to fund organic growth that isn't based on mergers. "To a degree," says Messinger, "their problems are of their own making. And to a degree, they were hoodwinked. They thought only of their pocket book, not the long-term interests of the practice."

So what are your options? According to **Jeffry Peters**, president of Health Directions, a Harvey, IL-based consulting firm, you may want to affiliate with a hospital or try another practice management company. Management service organizations, mergers, or loose affiliation with other practices also are options, But whatever organizational model you consider must meet the needs of your physicians, preserve quality of care, and generate revenues and value for the practice. "The success of any model depends on making sure that physicians are satisfied with their professional lives and working environment."

Hochschuler isn't sure what the future will bring. Other practice management companies are courting the practice, but it may opt to "do our own deal with Wall Street." There is a need for economies of scale and high-ticket items like computer systems in health care, he adds. That means there will be a need for capital. Practices need to remember, he says, that nothing can happen overnight. "You can't do things by revolution, but by evolution. People try to copy us, but it's taken 25 years to get where we are. Don't do things so fast they drown you. Before you make a decision to go with another organization, make sure your incentives are aligned, that you both win, and that you have a common vision. Know what you are willing to give up for capital." ■

SOURCES

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Outcomes

Disease-specific outcomes shared with plan members

Health Net program may be the first in a wave

In what could be a new trend to increase the information patients have about their care, the second largest health plan in California in December 1998 became the first in the nation to start ranking its practices on disease-specific outcomes. Health Net, based in Woodland Hills, ranked 47 practices on their treatment of asthma patients. The results were sent to members who have asthma, raising the specter that some will opt to leave practices that don't score well for those that provide above-average care.

Nine groups scored above average, 32 were rated average, and six were below average. Overall, the plan found "poor compliance with established asthma treatment standards." The study also found that specialists provided better

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care than primary care practices. With a new product that allows patients to go to any plan specialist without a referral for a $30 copayment, practices that don't provide the best care are even more at risk for losing patients.

Antonio Legorreta, MD, vice president of the Quality Initiatives Division of Health Net's parent company, Foundation Health Systems, wrote the report. "We strongly believe that providing the opportunity — and the information — that allows members to access the right provider, in the right setting, will help improve the quality of life for many of our members who suffer from several chronic conditions, including asthma."

Over the next nine to 18 months, Legorreta says, other report cards will be implemented and published. Among the chronic conditions surveyed will be diabetes, congestive heart failure, and cardiovascular disease — including hypertension and high cholesterol. Depression treatment will also be rated, he says, but probably using different criteria. Lastly, there will be report cards issued for two acute conditions, breast and prostate cancer.

The initial study ranked groups on quality of care and service measures, as well as outcomes. The care given was compared with practices of the National Asthma Education Program guidelines, and results were published in March 1998 in the Archives of Internal Medicine. Legorreta says that because the study appeared in a peer-reviewed journal, the 40,000 Health Net physicians were more likely to accept the results. He also made sure that the authors included one of their number, as well as an academic institution.

But there were still objections to the project. "Whatever analysis or ranking you do, you will have a bell-shaped curve," he explains, "and to the extent that you have that distribution, there will be a vocal minority against the project, and they tend to be those groups that rank in the lower end. The middle groups aren't thrilled, but they are pleased they aren't at the bottom, and those at the top are happy they are above average. But we are empowering patients to make informed decisions about their consumption of health care resources."

Along with providing members with these data so that they can "vote with their feet," says Legorreta, the plan will use the data as a method of determining practice reimbursement rates. "We are committed to using this as a way of determining a significant proportion of reimbursement," he says. "We want 10% or 15% to be attached to this." The plan is working up to that level gradually, starting at half a percent.

SOURCE

Antonio Legorreta, MD, Vice President, Quality Initiatives Division, Foundation Health Systems, Woodland Hills, CA. Telephone: (818) 676-6819.

Currently, about 3% to 4% of reimbursement is based on these performance measures.

"We think this is a positive cycle, that physicians will pay more attention to this kind of system, thus provide us with better data, and then we will be able to fine-tune our measurements."

Legorreta thinks other plans will adopt this kind of report card system as a way to provide the accountability that the government and employers are asking for. "The challenge has always been how to translate the parameters by which we are being made accountable to the physician level," he says. "How do you make it meaningful to physicians without letting it become some antagonistic system? This lets them see the benefits of performing well in a very concrete way."

Another benefit of the data collected, he says, is a verification of otherwise anecdotal information. "If you ask physicians in the community, they have a sense of which are the good medical groups and which are not. The reality is that the answers we got from these data are consistent with that anecdotal information. That's gratifying." ■

Marketing

Does alternative medicine fit into your practice?

Learn lessons from Tri-Rivers' experience

In recent years, an increasing amount of press has been given to "alternative medicine." Everything from acupuncture to aromatherapy has been covered in publications as varied as *Time* magazine and *The Physician Executive*, both of which featured cover stories on it last fall.

Depending on which numbers you believe, anywhere from 10% to 40% of Americans use complementary medicine, whether it's in the form of vitamin and herbal supplements or massage therapy. According to a recent study in the *Journal of the American Medical Association*, the number of

visits to alternative practitioners in 1997 exceeded the number of visits to primary care physicians by 243 million.

Because becoming more "customer" focused is increasingly important for medical practices, it makes sense that some are moving toward melding their practices with certain alternative therapies. One practice that has taken the leap is Tri Rivers Surgical Associates, a seven-physician orthopedic practice in Pittsburgh. In September 1998, it opened the Institute for Alternative Medicine, also in Pittsburgh.

"In the last 18 months, interest in alternative care has increased markedly among our patients," says **Martha C. Hamilton**, CPA, Tri Rivers Surgical's executive director. "This is what initially compelled our physicians to research alternative medicine aggressively and objectively, and to look at the perceived benefits of complementary care from our patients' point of view."

Tri Rivers' physicians said patients defined complete musculoskeletal care more broadly than traditional practitioners. For example, many patients turn to chiropractic and massage therapy for back pain. "Patients don't hold biases," Hamilton explains. "They will try alternative care if they think it can help. In our practice, we've always tried to be at the forefront of change, so the growing interest in alternative care is something we needed to address."

First, Tri Rivers' physicians concluded that they had an ethical responsibility to provide their patients with accurate information. "We needed to be informed, honest, and nonjudgmental," Hamilton says. "Then, as we learned more about alternative care, we saw that it could complement our approach to musculoskeletal care."

Hamilton and the physicians also recognized that this was a unique business opportunity. No other physician practice in the market had opened an alternative medicine center. Although there are many alternative medicine practitioners in Pittsburgh, most are independent; and few programs provide a truly integrative approach — one in which traditional and alternative practitioners work closely together as part of the same organization.

"We felt patients would be best served if we could bring orthopedic surgeons and alternative practitioners together in mutually inclusive way," she says. "We wanted to provide our patients with credible information about the efficacy of certain alternative therapies and give them a 'safe' place to learn about and explore alternative care options."

Reimbursement is changing

Hamilton says another reason for diversifying into alternative medicine is changing reimbursement — specifically, a possible move toward "episode of care" payments. This compels providers to examine their own preparedness, she says.

Under this model, providers will receive global payment for a specific patient issue, like back pain, says Hamilton. "This means we would receive one payment for all the services the patient would need — whether it's neuro-surgery, an MRI, bed rest, or chiropractic care. If we don't have the ability to treat the patient with our staff or independent contractors, we're not in a position to accept episode-of-care payments. If that payment mechanism is a potential next step in the market, why wouldn't we start looking for ways to provide a broader range of care?"

Once Tri Rivers Surgical made the decision to embrace alternative care, Hamilton and the physicians identified the scope of service.

At first, they focused on musculoskeletal care — "It's what we know best," she says — but quickly found that patients often have related concerns. These can encompass nutrition issues, such as supplements, and lifestyle issues, like exercise.

Tri Rivers hired a chiropractor to serve as medical director of the institute, as well as a certified

KEY POINTS

Depending on what studies you read, from 10% to more than 40% of Americans substitute or supplement traditional medical care with unconventional therapies. While for many practices, embracing alternative medicine seems like anathema, some savvy groups are pulling less traditional care into the fold.

One such practice, Tri-Rivers Surgical in Pittsburgh, has started its own alternative medicine institute. Although separate from the main practice, eventually, the physicians and practitioners at both will probably cross-refer patients. Within nine months of start-up, the practice hopes to be breaking even.

There are difficulties to overcome in starting such a practice, or in bringing alternative care into your existing care environment. One of them is overcoming the objections and fears of your

massage therapist and a certified registered nurse practitioner, who provides nutrition and lifestyle counseling. Tri Rivers expects to add other practitioners — including an acupuncturist — as the institute grows.

"Rather than providing a full scope of alternative care right away, we focused on core services," she says. "For patients who want information on other therapies, we make referrals to practitioners whom we think are reasonable."

According to Hamilton, the choice of practitioners was a crucial decision.

In addition to having an excellent understanding of musculoskeletal management, the chiropractor chosen by Tri Rivers trained at a school with a conservative curriculum. He believes in an integrative approach and shares with the physicians the philosophy that care shouldn't be overutilized. The massage therapist trained at one of the nation's top massage therapy schools, holds national certification and is considered an expert in neuromuscular massage. The nurse practitioner has 10 years of emergency department experience and — as a cancer survivor who used nutrition, exercise, and spirituality to assist in her recovery — brings a unique perspective.

"It was very important for us to find practitioners with whom we could work in a mutually respectful way," Hamilton says.

Getting the word out

With the staff in place, Hamilton and the physicians began building the program. They gave the center a name, settled on a temporary location, hired support staff, and began to market the institute. Marketing consisted of developing a "corporate" image that was distinct from the Tri Rivers image, but also made a connection to Tri Rivers' physicians to build credibility.

"Our patients tell us that they're interested in alternative care, but that they want to know their doctors are involved," Hamilton says.

Tri Rivers announced the institute through letters to patients, referring physicians, and other groups, including the local chamber of commerce and health food stores. Dozens of these letters included gift certificates for services.

Tri Rivers sent news releases, distributed an original newsletter to more than 15,000 households, and used print and radio advertising to build awareness. It also arranged for the institute's staff to participate in community events, such as health fairs and health education seminars at bookstores, hospitals, and arthritis support group meetings. Future marketing efforts will include targeting more directly and aggressively those people who are likely to use the institute's services — women 35 to 55, and senior citizens.

According to Hamilton, the institute has seen a steady increase in patient volume. The practitioners now work at about 30% capacity, but that number is rising. "We're growing every day, but the growth has been slower than we projected. We had initially thought it would take six months for the institute to break even. It now appears it will take nine months."

Another challenge has been the search for a permanent site. Currently housed in the chiropractor's prior office, Tri Rivers is looking for retail space that will provide excellent street visibility, as well as room for the institute to host community programs, like yoga classes and infant massage. "Without a permanent site, we held back on some marketing," she says.

Physician reaction to the institute has been surprising, she says. "We expected to hear from some referring physicians who would be skeptical, and we did. We've heard from many more who are supportive and think it's an idea whose time has come. But what surprised me most has been our own doctors. There have been moments when they realize how far they've strayed from their comfort zone. They recognize, though, that this is a natural reaction to something different and new."

Another issue to deal with was reimbursement, which for many alternative services is nonexistent. Hamilton sees this as both positive and negative. "Consumers spend billions of dollars on alternative care," she says. "The fact that services are out-of-pocket provides some insulation against declining reimbursement. Still, I think that more people would pursue alternative therapy if it were covered by insurers."

Despite these obstacles, Hamilton says the practice doesn't second-guess its decision.

"This is the direction medicine is going," she says. "We look at the institute as a way to provide safe, reasonable alternative care and to meet market demand without losing sight of our quality-of-care objectives." ■

SOURCE

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Guest Column

Practice growth strategies: Boosting the bottom line

By **Neil Baum**, MD, Consulting Editor

(Editor's note: In an era when seeing more patients seems to be the only way for a practice to bring money in the door, finding an alternative may seem like a pipe dream. But Practice Marketing and Management*'s Consulting Editor Neil Baum, MD, a urologist in New Orleans, says it can be a reality. Below is an excerpt from his book,* Take Charge of Your Medical Practice — Practical Practice Management for the Managed Care Market *[Aspen Publishers], that explains how.)*

Growth is a major goal of any business; however, as a business grows, a point of diminishing marginal returns is eventually reached, and adding more business increases revenue, but not profit. Unfortunately, additional volume can have a negative impact on customer service and, if allowed to increase unchecked, can actually lead to declining profit. This problem is accelerated when an industry becomes more price-competitive and volume continues to increase as a result of price discounting.

Most physicians focus on increasing patient volume. While this is an important strategy, many continue to add patients beyond the point where they are being "overbooked and overworked." These doctors feel they need to continue growth to maintain profitability, but the typical outcome of adding patients to a busy practice (beyond the point of replacing normal patient attrition) is to reduce profitability by increasing overhead costs and lowering the collection ratio. This problem is magnified when patient volume is increased as a result of discounting. Also, volume growth lowers quality by reducing the time available for each patient. An alternative to increasing patient volume is finding sources of non-patient-care income.

In a discount market, this is an important strategy for doctors regardless of the patient volume. The following are strategies available to any physician who wishes to add income without increasing patient volume. Using just a few of these will reduce the need for signing contracts with deep discounted fees for your services or for seeing excessively large numbers of patients!

1. Reduce overhead through efficiency improvement.

There is no perfectly efficient practice. Efficiency improvement is a life-long, continuous process. Efficiency improvement is a critical strategy for every practice because it results in improved quality of patient care as well as higher profit. Cost-cutting opportunities are more available with an increasing size of your practice, making overhead reduction the ideal strategy for larger groups. Even well managed practices carry at least 10% excess overhead. Some extremely busy, inefficient practices may carry overheads that are as much as 40% too high and have two times the number of staff required. Remember, every dollar cut from overhead goes straight to the bottom line. For most busy practices, the opportunity for increasing profit is greater through cost cutting than through increasing patient volume, and effective cost cutting also increases the quality of care.

2. Improve your collection ratio.

Most practices demonstrate a declining collection ratio as volume increases. (The collection ratio is the net collections divided by the net billings). Your target should be in the mid to upper 90%. One reason for a declining collection ratio is that each new managed care patient can generate 40 to 50 new business transactions. Additional transactions include insurance verification, obtaining authorization for surgery or requests for outpatient procedures, discussing the concept of copayments with a new managed care patient, ensuring that the ICD-9 codes match the E and M codes, etc. These added transactions increases the probability that bits of data will fall through the cracks and end up in non-collection or under-payment.

Because there is less time available for follow-up of overdue accounts, adding managed care patients reduces the collection ratio for the entire practice. Practices experiencing this magnified increase in data and billing complexities tend to hire more people. This is a costly solution. Adding personnel to an already inefficient reimbursement process cannot help the problems associated with either capturing data at the point of service or moving that data through the process. This requires a change in process. Most practices may be unaware that their collection ratio is declining, or they may believe that the

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decline is a result of contractual allowances and other phenomena of managed care. How large is this problem? Improving the collection ratio presents a tremendous opportunity for most practices. Remember, a low collection ratio represents delinquent dollars for which the work has already been performed and the overhead paid.

3. Improve your productivity.

Similar to efficiency improvement, this strategy focuses on using time effectively. In this age of transition from a fee-for-service method of reimbursement to a managed care environment, efficiency will be vital to the success of your practice. In the past we enjoyed the luxury of low volumes of patients and large profit margins. Today, it will be exactly the reverse, i.e., large volumes of patients and razor-thin profit margins. This will be especially important if you have capitated patients where you will be receiving a per-member per-month fee for your services and you may experience huge volumes of patients. The time made available through efficiency gains can be used to increase productivity. Efforts that improve efficiency, such as eliminating wasted tasks and reducing interruptions, give the doctor and staff more time for each patient. This not only makes better care possible, but also increases productivity for both fee-for-service and capitated patients.

Increased productivity is critical for any business competing in an industry where prices cannot be raised. Your productivity can also be improved by increasing the number of treatment rooms, the type and location of equipment, or staffing ratios. For example, a treatment room can be created by converting old charts to electronic data, freeing up the space previously used for filing the thousands of inactive charts that often line the shelves and consume valuable floor space. If you belong to a large group practice, you need to ask yourself whether all of your partners need a private office. By consolidating two or three physicians into a single office, you can easily find an additional treatment room. Time spent analyzing these areas may be more beneficial than treating additional discounted patients.

4. Merge with a nearby practice.

Practice mergers are not easy, but the potential cost savings are sufficiently high to be well worth the effort. While mergers provide an advantage under managed care, they make sense in any environment. A well-planned, efficient merger of two equal-size practices can add at least 30% to the bottom line for both practices. An efficient merger will reduce rent and staff size. Remember, if the office is efficient, charges are being posted at the point of service into the computer and follow-up services are scheduled at the point of service, requiring no new personnel. If the doctor uses electronic medical records, you no longer need a file clerk to file and move charts.

A merger has the potential to reduce the combined staff size by at least 40%. The use of electronic scheduling may increase the capacity to see more patients by 30%. How many strategies exist that can improve profit to this extent without the need for treating more patients? Mergers require careful planning of the new business' infrastructure. Otherwise potential savings can evaporate as group decision making begins to add unnecessary costs.

5. Stay focused.

Focused strategies lead to better outcomes and lower costs. It is no accident that the best outcomes and lowest price for open-heart surgery are achieved where the highest volume of these is performed. Dr. Denton Cooley, the famous heart surgeon in Houston, has reduced the cost of coronary artery bypass surgery from a national average of $43,370 to $27,040 and still has one of the best outcomes, even among high-risk patients. The higher the volume of similar procedures, the more skilled the doctors become at performing them, and unit costs decline as more procedures are spread over existing fixed costs. Treating every condition provides neither the highest quality nor the highest profit. In some offices, applying a cast may set the entire schedule back, while in others it is a routine, fast process. Some doctors enjoy treating certain conditions more than others, and narrowing the focus of a practice may revitalize a burned out practitioner. Focusing means increasing the number of profitable services while decreasing the less profitable services that consume more time and generate less money. This could mean either rebalancing your patient mix or adding a physician assistant who focuses on the services you prefer not to treat.

6. Renegotiate contracts.

Even in an environment where doctors have little control over price, contract terms can be improved. If you have been collecting patient

satisfaction data, you can present that information, if it's favorable, at the time of contract negotiation. If the MCO and patients are happy, they don't want to lose you. Even a small change in a contract can make a significant impact on your profit. Producing data that show better outcomes may even justify an increased fee for selected procedures — especially ones producing a "cure" in fewer visits or ones that eliminate the need for an ancillary service expense.

If a contract fee can't be increased, there may be other changes that would make the contract more doctor-friendly. Examples of doctor friendly changes might include an increase in the co-pay, or reducing paperwork requirements. Remember, when renegotiating contracts, you have more leverage than you might think.

7. Provide supplies and products.

Some doctors still feel that "selling" retail products in their practices is unprofessional. It is often a valuable service and leads to better patient care. For example, if a mother can obtain antibiotics at a pediatrician's office rather than driving with a crying baby to a pharmacy, searching for parking, and waiting for the prescription to be filled, she will probably appreciate the convenience and will pay a small premium for the time saved. Remember, this is not only a growing and acceptable practice in professional offices, it provides both better care and better service for patients — they even expect it! Patients and their families will pay for convenience. One-stop shopping also applies to health care.

8. Collaborate with peers.

Collaboration with peers is still in its infancy, but it represents one of the best potential sources of future non-patient-care income — especially if it includes collaboration regarding ways of improving patient care that can also reduce total cost for payers. Managed care is pushing doctors to collaborate for the purpose of managing contracts, but collaboration provides significant opportunities for reducing costs and increasing revenue. Additionally, activities such as group purchasing allow doctors to receive better prices from vendors for equipment, supplies, and services. Some doctors are expanding into ancillary areas such as ambulatory surgery centers. The cost of performing surgery in a single-specialty surgery center is substantially lower than performing that same procedure in a multispecialty ambulatory surgical facility. In addition, quality increases and costs decrease with higher volumes of patients. Lowering costs is a triple win, i.e., a win for doctors, patients, and payers. Previously, doctors working in academic health care centers and hospitals have had both administrative and clinical duties. Doctors in private practice who enjoy management duties will have similar administrative opportunities as collaboration leads toward larger physician groups and networks.

It will still be important to maintain a focus on growth and to continue securing sources of new patients; however, "growth opportunities" should not be limited solely to increasing patient volumes. Multiple opportunities exist for improving practices without increasing patient volumes beyond the point that leads to poor patient care. These strategies, coupled with better financial planning, may be all doctors need to make it through this difficult transition period.

Today's health care environment leaves little that we can do about changing the reimbursements that we receive from insurance companies. However, we can do a lot to improve the efficiency and productivity of our practices. These eight suggestions are a place to start. We think if you try one or two, you will observe a positive impact on your bottom line. ■

Practice Management

Management salaries show little progress

Some exceptions: MSOs, PPMCs

If you think the strong economy and burgeoning salaries you've read about have passed by your medical practice, you're right. According to the latest figures from the annual Medical Group Management Association *Management Compensation Survey*, salaries for key management positions moved little from 1996 to 1997 — the latest year for which figures are available **(see Table 1, p. 25)**.

With few exceptions, base salary increases among management in practices grew minimally, ranging from a half of a percent for practice administrators to 6.3% for an assistant administrator. The only exception among a selection of positions charted by *Practice Marketing and Management*

is the administrator working for a physician practice management company. Administrators for management service organizations (MSOs) also fared better than most, earning 4.7% more in direct compensation in 1997 than they did in 1996. "MSOs and PPMCs appear willing to pay top salaries for proven talent," says the report.

But while increases for management were low, there were some startling decreases in the amount of bonuses, incentives and retirement benefits combined paid to management at group practices **(see Table 2 at right)**. The biggest drop came for directors of marketing, whose 3.2% pay raise was offset by a 23.5% decrease in benefits.

Another big loser in benefits was the small practice administrator, who ended up with a worse average package in 1997 after seeing a 17% drop in bonuses and retirement benefits.

Only physician CEOs, assistant administrators, and MSO administrators saw increases — of 2.5%, 5.0%, and 10.1% respectively.

Bonus and incentive benefits amounts alone appeared to be responsible for the drop in total benefits packages **(see Table 3 at right)**. Marketing directors saw incentives fall by more than half, while a small practice administrator (fewer than seven physicians) saw bonus and incentive payments fall by a fifth. Only physician CEOs and assistant administrators had any gain in this area.

The *Cost Survey: 1998 Report Based on 1997 Data* is $200 for MGMA members, $250 for MGMA affiliates and $300 for others, plus shipping and handling. For more information, call the MGMA Service Center at (888) 608-5602. ■

Table 1
Median Direct Compensation

	1996	1997	Percent Change
Physician CEO	$241,820	$253,940	5.0
CEO	$123,000	125,000	1.6
Practice Administrator	$77,000	$77.373	0.5
Small Practice Administrator	$55,918	$57,000	1.9
MSO Administrator/Director	$77,500	$81,136	4.7
PPMC Administrator	$61,839	$75,000	21.3
COO/Associate Administrator	$78,876	$81,000	2.7
Assistant Administrator	$48,000	$51,000	6.3
Director of Marketing	$42,500	$43,864	3.2

Source: MGMA Management Compensation Survey, Englewood, CO.

Table 2
Median Bonuses, Incentives, and Retirement Benefits

	1996	1997	Percent Change
Physician CEO	$49,353	$50,566	2.5
CEO	$29,854	$25,565	-14.4
Practice Administrator	$14,304	$13,858	-3.1
Small Practice Administrator	$10,838	$9,000	-17.0
MSO Administrator/Director	$9,800	$10,792	10.1
PPMC Administrator	*	$9,500	N/A
COO/Associate Administrator	$13,306	$12,100	-9.1
Assistant Administrator	$6,467	$6,7878	5.0
Director of Marketing	$5,050	$3,862	-23.5

* = Insufficient data for inclusion

Source: MGMA Management Compensation Survey, Englewood, CO.

Table 3
Median Bonus and Incentive Payments

	1996	1997	Percent Change
Physician CEO	$31,667	$35,630	12.5
CEO	$17,854	$15,000	-16.0
Practice Administrator	$6,825	$6,331	-7.2
Small Practice Administrator	$5,000	$4,000	-20.0
MSO Administrator/Director	$7,000	$7,000	-
PPMC Administrator	*	$5,000	N/A
COO/Associate Administrator	$7,000	$6,250	-10.7
Assistant Administrator	$2,400	$2,717	13.2
Director of Marketing	$2,250	$1,000	-55.6

* = Insufficient data for inclusion

Source: MGMA Management Compensation Survey, Englewood, CO.

OB/GYN practice exports its management talent

Ohio practice helps manage cap contracts

Practices tired of the so-called hassle factors in managed care — from making sure precertification requirements are met to following up on payments owed the practice — have sought out physician practice management companies as a way to spend less time on administrative functions and more time taking care of patients. One Ohio OB/GYN practice has developed this kind of expertise on its own and is now using this experience to help other OB/GYN practices interested in better managing their managed care contracts.

OB/GYN Management Ltd. in Dayton, OH, has parlayed its four years of managing risk contracts for OB/GYN practices that contract with United HealthCare Corp. in the Dayton area into providing similar services for OB/GYN practices in other markets.

"We're not a practice management firm, and our doctors still practice medicine," says **David Astles**, executive vice president for the company. What the group does provide is utilization management, outcomes reporting, and other services necessary to manage capitated contracts for groups of OB/GYN physician practices that contract with the same payer.

Aligning incentives

OB/GYN Management was formed when the two-physician Huey & Weprin OB/GYN practice responded to a request for proposals that United circulated to manage all OB/GYN contracts under United's specialty network manager program. The practice now manages the capitation dollars for a 113-physician OB/GYN network in the 15-county Dayton region. "Our vision of the world is that OB/GYNs need to organize and deal with integrated health care systems and deliver quality, efficient care. If incentives are aligned correctly, you don't need to do the kinds of preauthorization and care denials that traditionally are associated with managed care," says **Stuart Weprin**, MD, CEO of OB/GYN Management. "We're offering stability to physicians; not only financial stability, but a way for physicians to regain control of their lives and speak with one voice."

The firm's experience with United was so positive that Weprin began speaking to groups in other markets. The exposure led to him being approached by payers and physicians in several markets outside Dayton. Within the past year, OB/GYN Management has signed deals with groups in Florida representing a 275-physician network contracting with BlueCross BlueShield Health Options and about 100 physicians in Kansas City, MO, who contract with Prudential HealthCare.

Using PMPM rates

The deals the company has with physicians and payers vary by market, but essentially allow OB/GYNs to receive a per-member, per-month (PMPM) capitation rate for physician services from the payer (facility fees for hospital care are not included). Unlike traditional subspecialty management network setups, OB/GYN pays the physicians in each network based on the number of patients seen. Weprin says incentives are built into the system for physicians who are efficient utilizers.

Weprin admits that outcomes data tracking is hard to set up, but he gives the group advantages by allowing it to demonstrate cost-effective care with good outcomes. The firm has its own proprietary software system that has been developed over the last four years and is still being modified. Day-to-day utilization management is left in the hands of physicians for D&C cases, laparoscopy cases, and hysterectomies performed by the 80% of physicians in the Dayton market who have demonstrated good utilization capability. For other cases that require an immediate decision, Weprin as medical director is consulted. In addition, cases are discussed at monthly governing board meetings that consist of eight physician representatives in each market.

The outcome is a win-win situation for both the physicians and the managed care organizations.

The bottom-line outcome, Weprin says, is a win-win situation for the physicians and the managed care organizations with whom they contract. "It gives the physicians a way to get their care in order, reduces the excesses in care, and allows the HMOs to be competitive," he says. ■

Pennsylvania sets stage for more HMO liability

Court ruling could change practices

A recent Pennsylvania appeals court ruling could lead to more malpractice lawsuits against HMOs when physicians in their networks are negligent.

An Oct. 5, 1998, decision in *Shannon v. McNulty, MD, and HealthAmerica Pennsylvania* determined the Pittsburgh-based HMO HealthAmerica of Pennsylvania could be sued for medical malpractice because it had corporate liability in the death of a premature infant.

"That has substantial implications for managed care companies," says **Charles Artz**, a health care law attorney and principal of Artz and Associates in Harrisburg, PA. Artz primarily represents physicians.

The decision means HMOs have a responsibility to recruit and ensure the quality of physicians who contract with them because they may be held responsible if the physicians are negligent, Artz says, adding that this is a huge change from current malpractice decisions.

Pennsylvania courts in 1991 had opened the doors for hospitals to be held responsible under corporate liability in the case of *Thompson v. Nason Hospital*. In this case, the court said the injured party does not have to establish the negligence of a third party because the hospital owes nondelegable duty directly to the patient.

The appeals court referred to the HealthAmerica decision, using the same four general areas of corporate liability.

Vicarious liability

The Oct. 5 decision also held HealthAmerica responsible under vicarious liability because a family member of the premature infant had called the HMO's nurse employees on a telephone triage line for medical guidance, and they gave her bad advice. This part of the decision could affect all managed care organizations that have nurses on call or medical triage lines.

Thus, the HMO was hit twice by the decision, Artz says.

"Employers can be held liable for vicarious liability where they are responsible for their employees," he explains. "But corporate liability means they're liable for what their independent contractors do."

The HealthAmerica decision could cause some profound changes in how HMOs deal with physicians, and some of these changes might be positive.

"I believe this ruling is going to make HMOs work with physicians on quality parameters, and utilization is a part of quality," says **Marc J. Schneiderman**, MD, past president of the Pennsylvania Academy of Family Physicians in Harrisburg, and the president of the Allegheny Chapter of the Pennsylvania Academy of Family Physicians.

"No HMO wants patient care sacrificed," he says. "But on a personal level, the HMOs are constantly bringing numbers to physicians that we over-refer, over-utilize tests."

When they show a physician these utilization numbers, the implication is that the physician should try to change his or her utilization patterns because the patterns are outside the norm in comparison to other physicians, Schneiderman says.

"When you ask them to show you the charts and show you where you can cut costs, they never do," he adds. ■

News briefs

MGMA publications cover PSOs to Y2K

Among the latest books published by the Englewood, CO-based Medical Group Management Association are offerings that can help your practice launch a successful provider-sponsored organization, understand health care consolidation, find information on managed care organizations, and make it through the year 2000 intact.

Medicare Managed Care: Developing Successful Provider-Sponsored Organizations aims to explain how you can assume risk directly from the Medicare program instead of contracting through an HMO. Written by Keith Korenchuck, JD, MPH, it covers legislative issues, how to create a PSO, and sample provider participation agreements. It costs $85 for members, $95 for affiliates, and $115 for others.

If you need to understand consolidation and collaboration in the health care market, then Korenchuck's *Consolidating and Restructuring Health Care: A Resource Guide* might help. Group practice legal structure, mergers and acquisitions, contracting networks, MSOs, PSOs, PPMCs, financial planning, forecasts, and projections are covered. The book is $65 for members, $75 for affiliates, and $95 for others.

Managed Care Resource Guide 1998/1999 can help your practice to find articles, Web addresses, and information on legislation about managed care. It costs $20 for members, $23 for affiliates, and $25 for others. J. William Appling, FACMPE, has written a companion book, the *Managed Care Contract Reference Guide* that provides an overview of common terms and provisions in managed care contracts. It also includes suggested contract language. The cost for it is $17.50 for members, $19.50 for affiliates, and $30.50 for others.

Lastly, those in need of basic advice on how to prepare for the Millennium Bug should consider the *Millennium Strategies Workbook* by Steven Epner, a consultant with BSW Consulting. It includes sections on project plans, responsibilities and target dates, operational triage, system analysis, customer analysis, vendor analysis, and responding to Y2K readiness queries. The cost is $59.95 for members, $69.95 for affiliates, and $79.95 for others.

For all of the books, shipping and handling is extra. Information on these and other MGMA publications is available by calling (888) 608-5602. ▼

Ed board member named to foundation

Keith Borglum, a member of the editorial advisory board of *Practice Marketing and Management*, has been named a trustee of the California Academy of Family Physicians Foundation. Vice president of the Santa Rosa, CA-based consulting firm Professional Management & Marketing, Borglum joins members from corporations such as GTE and Health Net, and educational institutions such as UC San Francisco.

Borglum is also a member of the medical practice consultant panels of the American Medical Association and the American Academy of Family Physicians. ■

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