

PHYSICIAN PRACTICE OPTIONS™

November 15, 1999

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

CONTENTS

Features

Case Study
Ohio IPA Aims for
Provider Integration 3

Organizational Options
Data That Drive
Physician Decisions 6

Interview
Refusing To Use the
Internet Will Not Be an
Option for Physicians,
Expert Says 12

Departments

Editorial
Capitation Backfires on
California Doctors 2

Capital Ideas
Physicians Find Profits
in Clinical Trials 10

Newsline 15

Acquiring a Loan May Be Getting More Difficult

Over the life of a group or solo practice, physicians often find themselves in need of working capital, whether for something as straightforward as purchasing equipment or for more speculative ventures, such as developing a PHO or IPA. Given the demands that managed care places on a group practice, physicians may have a more significant need for access to capital today than at any time in the past.

Despite the growing need for capital, physicians face some special challenges when seeking to obtain a loan for their practice, says Tom Kumura, corporate vice president at Superior Consultant Co. Inc., a health care information management and technology company in Southfield, Mich.

Shock Waves

"At one point, physician practices would have been considered good credit risks when compared with other businesses," Kumura explains. "It was not uncommon for physicians to be able to get a signature loan—a loan with little credit information or collateral needed—based on the fact that they had 'MD' after their names. Under managed care, reimbursement levels can be uncertain—they are certainly lower than under a fee-for-service system. Even though bankers still view physicians as highly educated, highly skilled, and highly motivated, there is now much more consideration given to whether a physician practice loan will be funded or not."

Jill Frew, managing director of Townsend Frew & Co., an investment banking firm in Durham, N.C., that specializes in assisting physician groups on capital acquisition, says another environmental factor affects lenders' assessments

of physician practices. "Right now, commercial banks are expressing some hesitancy about the risk associated with lending to physician practices," she says. "Many banks that have lent funds to physician practice management companies (PPMCs) for the acquisition of physician practices have experienced defaults on loans, because as a whole, PPMC's have performed poorly over the past two years. This has sent some shock waves through the commercial lending community, which now may view lending to physician practices as a poor investment."

Frew acknowledges, however, that most lenders make a distinction between the financial difficulties of PPMC's and physician groups that need capital to fulfill a specific need. "Obviously, considering the loan application of a group that wants to purchase a piece of diagnostic equipment is a different lending decision than lending to a publicly traded PPMC that has a rapid acquisition strategy and a significant need for capital for practice acquisitions," she says. "But individual physician practices are subject to some of the same factors and dynamics that the big companies are."

Such factors include the increase in managed care, declining reimbursement, growing competition, and growing administrative needs. "All of these dynamics are making the business environment for small practices very difficult," says Frew. "These forces constitute risk factors that lenders will take into account when assessing a loan application."

Furthermore, Frew notes, physician practices don't have a reputation for

(Continued on page 8)

Capitation Backfires on California Doctors

In 1994, the Advisory Board Co., a research organization in Washington, D.C., said the compelling economic advantage of capitation would cause it to migrate “outside large California group practices to the more traditional provider settings in the East.” In a report, *Capitation I: The New American Medicine*, the company projected that 50% of Americans would be enrolled in capitated health plans by 2005 and that capitation would flourish in California, where about half of all physicians belonged to groups of 100 or more.

But this year capitation backfired on many California physicians. The California Medical Association (CMA) says a number of physician groups will become insolvent this year, and many California medical groups are already near bankruptcy. If the CMA's calculations are correct, health care for 10.5 million Californians may be in jeopardy.

In fact, mounting evidence collected by CMA and PricewaterhouseCoopers points to an imminent collapse of a key element of the state's health care delivery system—the medical group. The system is so dramatically underfunded that at least 34 medical groups or IPAs (roughly 10% of the total) will fail before the end of this year, and as many as 90% of California's physician organizations are poised for bankruptcy, the CMA says. PricewaterhouseCoopers is a CPA and health care consulting firm in New York.

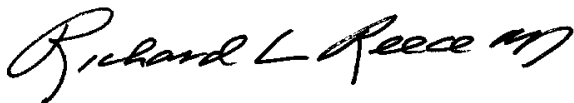
In the past three years, 113 medical groups—out of more than 300—have gone bankrupt or closed down, the CMA says. Two of the groups, FPA Medical Management and MedPartners Provider Network, provided care to more than 1.5 million people.

The CMA attributes physician financial problems to HMO marketing wars and a declining physician share of the HMO premium. In California, physicians are paid 13 cents out of every managed care premium dollar while in other states, physicians are paid 20 cents on the dollar, the CMA says.

There may be another factor as well: Large medical groups need significant investments to assume risk. An aggressive 100-member physician group may require \$24 million over six years to add offices, bring in specialists, hire a management team, invest in information systems, and establish protocols and practice guidelines, says *Capitalizing Medical Groups*, a book published this year by McGraw-Hill in New York.

To help remedy the situation, the CMA is suing Blue Cross and eight other HMOs for back payments. It is also seeking state legislation to make premiums actuarially sound, it is negotiating with HMOs to prevent the passing of the risk of rising pharmacy costs to physician groups, and it is asking the federal government for antitrust relief so physicians can bargain collectively with HMOs.

Physicians seeking to dodge the trouble that has befallen many groups in California should avoid total capitation, invest modestly in risk-assuming systems, outsource support services to protect cash flow, and monitor pharmacy costs. Physicians also should carefully choose their contracts by first reviewing data on their practices and then comparing that data with information that HMOs collect on physician practices. (For more on this topic, see “Data That Drive Physician Decisions,” page 6.)



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Ohio IPA Aims for Provider Integration

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

Many physicians in private practice today are overwhelmed by the number of strategic opportunities available. Should they sell their practices to a hospital, health system, or physician practice management company? Should they merge with other practices to form a large group? Should they form looser alliances solely for managed care contracting? At the same time, physicians face confounding financial pressures, such as falling reimbursement and rising overhead, that tax their ability to maintain and grow their income.

Physicians in The Medical Group of Ohio, in Worthington, have found some direction. Due to the efforts of many physicians who have been involved over time, and the coordinating leadership provided by its 21-member board, the group offers its members satisfying and successful strategic relationships with hospital providers and payers, and value-added practice management services.

A Large IPA

"We refer to The Medical Group of Ohio as an IPA, but in our case we think of ourselves as an integrated provider organization as opposed to an independent practice association," says Benjamin Humphrey, MD, CEO of the group, and a practicing family physician. "Indeed, our physicians are in independent practices, but we are working very hard at becoming an integrated delivery system of providers. We include psychologists, podiatrists, oral surgeons, and other specialties traditionally included in physician organizations."

The Medical Group of Ohio includes approximately 1,800 physicians located across 36 Ohio counties, and it is growing. "The Medical Group of Ohio was formed at the end of 1994 with 20 physicians,"

Humphrey explains. "In the spring of 1995 we held our first stock offering; by the end of the spring, more than 600 physicians participated in the organization and most of them were stockholders. We have continued to grow gradually since that time."

The IPA serves patients in more than half of the state, providing care in 46 of Ohio's 88 counties. Given such a large market, the IPA is careful to monitor its physician consolidation so that it does not invite antitrust scrutiny, Humphrey says. "Department of Justice guidelines indicate that medical groups should not exceed 40% market share in their service area," he says. "We keep a very close eye on those guidelines. We examine our market share on an ongoing basis, and analyze our overall number of physicians and the number of physicians by specialty. At the present time we fall well under the share guideline in our market area."

Despite the size of the organization, Humphrey is optimistic about continued growth. "We are an organization that is growing not just in size, but in maturity as well," he says. "We are working increasingly effectively to assist our physicians in meeting their needs in their daily practices and in the care of patients."

Value-Added Services

To help its physicians meet patients' needs, The Medical Group of Ohio maintains or has facilitated access to a series of value-added products for its participating physicians. "Physicians need financial, business, and information support," Humphrey explains. "That's why we've chosen to be an IPA. Many of our physicians had the option to sell their practices to a hospital or to a physician practice management company. These options are not attractive to many physicians who

want to own their practices. Instead, physicians at The Medical Group of Ohio receive support services from a friendly source. We've focused on bringing value-added services to our physicians that may help them lower the overhead in their offices. Through our size, we have the opportunity to contract with companies that can bring value-added services. Our IPA allows physicians to pursue such business relationships that are good for the physicians and their businesses."

For example, the IPA maintains a relationship with Salomon Smith Barney, a financial services firm in New York, giving the physicians access to financial and business planning assistance.

"Our Salomon Smith Barney relationship is one we're very proud of," Humphrey says. "This relationship targets the real professional and personal needs of practicing physicians, and brings significant value to the IPA's physicians."

For the shareholders in the medical group, Salomon Smith Barney offers comprehensive financial-related services that provide each practitioner and his or her respective private practices with sophisticated management tools and financial advice. "Basically, we have brought together specific business management and financial-related services to help the group's physicians in the ongoing management of their businesses and personal finances," says Jerry Colletti, a financial consultant at Salomon Smith Barney who manages the relationship with the IPA.

The services offered are diverse in nature, including credit and lending, cash management, retirement plan options, investment programs, and estate planning. Last year, Salomon Smith Barney presented an educational conference to the group

(Continued on page 4)

The Medical Group of Ohio has 1,800 physicians, including psychologists, podiatrists, oral surgeons, and other specialists, and is affiliated with a hospital network that owns an HMO.

(Continued from page 3)

on physician practice management organizations and the potential benefits and pitfalls of such relationships. "The conference was very timely, since we knew at that time the PPMC alternative was seriously being considered by many practicing physicians," says Colletti.

"All we're doing is bringing to each practitioner the same types of services we offer to small businesses throughout the United States," Colletti explains. "A large percentage of the IPA's physician shareholders own businesses—their private practices. Since the advent of managed care and the subsequent decline in physician practice revenues, physicians must be more diligent in the management of both their business and personal financial matters. Physicians are working in an industry that is undergoing rapid and extraordinary change. They must adapt quickly and correctly to ensure they will be in business five years from now."

To date, Colletti has received positive feedback from the group's physicians. "In particular, they appreciate the fact that the services as well as the service provider, Salomon Smith Barney, are endorsed by the IPA, which has performed the necessary degree of due diligence on their behalf," he says.

The Medical Group of Ohio maintains other relationships with consultants and product vendors important to the IPA's physicians. Physicians appreciate the vendor analysis performed by The Medical Group of Ohio, and often, they receive discounts on products and services as a result of these relationships. "In addition to our relationship with a brokerage firm, we work with two professional liability companies," says Humphrey. "We also have a relationship with a company that handles compliance services so that the physician practice looking to meet federal safety and other regulatory requirements has a resource to assist in that process. We have contracts with a computer vendor, a practice management software vendor,

and an electronic data interchange provider so that our physicians receive discounted products and services."

To facilitate medical information sharing among IPA participants, The Medical Group of Ohio formed a subsidiary company called Ohio Medical Information Services (OMIS). "We believed that forming an information company was an important strategy for a variety of reasons," says Humphrey. "First, the large size of our physician network presents a challenge in communication. OMIS facilitates our communication by providing numerous tools, such as e-mail, a physician-to-physician referral application, and an online eligibility verification and claims submission application. This enables us to act in an integrated fashion.

"Second, OMIS connects physicians to their local hospitals so they can easily retrieve data on their inpatients," Humphrey continues. "This enhances the quality of care, as it enables care to be delivered in a more timely and cost-effective fashion. Third, OMIS reduces overhead by enabling physicians to use electronic claims submission, and includes patient insurance eligibility data online.

"Finally, perhaps the most important benefit in the long run is that OMIS compiles data on physician performance drawn from claims data," Humphrey explains. "This gives physicians more information about their practices than they can get from any other source, along with a comparison to their peers."

A Joint Venture

Beyond offering value-added practice management services, the IPA has pursued strategic relationships that help ensure the success of its physician practices. To build patient volume and enhance managed care negotiating strength, the physicians in The Medical Group of Ohio agreed to partner with Ohio Health, a system of 11 hospitals based in Columbus. Called Ohio Health Group, the joint venture owns an HMO and contracts with other managed care

organizations, and currently includes some 300,000 enrollees.

Since Ohio Health Group owns an HMO license, The Medical Group of Ohio, in essence, is a 50% owner of that license as a result of its partnership with the hospital network, Humphrey says. "We have about 26,000 enrollees in that HMO," he explains. "We also have a PPO license with about 170,000 lives and a new point-of-service product that covers about 2,000 lives so far. All of these contracts constitute direct relationships with employers. So now we offer a suite of health care products for employers who want to use us as their delivery system. We also bring that same delivery system—which offers claims processing, health promotion, wellness services, and case management—to serve payers. We cover over 130,000 lives for external HMOs, PPOs, and point-of-service products."

Physician Participation

The physicians are pleased to be working with Ohio Health, Humphrey says, because the hospital system focuses on quality care. "It is more enlightened than many hospital systems in recognizing that the key to their future—and the future of the physicians working with them—is to improve care and deliver high quality care at a fair price," Humphrey explains. "Because The Medical Group of Ohio and Ohio Health share the same goal, we will be successful together. Relationships where one party tries to drive the behavior of the other party are the ones that tend to fail."

In addition to these services, The Medical Group of Ohio also benefits physicians by allowing them to direct the progress of the organization. Humphrey maintains that physicians should participate in all of the IPA's business decisions. "I always include the physicians at the negotiating table at the outset of all of our business ventures," he says. "Getting them to participate early is an important approach. Everything we do reflects the fact that our business is 100% physician owned.

"Physicians must adapt quickly and correctly to ensure they will be in business five years from now."

—Jerry Colletti, Salomon Smith Barney

Although we employ talented individuals—MBAs and others who are part of our management structure—physicians operate the IPA. The board is composed solely of physicians, and at every level in the process it is our physicians who drive the mission and direct the organization. We made it clear early on that the physicians do not work for the organization; the organization is working for its physicians.” Each board member also serves on one or more of the committees of Ohio Health Group.

Each June, The Medical Group of Ohio shareholders hold their annual meeting. The IPA includes a board of 21 physicians who are particularly active on committees that comprise several physicians each to address issues such as negotiating contract fees, quality oversight, and ethics. “We also have advisory committees by specialty to ensure that we’re meeting the needs of physicians who participate in carve-out contracts,” Humphrey says.

Humphrey believes the IPA’s structure and its focus on physician participation are important in managed care markets. “One of the challenges in a managed care

“Physicians have a say in how we proceed. This is preferable to forcing a group of physicians to do what a small cadre at the top has decided.”

—Benjamin Humphrey, MD, The Medical Group of Ohio

environment is dealing with the many forces that are trying to influence physician behavior,” he says. “Generally, these forces, such as physician practice management companies, have had limited success. What we are doing is enabling physicians to drive their own success. Physicians have a say in how we proceed and they help to implement those decisions. This is preferable to forcing a group of physicians to do what a small cadre at the top has decided.”

Strong Leadership

Despite his executive status, Humphrey still operates a medical practice, a factor that helps him maintain credibility among fellow physicians. “After 15 years of full-time practice, my colleagues in my six-

physician family practice group have allowed me the opportunity to explore other avenues,” he says.

Humphrey’s vision for The Medical Group of Ohio calls for a greater alignment of incentives among those in health care with the aim of providing better patient care.

“My vision is this: I believe through The Medical Group of Ohio, and through our partnerships with other organizations, we have the opportunity to develop a true alignment of incentives among all players in the industry,” Humphrey says. “That alignment ultimately will result in improving the health care provided to the people we serve.”

—Additional reporting and writing by Deborah J. Neveleff, in North Potomac, Md.

Data That Drive Physician Decisions

By Thomas M. Gorey, JD

The characteristics of the market in which a physician is practicing (or considering practicing) are a significant factor to consider when developing a practice organization strategy. For this reason, it is important to conduct a market analysis before finalizing a practice development decision. This is a service health care consultants provide frequently.

A market analysis will provide detailed current and projected demographic information on the population; on the number, location, specialty, and age of physicians providing medical services in the physician's primary and secondary service areas; on managed care organizations in

ware has made the task of collecting and compiling practice demographic and financial information much more manageable. Consultants can assist in this effort or physician office staff can be trained to handle this responsibility.

In developing a strategic plan—and particularly in developing a strategy for dealing with managed care—it is important for physicians to have detailed information on their current base of patients, the number and types of services they provide, and the cost of delivering those services.

The following are some specific examples of the types of information that should be collected.

capitated amount per patient, he or she will need to predict with reasonable certainty the number of patient visits likely to take place each year.

Total number of yearly visits and percentage distribution by age. If the physician knows the ages of his or her patients, the number of patient visits can generally be estimated. Physicians should carefully examine practice data about patient age and utilization of services, particularly if a physician is presented with one capitation amount for all patients. Based on an analysis of these data, the physician should be able to determine whether the amount being offered in aggregate for these patients is reasonable given the physician's population base. Many physicians prefer an aged-based capitation rate because predicted utilization is more likely to have already been calculated in the rate. It is still important, however, to verify the managed care organization's assumptions regarding patient visits against your actual experience.

Average number of new patients and number of patients who leave the practice each year. Having these numbers can help determine the need for participation in managed care plans. If the number of new patients has begun to decline, it is important to determine the reason. If increased managed care activity in the area has caused the decline, it is particularly important to consider options to increase access for patients receiving managed care.

Total number of referrals and referral sources. Physicians should keep a complete list of referral sources (such as patients, physicians, and other health care professionals) and the number of referrals from each source. This information is important for all physicians, but particularly for specialists who need to know who is referring patients to them. It is also important for specialists to communicate frequently with their key referral sources to determine which managed care plans they are affiliated with and how these affiliations affect previously established referral patterns. Physicians

Under a capitated contract, a physician will need to predict the number of patient visits each year.

the market; and on the major employers and the provisions of the health plans they offer.

As important as it is to have such data on the external environment, however, it is perhaps even more critical for physicians to have detailed internal data on their practice. With key information on the physician's patient demographics and practice characteristics, it is possible to make an informed assessment of the practice's strengths and weaknesses and an objective evaluation of practice alternatives.

Having detailed, reliable data of this type also can enable physicians to negotiate with payers from a position of strength, derived from a realistic understanding of the physician's competitive position in the market. Although collecting this type of data would have been a daunting undertaking 10 or 15 years ago, the proliferation of computers and the expanding array of medical practice soft-

Total number of active patients. The total number of active patients in a practice is important because it provides information on the base of patients who potentially need care. These data can be useful in projecting the services that these patients will need. After many years of practice, a physician often may have records on many patients who no longer use the physician's services. This fact is increasingly true in markets where frequent shifts in PPO contracting networks have prompted patients to change providers.

Average number of patient visits per week. Is the physician as busy as he or she wants to be? How many more patients could be seen without having to bring additional physicians into the practice? Physicians need to determine their willingness and ability to see more patients because some managed care plans specify the number of patients that the physician may, or must, see. Although deciding to participate in a managed care plan is not a guarantee of increased patient volume, the physician needs to be prepared for the results of a decision to participate. More important, if a physician is being paid a

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should be thoroughly familiar with their rate of utilization of specialty services.

Total number of in-office ancillary procedures per patient per year. It is important for physicians to determine how much revenue is generated each year by laboratory tests, such as throat cultures, blood tests, and urinalysis. Some managed care plans will pay a separate amount for these tests but have strict guidelines about when they can be performed. Other managed care plans contract with independent laboratories for a discounted fee to provide these services. In this case, affiliation with a managed care plan may result in a loss of income. Finally, some plans may include certain tests and procedures in the capitation amount, which will need to be considered carefully in evaluating the adequacy of the capitation payment.

Payer mix. Physicians need to know the exact breakdown of payers, revenue by payer, and the percentage of revenue by payer. This information will influence the physician's decision regarding managed care plans with which to affiliate. For example, if one of the practice's major payers changes from primarily offering a fee-for-service plan to offering several managed care plans requiring substantial discounts, the physician will need these data to make an informed decision about whether to continue participating in that plan.

Or, a physician may decide to limit the revenue from one particular payer to a specific amount or percentage of total revenue. This decision may be made because of low reimbursement, difficulty in obtaining prompt payment for clean claims, or other issues associated with this payer. Physicians may be concerned about relying too heavily on one or two managed care organizations for patients and reimbursement. If an employer has a contract with a major managed care plan that constitutes 20% of a practice's revenue, for example, and the employer changes to a different managed care organization in which the physician is not a provider, this change may result in a sudden loss of income to the practice, which can be financially devastating.

Physicians should monitor any shift in

Not having these data puts a physician at a severe disadvantage when negotiating with managed care plans, because these plans have all the data.

the practice's payer mix. In markets in which managed care does not have a significant presence, physicians may be able to adapt successfully through increased involvement in PPOs and other discounted fee-for-service arrangements.

Services provided. Physicians should develop a list, by current procedural terminology (CPT) code, of the major services they provide. The easiest way to obtain this information is by reviewing the practice's superbill and adding hospital care and procedures. This information is important because managed care plans sometimes list in the provider contract the services covered and not covered in a discounted fee-for-service plan. The services usually are listed by CPT code. Under capitation, an HMO payment arrangement may state that all covered services will be provided by the physician at the per-member-per-month (PMPM) fee except for excluded or carved-out services as defined by specific CPT codes.

Most common principal diagnoses. The physician needs to have a list of the most common diagnoses encountered in the practice. These diagnoses are listed by the International Classification of Diseases (ICD)—9th Revision—Clinical Modification (CM), commonly known as ICD-9-CM codes. This information may help the physician evaluate fee schedules and level of patient acuity in their practice.

Practice expenses and overhead. Physicians should have detailed information about practice expenses. The practice expense directly associated with the care of the patient is considered a direct expense and should be allocated to the specific diagnosis and procedure codes. Such expenses include clinical supplies, professional staff expenses, and administrative expenses attributable to scheduling and billing for the service. Indirect costs, such as rent, utilities, other office expenses, and capital equip-

ment, should be allocated over all services. When defining practice expenses, it is necessary to make sure that the physician's income and profit margin are considered. Having this information will assist in determining the costs of providing care per patient per visit. It is particularly important to have these data if a physician is contemplating entering into a capitation payment arrangement in which the PMPM payment must be adequate on average to cover the cost of providing care to patients.

Patient satisfaction. Finally, it is important to collect data regarding patient satisfaction. Information to be gathered should include patient feedback on factors such as:

- Waiting time in the office
- Length of visit
- Information provided by the physician
- Nursing service
- Scheduling of services
- Availability of appointments
- Appropriate referrals

If improvements are needed in any of these areas, physicians should take steps to make the necessary changes. Managed care organizations often collect similar data to determine if physicians meet the established criteria to be included in the managed care organization's provider network.

The concept of "knowledge is power" is particularly appropriate in a medical practice. Without a good database of information on one's practice, it is difficult for a physician to make informed practice-related decisions. More important, not having these data puts a physician at a severe disadvantage when negotiating with managed care plans, because these plans have all the data. Taking the time and committing the funds needed to compile a solid physician practice database can provide a sense of physician empowerment that will pay dividends for years to come. ■

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retaining earnings to invest for the future. "Like most professional firms, at the end of the year the practice will calculate its excess cash and pay these funds out to the owners in the form of compensation," she says. "Typically, there has not been a desire to retain cash in the business for future investment."

Now, physicians are facing significantly greater capital needs. They might seek opportunities to increase revenue due to declining reimbursement, or they might need to hire more staff members or computerize to handle the growing administrative burdens. As a result, they are forced either to reduce their take-home pay to set aside investment capital or to find an external source of capital.

In Search of Capital

Seeking a loan can be as simple as gathering the relevant information and then meeting with a local banker. "Many times, practices have an existing relationship with a bank, because they have business checking accounts there," says Frew. "The physicians can simply approach the lending officer, let him or her know what their needs are, and begin discussions."

If a group needs a significant amount of capital, physicians may be turned down by a commercial bank, however. "They may not be able to get a sizable loan if they cannot provide a significant amount of collateral to secure the loan," Frew says.

Sometimes, professional physician associations maintain relationships with commercial lending institutions, which provide association members with preferred interest rates. For example, the American Professional Practice Association (APPA), in Deerfield Beach, Fla., which provides member physicians and dentists with financial services, and its sister organization, the National Association of

Residents and Interns (NARI), sponsored a program in which they will negotiate rates with lenders for an unsecured loan or a line of credit.

Physicians might consider other potential avenues for capital as well. "Leasing companies will extend loans secured by the practice's accounts receivable or equipment," Kumura says. "Physicians can get several estimates of interest rates and then shop the deal among banks and leasing companies. Very large physician practices might even find insurance companies that are willing to extend a loan."

A traditional source of capital might be a local hospital. "If the physicians have a good relationship with the local hospital, the hospital might be willing to provide capital or participate in a joint venture where it would fund the project," Frew says. "Borrowing from a hospital is a little more complex than approaching a commercial lending institution, which has automated systems for processing loans." Furthermore, physicians do not always find this option palatable.

"Usually, there are some strings attached to a hospital loan," Frew adds. "The hospital might want to share ownership, or want some type of preferred relationship with the physicians in return for the capital. Also, physicians may be concerned that they will alienate other hospitals with which they maintain alliances."

The amount of the loan obviously depends on the need. "If the practice is growing rapidly and capital is required to fund that growth, the physicians will probably want to have a line of credit that they can draw upon as needs arise," Frew says. "Applying for a line of credit helps physicians build in a cushion for their capital needs." However, if physicians are borrowing funds because they want to buy a large piece of equipment or some land

for a new facility, the amount of the loan will tie directly to the price to be paid for that asset. "In this case, there's no need or incentive to borrow more than that amount," she explains.

Risky Business

In addition to the loan amount, the intended use of borrowed funds will affect the lender's analysis of whether to extend a practice loan, and if so, on what terms.

"Obviously, lenders will be more willing to extend capital for uses that are considered less risky from their standpoint," Frew says. "For example, a commercial lender will be more willing to lend to a physician who is borrowing funds to buy a piece of equipment, land, or other fixed asset. In these cases, the asset serves as collateral to the loan." If a group wants to borrow funds to use as working capital, often the lender will tie the amount of the loan to the amount of receivables the practice holds, so that an asset secures the loan.

Kumura adds that the purchase of fixed assets is not in itself enough to guarantee that a loan will be extended. "For instance, a banker with knowledge of the local health care market will not approve a loan for physicians who want to use the money to establish a satellite clinic in an area that is overpopulated with physicians, because the competition might reduce the venture's chance for success," says Kumura. "Physicians will need to show demographic information that was considered in the decision to proceed with the venture."

On the other hand, obtaining an unsecured loan, or a loan that is not secured by an asset, will depend on the group's ability to generate cash flow in the future. "An unsecured loan is inherently more risky, and is a tougher loan to get," Frew says. "If

(Continued on page 9)

In the past, physician groups were considered better risks than they are today. "Under managed care, reimbursement levels can be uncertain...and there is now much more consideration given to whether a physician practice loan will be funded or not."

—Tom Kumura, Superior Consultant Co. Inc.

Seeking a Loan Brings Financial Awareness

Applying for a loan for the first time gives physicians a chance to look closely at the financial health of their practices in an organized and comprehensive manner.

Tom Kumura, corporate vice president for Superior Consultant Co. Inc., in Southfield, Mich, says, "Usually, physicians retain a CPA and have their financial statements produced on a regular basis, but they're not comfortable examining the numbers to discern overall trends."

Therefore, the loan-application process itself can be insightful. "Physicians can gather significant qualitative information through examining quantitative trends," Kumura says. "I encourage physicians to sit down with their office managers

to examine revenue and expense trends. This exercise can reveal problem areas ahead of time, so that mid-course corrections can be made. At the least, the numbers can substantiate their perception of how their practice is performing.

"For example, under capitation, seeing more patients does not necessarily mean a physician will increase his or her earnings," Kumura says. "Being busier is no longer an accurate way of monitoring the financial health of a practice. As a result, physicians who receive reimbursement under managed care contracts must carefully examine and understand financial statements in order to ensure the success of their practices."

—DJN

(Continued from page 8)

physicians can obtain an unsecured loan, they will pay a higher interest rate in order to compensate the lender for assuming the higher risk, or be required to offer more collateral to secure the loan." Unsecured loans might be extended for purposes such as acquiring another physician practice, funding the compensation of new physicians who will not be fully productive for a year or two, or creating a new alliance or organization, such as an IPA or PHO.

"Usually, a significant amount of money is needed when physicians decide to create a new organization whose purpose is negotiating managed care contracts," Frew explains. "A venture like this is more speculative from a lender's standpoint. Physicians will need to provide a detailed business plan to demonstrate the profits the organization is expected to generate, along with an estimate of how quickly the physicians expect to pay back the loan based on those profit projections."

Enhancing Credibility

In fact, providing a business plan outlining the projected uses of borrowed funds can go a long way toward increasing lenders' perception of the physician practices as good credit risks.

"A business plan presented to a lender should outline how the borrowed funds will be used and how the repayment of those funds will occur," counsels Kumura. "Bankers typically like to see that the money will be used to enhance the practice so that it becomes more profitable, so that

the physicians will have the ability to pay back the loan." Items included in the business plan could include a brief history of the practice, its location and hours of operation, examples of advertising, market share, patient volume projections, financial forecasts, and reimbursement sources. "A thorough business plan demonstrates to lenders that the physicians know their business and have a good idea of where they expect the business to go in the future."

Being realistic is extremely important when designing the business plan. "The business plan will reflect on the credibility of the physicians," Frew says. "Projections that show a significant upward trend should not be created if historically that trend has not been there. If the numbers don't make sense, the lender will be skeptical and discount them significantly. Physicians should incorporate a fair representation of growth opportunities in the community, the potential for improving expense margins and increasing profit, and the physicians' commitment to retain a portion of capital to demonstrate the plan to invest in the future of the group."

Along with a business plan, physicians should be able to provide clear, complete financial records of their practices. "Historical financials ideally will show positive trends in terms of consistent gross income, as well as consistency in expenses," Frew says. "Lenders look askance at financial performance that is extremely volatile, because predicting future income or cash flow will be difficult." A practice should be able to demonstrate that its

accounting and financial systems and controls are thorough and complete, and that it uses a competent CPA who ensures that all reporting is accurate. "The practice also should provide to the lender a forecast that gives the lender some confidence that the practice will generate adequate income in order to repay the loan," she says.

Other factors also enhance the practice's position as a borrower. "A larger group is more likely to be considered a better risk, whereas the success of a solo practice depends on one person's productivity," Frew explains. "Larger groups are more likely to have equity built up and a significant asset base that can serve as collateral for a loan. Furthermore, a large group will likely have a proven track record after being in operation for several years." A larger group also might have older and more experienced physicians than a smaller group would have and this factor can affect the lender's assessment of risk.

Finally, Frew emphasizes that it is important for physicians to present themselves in a polished, thoughtful, and credible manner. "The worst thing physicians can do is to be reactive to the lender's needs, as opposed to taking the initiative in approaching the lender in a very organized, methodical manner," she says. "Physicians may choose to bring in consultants or advisers who can help them prepare, and make sure they are putting their best foot forward."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md.

Physicians Find Profits in Clinical Trials

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

The rapidly expanding drug development industry is taking clinical trials out of the traditional academic setting and into the offices of private practitioners. A recent rise in the number of drugs in testing, and the corresponding need for patients to participate in clinical trials, has allowed private physicians who have direct access to large patient pools to play an integral role in drug development.

In the past, most clinical trials have been conducted at academic medical centers where patients are evaluated and entered into studies by specialists and subspecialists. Pharmaceutical and biotechnology company sponsors appear to be discontent with the complex nature of the academic trial system and have begun to look for other alternatives.

Slowed by Bureaucracy

The major challenge drug developers face is recruiting and retaining participants for studies. Private physicians have access to large numbers of disease-state-specific patients and can enroll these diverse patient populations relatively quickly, satisfying the growing demand for clinical trial participants. Private practitioners also can avoid the bureaucratic interference that often plagues the academic setting.

At academic medical centers, each clinical trial is scrutinized by a board of unbiased experts who review each participating patient's contractual agreement to be a part of the study. Such institutional review systems at university-based clinical trials can add six weeks to approval times and cost drug developers as much as

\$1 million per day in lost sales.

Drug developers and pharmaceutical companies now recognize that the institutional process is simpler and less time consuming when trials are performed by private physicians. Also, trials done by private physicians maintain the same level of quality as trials done in academic settings.

Advantages for Physicians

Heightened awareness and interest in clinical trials among physicians can be attributed to the opportunity to provide sophisticated treatment to patients, the prospect of learning new

meet an enrollment quota, the prospect of taking on clinical studies seems even more lucrative to physicians.

Today, approximately 22,000 private physicians, representing only about 5% of the U.S. physician population, conduct clinical studies. Pharmaceutical companies are most likely to recruit specialists and subspecialists who deal directly with disease-specific patients for trial research.

No special training or government certification is required for physicians who choose to take on these studies. Sponsors simply recruit physicians who are actively practicing medicine, are

In the United States, pharmaceutical companies spend \$3.3 billion annually on drug development. This amount translates into potential per-patient revenue of \$2,000 for testing routine drugs on patients with uncomplicated conditions (such as colds or flu), to \$15,000 for testing sophisticated drugs on patients with critical illnesses (such as HIV).

aspects of medicine, and the ability to supplement revenue significantly.

In the United States, pharmaceutical companies spend \$3.3 billion annually on drug development, according to *CenterWatch* magazine. This amount translates into potential per-patient revenue of \$2,000 for testing routine drugs on patients with uncomplicated conditions (such as colds or flu) to \$15,000 for testing sophisticated drugs on patients with critical illnesses (such as HIV).

Some physician groups have established research units that comprise only a small number of the group's total patient base but generate a majority of the group's total revenue. When a drug developer is willing to pay a bonus of as much as \$2,000 per patient in order to

board certified in their specialty, and who can produce a patient base that meets the essential requirements of the particular study.

Significant Commitment

It can be difficult for busy physicians to incorporate clinical studies into their practices because the required commitment can be significant when coupled with a physician's daily workload. Supervision of a clinical study requires an acute attention to detail, an ability to coordinate an enormous research plan successfully, and a willingness to follow the industry's standardized treatment protocols accurately.

Physicians seeking to perform a large number of studies must develop a set of standard operating procedures and

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appoint a coordinator to oversee the study's routine operations. For many groups, appointing a study coordinator means assuming the expense of hiring an additional nurse or physician assistant.

Physicians also must develop creative ways to market their services to pharmaceutical and drug development companies, and they must be able to prove that they are suitably qualified. A popular way for physicians to showcase their willingness and ability to conduct clinical studies is to do so on a Web site or to advertise in a professional trade publication. Many physicians who have considered conducting clinical trials have been dissuaded from doing so because of the significant outlays of time, effort, and money required to promote their practices in this way.

Questions of Ethics

In recent months, questions of ethics have been raised about private physicians performing clinical trials. Many critics, including physicians and patients' rights advocates, believe that the added task of performing clinical trials can compromise the quality of care offered to regular patients. A physician must be able to adjust his or her plan of care between regular and clinical trial patients.

Normally, a physician's task is to identify and diagnose a patient's ailment and prescribe a proper remedy. In a clinical trial, however, a doctor must collect compatible patients who share the same illness and apply the same remedy to each one. Some physicians have developed systems in which they set aside a certain day of the week specifically for seeing study subjects in an effort to separate the two modes of care.

Physician investigators also have been challenged on their methods of recruiting patients for their studies. Critics have argued that physicians exert improper influence on patients by urging them to participate in clinical trials. FDA officials also have voiced concerns about the financial incentives associated with private practice clinical trials. They fear that the integrity of important data may be compromised, considering the level of competition for subjects and the rising economic stakes.

Site maintenance organizations affiliate with physician practices and help them gain experience through linking them with pharmaceutical sponsors, assisting them with the development of standardized operating procedures, and providing them with qualified study coordinators.

Resources for Physicians

Physicians who have limited experience with clinical trials and who are interested in learning more about the process have several options. One is to contact the Association of Clinical Research Professionals (acrpn.net), in Washington, D.C., an international society dedicated to clinical research and development. Founded in 1976, the association currently has 11,000 members. Also, the Drug Information Association (diahome.org), in Fort Washington, Pa., is a nonprofit association of more than 22,000 members that provides a neutral forum for the exchange of information on the discovery, development, evaluation, and utilization of pharmaceuticals and related health care technologies. At these sites professionals can exchange ideas about clinical trials and discuss their experience and resources with other professionals in the field.

Site maintenance organizations (SMOs), such as Protocare Inc., in Santa Monica, Calif. (protocare.com) and Radiant Research, in Kirkland, Wash. (radiantresearch.com), specialize in connecting physicians and sponsors and helping to install the infrastructure for clinical studies at each site within a trial. SMOs help physician groups with contract and budget negotiations, completion of regulatory filings and development of marketing campaigns to promote sites or to recruit volunteers. These companies aim to shorten the time to market for new pharmaceuticals, while reducing development costs, and helping to improve the quality of human clinical trials research for pharmaceutical companies, biotechnology companies, physicians, and other research organizations.

These companies have affiliated with physician practices and help them gain experience through linking them with pharmaceutical sponsors, assisting them with the development of standardized operating procedures, and providing them with qualified study coordinators. Many SMOs have developed business plans that involve purchasing physician practices dedicated exclusively to conducting studies for clinical trials.

Trials conducted by SMOs account for only about \$200 million, or 6%, of the \$3.3 billion market for clinical trials. Dedicated and part-time private physician clinical trials account for 44% of the market, and academic medical centers make up the remaining 50%. Of the \$200 million market share that SMOs command, 60% goes to SMO-owned sites, 22% to SMO-affiliated practices, and the remaining 18% represents a hybrid model.

For physicians, another avenue into the clinical trials market are "study brokers" who perform services similar to those of SMOs. Study brokers are also called site representatives and help match sponsors to qualified investigators. Recently, study brokers have begun to offer more comprehensive services, including contract negotiation and promotion of individual sites. Essentially, study brokers offer many of the same services that SMOs offer but are typically paid by the physician investigator, not the sponsor.

Clinical trials will continue to play a critical role in the overall improvement of health care by making new, promising treatments available to the patients who need them most. When considering clinical trials, physicians may want to gather as much information as possible and discuss the process with other physicians who have firsthand experience. ■

Refusing To Use the Internet Will Not Be an Option for Physicians, Expert Says



Tom Ferguson, MD, is an expert in patient self-help strategies and health information available to patients on the Internet. He is editor and publisher of *The Ferguson Report*,

a newsletter about consumer health information and online health information. Ferguson is also associate professor of health informatics at the University of Texas Health Science Center in Houston, and senior associate at the Center for Clinical Computing, researchers associated with the Harvard University School of Medicine and the Beth Israel-Deaconess Medical Center in Boston. He received his medical degree from Yale University. Richard L. Reece, MD, editor-in-chief, conducted this interview.

Q: What experiences led to your interest in self-care?

A: I went to medical school at Yale after working for a number of years in several different community health programs. As I observed the practice of medicine during my training, I noticed that health professionals rarely considered patients to be a resource that might be tapped for assistance so that patients could address their own health problems. I became very interested in that perspective, and completed a doctoral dissertation on the potential role of self-help and self-care in health care. I started a journal on self-care called *Medical Self-Care Magazine* in 1976, and served as the editor until 1989.

In this period, numerous self-help issues came to the forefront: teaching

people with high blood pressure how to take their own blood pressure measurements, showing women how to do a breast self-exam, teaching mothering skills to new mothers. In 1993, I noted the early development of health information availability on the Internet, particularly with the addition of physician Web sites offering support to various communities of patients.

It seemed to me that self-care was going to become an important trend, and at that point I entered the field full time, by developing *The Ferguson Report*. I also wrote a book, *Health On-Line*, which was published by Addison-Wesley Publishing Co. in Reading, Mass., in 1996. Perhaps it was a little ahead of its time, but it certainly was one of the first books to point out the importance of new patient behaviors on the Internet. I think the book is more popular now than when it was first published.

Q: How has the Internet enhanced self-care?

A: The availability of online communication has made it possible and convenient to accomplish what only the most committed and motivated people could accomplish before in terms of finding detailed information about their medical conditions. Online technology has also made it possible for people to gain access to disease support groups and to research information about their diseases.

It provides an environment in which some patients can play a role that's different from the role they've played traditionally. The online revolution is changing the roles of both physicians and

patients. Patients spend a good portion of their time away from the physician's office, caring for themselves. Also, when patients are motivated they are willing to put almost endless time and energy into being a resource for their own care.

Q: Have physicians responded to the patient self-care movement by perusing online resources available to patients?

A: Physicians have to decide if they are willing and able to deal with these empowered patients who are using the Internet to play a different role in their health care. Physicians should do their patients the courtesy of recognizing that some of them want to be more involved in the decisions relating to their care. Certainly, physicians can feel confused when patients come into the office already involved in the process of medicine. I was trained on the following model: Patients have a problem, they come to the doctor, they put themselves in the doctor's hands, the doctor conducts a multistep process of taking the history, assessing the presenting complaint, doing the physical exam, ordering diagnostic tests, making a diagnosis, and presenting a treatment plan.

But many patients first see their physicians now at a different stage of the process than we physicians were taught to deal with. They may already have a diagnosis or a tentative diagnosis, they may already have a treatment plan that they are interested in, and in some cases they want to come in for a consultation on their process and want the physician to listen and engage them in a dialogue. Some physicians find it confusing or diffi-

"If a physician creates a Web page and informs patients that he or she is not only willing to entertain their communications by e-mail, but also willing to accept reasonably short questions from their friends, then many of these individuals will come to that physician's office seeking care."

cult to make the transition from the old model to the new one, where the patient is consulted about treatment options and retains control over the final decision.

Q. *Are physicians helping patients access information online?*

A. At this point, what appears to be happening in most cases is that the patients are teaching the physicians. There are some exceptions, but by and large patients walk into the office with information from the Internet and present it to the physician. Patients are raising the issue of the availability of information on the Internet and they're attempting to engage their physician in a conversation on that topic. Many times, the physicians' response is that they don't want to deal with it—perhaps, for some reason, they just don't trust it.

The physicians who most impressed me also responded that way, but then had an experience that turned them around. For example, one doctor recently told me he was very uneasy about Internet information until he delivered a baby who had a rare form of congenital dwarfism. The physician expected to spend three days in the medical library because he hadn't seen a case like this since medical school. But the baby's father went on the Internet and amassed the relevant information, printed a copy for the physician, and made him a book. This saved the physician days of work. Some patients can be amazing resources and colleagues for their doctors.

Q. *Why is patient knowledge important to the physician?*

A. Patient knowledge is different from physician knowledge. Depending upon area of specialization, a specialist might have to stay current on 30, 200, or 400 medical conditions. A general practitioner might have to keep up on 600. Patients only have to know about one—their own. So, they can approach information gathering in a very in-depth way. They can become the experts on their particular manifestation of that condition.

Q. *How has the Internet changed the nature of health information?*

A. I was trained to think of health information as, for example, a patient handout. Traditionally, in the process of treating patients, physicians would identify information they really

wanted their patients to know and would impart that information to them. The format was typically a patient handout, with linear text printed on a sheet of paper or a pamphlet handed to the patient in the clinic or physician's office.

When I first got involved with the Internet, what I imagined I'd find was kind of a giant medical encyclopedia of patient handouts. But in fact, what we find is much

office seeking care.

I'm asked all the time whether e-mail will degrade the quality of the interaction between physicians and patients. In fact, e-mail does just the opposite. Physicians who use e-mail can personalize and deepen patient communication beyond anything they could imagine. This is because they can focus on answering e-mail when they have the time. Once physicians

“E-mail can be the salvation of the doctor-patient relationship. It not only deepens the level of information shared but also can enrich the relationship.”

more complex and interesting than that. In talking to hundreds of patients online and asking them what they want when they go on the Internet, at the top of the list is being able to ask a question and obtain an answer from a knowledgeable person. They want to be able to identify their specific concerns and get a tailored response. It's actually quite easy for people to get that, and it's particularly easy to get it from online support communities.

It's not difficult to find a health professional who is willing to answer a question online. Health information is also provided on lists of frequently asked questions (FAQs) on a particular health condition. Many online support groups provide FAQ lists that often are very useful to other patients coming along with the same question. Compared with these resources, the things that I regarded as patient education materials are considered by patients to be of fairly limited utility.

Q. *Should physicians encourage patients to communicate with them via e-mail?*

A. Physicians can enhance their practices by encouraging patients to be involved in their care and to use online technologies such as e-mail to facilitate this empowerment. If a physician creates a Web page and informs patients that he or she is not only willing to entertain their communications by e-mail, but also willing to accept reasonably short questions from their friends, then many of these individuals will come to that physician's

become proficient at answering patients' e-mail, they provide useful and appropriate responses to patient questions within a few minutes. On the other hand, phone conversations can be very inefficient. The physician has to reach the patient on the phone, and both parties may have been focused on something else so they end up having a harried conversation. E-mail can be the salvation of the doctor-patient relationship. It not only deepens the level of information shared but also can enrich the relationship.

Q. *How can physicians negotiate the legal and ethical questions surrounding physician-patient e-mail and the security of e-mail exchanges?*

A. An April 1999 *Healthcon* survey indicates that 33% of physicians were communicating with patients by e-mail. That's up from probably a tenth of that two years ago. So the growth rate of doctors who are at least experimenting with patient e-mail is increasing dramatically. And almost all of those e-mails are not secure. One reason for this is that using secure e-mail is technically challenging.

At one facility that offers the option of secure e-mail I asked the manager of the clinic how many patients use secure e-mail. He said it was somewhere around 5%, meaning those patients who had advanced degrees in information technology and who have AIDS. That's pretty much the state of the usage of secure e-

(Continued on page 14)

(Continued from page 13)

mail at this point. It is so challenging that patients need both a technical background and a good reason to use it before they are motivated to use it.

Basically, if a physician has legal or ethical concerns about using e-mail, he or she can simply ask patients to sign a release. Physicians probably should have an e-mail policy with communication, medical-legal, and administrative components. They can find a set of these guidelines in *Essential Informatics for Medical Groups*, July 1999, a newsletter published by Aspen Publishers in Gaithersburg, Md.

Q. What is the value of online support groups?

A. Patients who are motivated to be their own resource for care can also be a resource for others with similar conditions. Online support groups—sometimes called disease tribes—seem to be a powerful educational tool. That is a very interesting development that no one predicted. Health-related chat groups represent one of the biggest and most interesting surprises of this whole field for me. When people have a medical condition, particularly a chronic or serious medical condition, one thing they value highly is talking to other patients with the same condition.

Online support communities have been formed for just about every physical, psychological, and social condition or problem you can name. The more common the condition, the more groups there are that address it. For example, let's say a woman with breast cancer searches the Internet for breast-cancer resources. The people who are active in self-help and in breast cancer support groups run breast-cancer Web pages, and they know other people involved in breast cancer resources. The woman with breast cancer doesn't get just a bunch of separate books, as she would if she went to the library. She can interact with other breast cancer patients. In fact, many of the Web sites for breast cancer have links to all the other Web sites for breast cancer. So these people know each other and link to each other. They may be members of a Web ring—a consolidation of Web sites devoted to the same topic.

A survey of support group members

"On the Internet, physicians should expect a learning curve, so it's better to get it over with now."

conducted in January 1999 found that most members trust each other and believe they gain better information from each other than from their physicians. Online support group patients are active members of the group, not random online patients. Half or more of them log on every day, and about 90% log on to the Web community at least once a week.

In the survey, patients were asked to compare their online support group, their primary care doctor, and their specialist on 12 different dimensions of health care services, such as diagnosis, development of a treatment plan, convenience, and support. As expected, the groups ranked higher for convenience and support, while the doctors ranked higher for diagnosis and treatment.

It was stunning, though, that the groups, rather than the physicians, came out ahead in the categories related to disease information.

Q. In your book, you encourage physicians to get on the Internet. Why?

A. Physicians will find it difficult to understand the scope of health information on the Internet without experiencing it themselves. Physicians need to use the Internet, not only by browsing the health sites but by searching for information about general interests, such as stocks or cars. Physicians who follow their interests, needs, and concerns on the Internet will develop a better feel for patients who are doing the same thing, pursuing their needs and concerns.

Age is no obstacle. The Internet represents a certain way of relating to people, finding information, and accomplishing tasks. It can't really be understood well unless you have hands-on experience. Eventually, refusing to use the Internet will not be an option. So, physicians have the choice: Use it now or use it later. Physicians should expect that there's going to be a learning curve, so it's better to get it over with now.

We will get to the point where physicians won't be able to practice without

the Internet. Physicians can begin by visiting some nonprofit online support groups. A good starting point would be www.selfhelpgroups.org. Such support groups were around for a long time before the Internet came along, but they operated face-to-face and often had traditional newsletters. The selfhelpgroups.org site is the searchable database of the American Self-Help Group Clearinghouse at St. Clare's Hospital in Denville, N.J. It provides an overview of, and links to, all the no-fee support groups that exist for hundreds of different conditions.

Q. You also encourage physicians to look for creative ways to "give away the store." What does that mean?

One thing that characterizes the network economy is the transition from a pre-online mode, in which money and power stem from holding onto information, to a post-online mode in which money and power grow out of sharing information. Netscape was one of the first pioneers in this way. It gave away its browser and suddenly the software was everywhere. The model for an Internet business is often to give away 99% of what you produce and make a living on the high value 1% that some people might be willing to pay for. Physicians can give away general health information on the Internet, and patients will come to them for more specific and personal answers.

Q. What is the effect of online information on a physician's business?

A. Physicians need to decide if this is a market that interests them. Many patients will not be heavily involved in self-care, but over time this will become an older, probably less sophisticated population. In more rural areas, this is not an issue. But physicians who live in a high-tech urban area and want to treat a well-educated young adult population will have to be proficient on the Internet or they won't have any patients left in five years. ■

Medicare Is Overpaying Hospitals That Own Physician Practices

The federal government and Medicare beneficiaries are likely paying millions of dollars more than they should to hospitals that are not making clear their ownership arrangements of physician practices, according to a new report from the federal Department of Health and Human Services Office of Inspector General.

Depending on how and if hospitals report such ownership arrangements to the federal government, "Medicare could be paying excessive amounts for services provided in the practice," the report says. As of June 1998, hospitals are required to report to Medicare any current—not past—physician practice purchases. Medicare knows about such physician practice ownership by hospitals in only half the instances, the report indicates.

About 62% of general hospitals in the United States own physician practices, according to estimates by the Office of Inspector General. Hospitals have increasingly been purchasing physician practices in

order to build networks to compete against managed care organizations. As a result of such purchases, Medicare also pays hospitals for services performed in these practices.

Hospitals have two ways to account for purchased physician practices, either as free-standing or provider-based (meaning hospital-based) entities. Medicare's claims processors are frequently unaware of how hospitals treat such practices in hospital cost reports. Payments for provider-based services are generally higher than for services performed in a free-standing physician office.

The IG report says Medicare overpays in instances when hospitals fail "to seek provider-based status for their practice but claim the costs for the practice in the cost report." As a result, the IG believes an undetermined portion of the \$548 million Medicare reimbursed hospitals for outpatient clinic services in fiscal year 1996 could have been paid inappropriately.

In instances in which hospitals elect to treat the physician practice as free-

standing, hospitals have to include costs for practice operation on their Medicare cost reports, but as nonallowable costs. If a hospital fails to do so and the error is not discovered, a substantial amount of federal reimbursement may be in question, the report says.

As a result, the IG recommends that the federal Health Care Financing Administration "require hospitals to report all physician practice or clinic purchases, and declare how the operating costs associated with these entities are handled in hospital cost reports." It also said HCFA should "seek legislation to sanction hospitals for failure to report the ownership of physician practices." HCFA agreed with the IG on these two recommendations.

However, HCFA does not agree with the IG's recommendation to take action to eliminate differences in payments across sites, which may ultimately require the elimination of the option of provider-based status for hospital-owned physician practices.

Enforcement of Fraud, Abuse Laws Rising

The U.S. government is cracking down on health care fraud and abuse, according to Paul E. Kalb, MD, a physician-attorney from the law firm of Sidley and Austin in Washington, D.C.

"Fraud and abuse law has now or should now have far surpassed malpractice law as the primary area of legal concern for physicians," Kalb said. He discussed the enforcement of health care fraud and abuse legislation in the September 22-29 issue of JAMA.

"The statistics reflecting current law enforcement are striking," Kalb said in the journal. The number of criminal health care fraud cases filed by federal prosecutors increased more than threefold between 1993 and 1998, from 105 cases to 322. The number of civil cases filed by the U.S. Department of Justice increased from 29 in 1993 to 107 in 1998, and the judgments won or negotiated totaled \$480 million in 1998.

In the same year, the U.S. Department of Health and Human Services excluded more than 3,000 individuals and organizations from government programs as a result of health care fraud, representing an increase of 11% from the prior year, Kalb reports in the journal. "This trend almost certainly will continue in the foreseeable future," he said.

The fraud and abuse legislation that Kalb describes generally prohibits three types of activities: false claims, kickbacks, and self-referrals. However, he expects that in the future the same laws that prohibit this conduct will be used increasingly often "to impose liability on those who provide care that is perceived to be substandard."

(Source for all items: Reuters Health)

Medicare HMOs Raising Premiums, Cutting Benefits

Medicare beneficiaries in private managed care plans will have to pay more to get less, according to a report released by Vice President Al Gore.

"Across the nation, co-payments and premiums are going up rapidly, while benefits are going down," said Gore, who added that an analysis by the federal Health Care Financing Administration points up the need to add a prescription drug benefit to Medicare, and to overhaul the program in general.

Prescription drug coverage is taking a particularly hard hit, according to the report. While an estimated one million beneficiaries in Medicare HMOs this year have prescription drug coverage with no co-payments, that number will decline to zero next year. At the same time, the percentage of plans that cap the drug benefit at \$500 or less is rising by half; from 21% this year to 32% next year, the report said.

Premiums are rising, the report said. A total of three million fewer Medicare beneficiaries will live in an area with access to a Medicare managed care plan that does not charge a premium next year compared with the number of beneficiaries who have access to such plans this year. At the same time, the average Medicare HMO premium, which is in addition to the regular premium for Medicare Part B, will triple, from \$5.35 to \$15.84. And the number of beneficiaries who live in areas where plans charge the highest monthly premiums (more than \$80) will quadruple.

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Richard L. Reece, MD
Editor-in-Chief

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