The Changing Private Practice Environment: How To Analyze Opportunities

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The physician private practice arena has evolved from the days of the single family practitioner delivering house calls to one where options such as an affiliation of independent practitioners to purchase supplies or the integration of multi-specialty medical groups and hospitals into regional health systems are available. The transition to these sophisticated systems for the delivery of medical care has been stimulated by myriad changes in all segments of the health care industry; the payment system has become more complex, demands of all consumers have risen, and the ability to survive financially has become more of a challenge.

While the business side of delivering medical care is becoming increasingly complicated, many physicians are looking for more manageable career and personal life styles. An interesting study in this regard (Schwartz, Jarecky, Strodel, Haley, Young, & Griffen, 1989 showed an increase, between 1978 and 1987, in the percentage of top-ranking students at selected medical schools choosing specialties with controllable life styles, as defined by the researchers. Although the study does not specifically address the direct linkage between specific characteristics of a “controllable” life style and certain specialties, the trend is noteworthy. A chronic complaint voiced by physicians in solo or small group practice today is that the time required to understand updates to billing policies and revisions to regulatory requirements is preventing them from devoting their energies to practicing medicine. Successful staff model health maintenance organizations (HMOs) are responding to this problem; they are, for example, to offer primary care physicians salaries close to $100,00 with flexible work hours, minimal paper work, and no administrative responsibility. Although the loss of independence and control associated with employment with an HMO as well as potential differences in philosophy is deterring many physicians from accepting these offers, it can be an attractive alternative for newly graduated and established physicians.

TRENDS IN GROUP PRACTICE

The growth in managed care may have been the single greatest force prompting physicians of all ages and practice longevity to seek group practice opportunities. A group offers the clout required to negotiate aggressively with the plans, the efficiencies necessary to deliver care in a manner consistent with the payment provided, as well as an attractive alternative to employment in staff-based model HMOs. Other factors prompting physicians to look for alternatives to solo practice include substantial practice start-up costs, the growing disparity between

increases in operating costs and growth in revenues, the desire to have a more stable career and personal life style, and the increasing importance in owning an entity with long-term value.

The trend toward group practice settings is confirmed by an American Medical Association (AMA) survey that showed that the number of physicians in groups, defined to be three or more physicians, grew 10.8% between 1984 and 1988, or 2.7% annually. By 1988, approximately 30% of total non-federal physicians were in groups (Havlicek, 1990).

The literature also indicates a trend away from solo practice by younger physicians. Among physicians between the ages of 56 and 65, 48.9% are in solo practice; this percentage steadily declines to 20.3 once the 36 years and younger age segment is reached (Marder, Emmons, Kletke, & Wilke, 1988). Moreover, the decline in solo practice participation over time is greater, on a percentage basis, in the younger than in the older age groups.

The interest in group practice settings will continue to grow and the percentage of physicians in groups will reach 40% by 1996 according to a panel of physicians who participated in a Delphi study conducted by Arthur Anderson & Co. and the American College of Healthcare Executives (1991). A 1990 survey conducted by the Association of American Medical Colleges lends credence to these projections; it showed that 2.9% of medical students plan to enter solo practice and 37.8% plan to practice in a group with at least three practitioners in total. Among the students indicating preference for a private clinical practice career path, two thirds indicated a preference for group practice.

The growth in physicians entering group practice has resulted in an increase in group size, as opposed to a proliferation of smaller groups. The number of physicians per group has increased from 6.6 in 1965 to 8.2 in 1980 to 9.6 in 1988 (Havlicek, 1990). This has been attributed to the merging of existing groups as the need for economies of scale and market clout has increased and the desire of physicians to take the less risky path by joining existing groups rather than forming new ones has become more prevalent.

Since the pressures to enter a new practice setting are impacting established, as well as newly graduated, practitioners, a structure that can satisfy a unique combination of goals and objectives is critical. Physicians who have been in solo practice, for example, may have difficulty adjusting to a system that attempts to distribute income equally among practitioners without accounting for differences in hours worked, patients seen, or expenses incurred. Fortunately, the available information system technology enables practices to track provider-specific revenue and expense information easily and, therefore, develop flexible policies for physician compensation. Moreover, new practice options are available that provide some of the advantages of a formal group without requiring complete practice integration.

The specific structure that is ultimately chosen by each group of providers will vary based on its goals and objectives as well as on factors in the external environment. In California, for example, competitive pressures raised by the penetration of capitated risk arrangements has prompted multi-specialty physician groups to form and affiliate with hospital systems to affect contracting capabilities significantly (Grant, 1991).

OUTLINE GOALS AND OBJECTIVES

As the choices in practice structure expand, the decision regarding the preferred option becomes more difficult. To evaluate the alternatives adequately, a cost-benefit analysis must be performed by each individual practitioner as well as by the interested group as a whole. The evaluation process begins with each practitioner defining his or her specific short-and long-term goals for the new entity in areas such as expected financial performance, business purpose, impact on the operating environment, desired level or risk, and quality of care controls. A list of criteria that should be considered is provided in Figure 1. Some of these goals can be satisfied through an affiliation whereas others can only be realized with a formal group practice. For each criterion, the individual should assign a relative weight or rank so that the cost and benefit of required trade-offs can be measured. Each structural option can then be evaluated based on how well it fulfills each criterion individually and the range of objectives in total. In some cases, the perceived financial and emotional costs of structuring a formal group will cause practitioners to decide to enter an affiliation arrangement but not to merge fully into a group.

IMPACT ON FINANCIAL PERFORMANCE

Since the impact of the chosen option on financial performance will be critical, it is important to review the key variables contributing to financial viability. A practice's financial position is summarized in three financial statements:

1. Statement of Revenue and Expense or operating statement;
2. Statement of Cash Flow; and
3. Balance Sheet, which shows the assets and liabilities of the organization at any point in time.

Although a comprehensive financial analysis will include a review of all financial statements, for the purposes of this discussion, only specific components of the operating and cash flow statements will be examined.

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Statement of Revenue and Expense (operating statement)

As shown in the sample operating statement in Figure 2, net income is calculated by subtracting expenses from revenues. Similar to all businesses, to improve

	Each Practitioner Should Indicate Level of Importance
1. *IMPROVE FINANCIAL PERFORMANCE*	
Increase Revenue	
Increase Volume	
Improve Payor Mix	
Improve Service Mix	
Improve Billing/Collections	
Control Expenses	
Selected Expenses	
Full Range of Expenses	
2. *DESIRED IMPACT ON OPERATING ENVIRONMENT*	
Increase flexibility in work hours	
Impact on control in decision making	
Impact on control of workload	
Impact on practice independence	
3. *DEFINITION OF BUSINESS PURPOSE*	
Improve managed care negotiations	
Increase market clout	
Increase long-term value	
Reduce long-term risk	
Impact on marketing	
4. *ORGANIZATIONAL STRUCTURE OPTIONS*	
Preferred ownership structure	
Preferred management structure	
Affiliate with nonprofit entity	
Desire to affiliate with hospital	
5. *DISTRIBUTION OF REVENUES & EXPENSES*	
Define preferred policy	
6. *REDUCE CAPITAL RISK*	
Affiliate with entity to provide access to capital	
Achieve expertise in cash management	
Level of capital commitment desired	
7. *IMPACT ON QUALITY OF CARE CONTROLS*	
Ability to develop standards of care	
Ability to develop and enforce utilization review	
Ability to structure quality management	

Figure 1. Criteria for cost-benefit analysis, some examples.

financial viability, physicians must maximize revenue and control expenses. As shown in Figure 3, the variables that can be enhanced on the revenue side of the equation include total volume, price and payment per service rendered, payor mix, service mix, and billing and collection efficiency. Each alternative practice option will have a specific impact on each of these variables.

Revenue enhancements

Volume

The volume of patients seen, or of procedures performed, is primarily dependent on the ability to attract patients through activities such as development of provider referral networks and contracts with managed care plans, employers, and hospitals. (The third article in this issue discusses marketing for physician practices in more detail.) Once patients are attracted to the practice, volume becomes dependent on the time to complete each visit or procedure and the time each practitioner has available to see patients. As time required to monitor billing and perform other administrative tasks declines, time available for patient care is directly increased. Some practices use nurse practitioners and physician assistants to perform some of the patient care activity, thereby maximizing available physician time and increasing patient volume.

Price and Payment

The price and payment per unit of service is becoming increasingly more difficult to control as other payors emulate Medicare's Resource Based Relative Value Scale (RB-RVS) methodology. The fixed pricing inherent in fee schedules, in

TOTAL REVENUE COLLECTED	$300,000
OPERATING EXPENSES	
Salary	
Fringe Benefits	
Insurance	
Medical Supplies	
Office Supplies	
Equipment/System/Furniture	
Answering Service	
Rent	
Utilities	
Marketing	
Other Non-Salary Items	
Depreciation Interest	
TOTAL OPERATING EXPENSES	$230,000
OPERATING INCOME BEFORE TAXES	$70,000
INCOME TAXES	$20,000
NET INCOME (LOSS)	$50,000

Figure 2. Operating Statement

REVENUE	=	PAYMENT PER UNIT OF SERVICES	X	NUMBER OF UNITS (VOLUME)
Enhancements:		Increase price or payment per unit of service Improve mix of payors Improve mix of services provided Improve billing and collections		Increase total volume Improve mix of services provided

Figure 3. Practice revenue enhancements

combination with the growth in capitation arrangements, leave practitioners with little pricing flexibility; charges are becoming as incidental to physician practices as they are to hospitals who are constrained by Medicare's Prospective Pricing System and negotiated contracts developed by many of the other payors. With fixed pricing, raising charges will have little impact on net income since few payors will pay charges and the increase in revenue received for inpatient copayments is usually minimal, particularly in practices that accept Medicare assignment.

Billing and Collections

In light of the restrictions on pricing, the billing and collections functions must be improved to ensure collection of the allowable fees in a timely manner, thereby enhancing cash flow. (The second article in this issue discusses improving the efficiency and effectiveness of these functions in more detail).

Payor Mix

Improvements in the payor mix can enable practitioners to balance the fixed payment payors with those who pay charges or with whom more favorable contracts can be negotiated.

Service Mix

When possible, changing the mix of service provided can also change payor mix and service volume. For example, focusing on services that are predominantly needed by the non-Medicare population can be beneficial financially; this, for example, may be one factor in the decision of orthopedic surgeons to pursue sports medicine programs. The ability to change payor and service mix is clearly dependent on physician specialty, the area demographics, the services offered by other area practitioners, and the internal capabilities of the practice.

Control of Expenses

Despite the success of revenue enhancement strategies, a practitioner is, at some point, limited by available hours in each day, which sets a ceiling on the volume of patients that can be seen to compensate for lost revenue through reduced payment. In light of this, flexibility is needed on the expense side of the equation to affect financial performance positively; again, alternative practice options can provide opportunities to control all or a portion of expenses.

The primary means for controlling expenses is to achieve economies of scale through group purchase or sharing of the costs of personnel, fringe benefits, billing systems, answering services, insurance, supplies, and other non-salary expenses. To the extent that the sharing of office space is possible, significant cost savings in rent/mortgage, utilities, and equipment can be realized. Further savings can be realized in the sharing of marketing resources such as personnel and supplies associated with recruitment, referral services, and contract negotiations.

Statement of Cash Flow

Although many practices monitor and, often forecast, operating statement performance on a routine basis, most fail to monitor and forecast the practice's cash position. In general, a cash flow statement starts with cash at the beginning of the year, applies the sources and uses of cash during they ear, and projects cash remaining at the end of the year. Many practices distribute all remaining cash annually, and therefore, do not adequately plan for equipment, information system, joint venture, or recruitment needs nor do they plan for fluctuations in cash inflow. For example, many practice managers are projecting serious cash shortfalls in January and February 1992 as the RB-RVS system is put into operation. Those practices that have anticipated and adequately planned for the shortfall will be in a better position to survive the period of reduced payment. Since cash availability and cash management are critical to practice expansion and longevity, alternative practice options that enhance access to capital and cash management expertise will benefit the practice.

IMPACT ON OTHER PRACTICE COMPONENTS

The impact of the preferred option on other, less easily measured components of the practice as identified in Figure 1 must also be considered; each option will impact these components differently.

EXAMPLES OF AFFILIATION AND GROUP OPTIONS

The structures that have been developed to address specific objectives range from the creation of an independent practice association (IPA) for the purpose of negotiating managed care contracts to the formation of a nonprofit foundation that provides all nonphysician services and contracts with a physician group to provide medical care. Between these two extremes is a continuum of arrangements that can include, but is not limited to, those listed below. Many of the existing structures are still in the evolutionary phase and will be refined as experience and changing environmental pressures dictate.

A *physician hospital organization* (PHO) has historically been formed as a vehicle for jointly negotiating with managed care plans but has evolved to include physician recruitment and joint ventures for group purchasing, service development, and equipment acquisition (Kove & Perry, 1988).

A *service organization* where one or all nonphysician services are provide by a separate, for-profit organization owned by physicians, hospitals, a separate entity, or a combination of all three. Typically, each individual practitioner contracts with the service organization to obtain selected services or resources; the organization bills based on usage. Any revenue generated is used to reduce the per unit expenses so that no net income remains in the service organization. This option enables practitioners to obtain some benefits of a formal group practice, such as economies of scale, without losing the operating independence of solo practice. (See Figure 4 for a graphic description of a service organization). The largest disadvantage of the service organization is that it is limited in its benefits because it has little control over the behavior of its associated physicians. For example, if only a small number of physicians decide to "buy" fringe benefits through the organization, the economies of scale will be limited.

A service organization is an excellent transition step between solo practice and a formal group arrangement. It enables cautious practitioners to obtain some of the benefits with minimal risk. Once the individuals feel comfortable they may be ready to take the more difficult step to obtain significantly greater benefits.

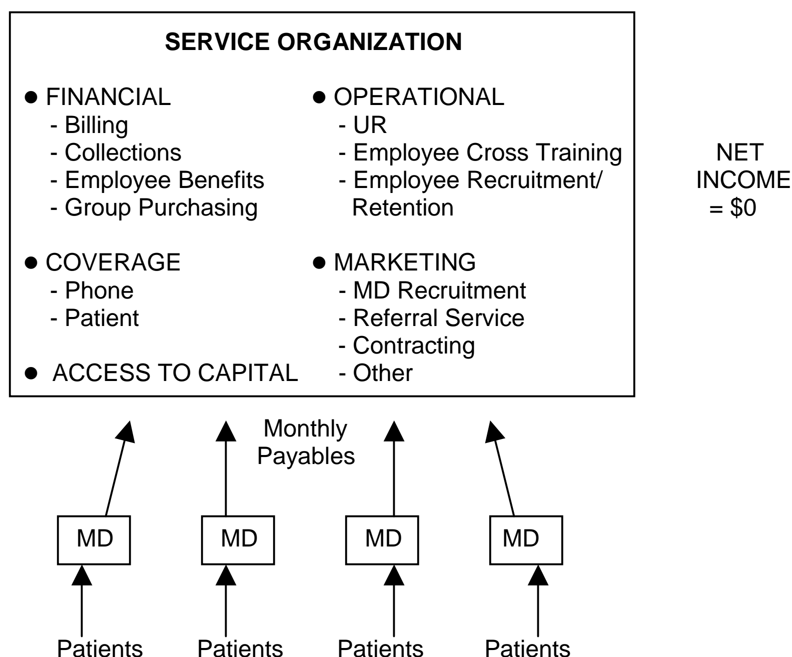

Figure 4. Overview of service organization.

A *group practice without walls* consists of a formally organized group practice that has centralized all functions except the delivery of patient care (Forster, 1988). "Without walls" refers to the fact that most practitioners maintain their own office. The economies of scale are less in this arrangement than they would be in a group that has centralized the delivery of care and shares office space and other overhead.

A *medical foundation* is a nonprofit entity that provides capital and nonphysician services and contracts with a medical group to provide patient care services (Johnson, 1988).

If desired, all of these options may be strengthened by developing them in concert with a hospital.

THE EVALUATION PROCESS

Whether it is a medical student evaluating postgraduation plans or a group of existing practitioners looking for alternatives to their current practice, it is critical to examine each option through a structured process. At the outset, goals and objectives must be defined at the individual and group levels, as mentioned earlier. As the evaluation process continues and more information on likely future environmental scenarios or financial issues becomes available, the goals and objectives may need to be refined. Each time, consensus on the new goals and objectives must be reached before proceeding. Objective setting can appear to be a slow process but, without consensus, the new entity is at risk for failure. Based on experience, one of the new most common reasons for failure of a new venture is that it was developed without clearly defined and agreed upon objectives.

Once consensus is reached, a financial analysis of the new entity must be completed. A second, related, reason for failure of new ventures is that rigorous financial analysis was either not performed or not analyzed adequately. To begin the analysis, a number of assumptions need to be made regarding the future health care environment. For example, will managed care penetration increase in the area? How quickly will other payors adopt Medicare's payment methodology? What types of equipment and information systems will be needed? What will expense inflation for salaries and supplies be relative to increases in the fee schedules?

Based on experience, one of the most common reasons for failure of a new venture is that it was developed without clearly defined and agreed upon objectives.

Then based on information from existing practices, assumptions need to be made regarding the expected impact of the new entity. For example, how can it increase volume of services? How will it improve managed care negotiations? What savings can be realized through group purchasing of employee benefits? What will be the net impact of centralizing the billing and collections functions?

Based on the answers to these and other questions by those involved, a full set of financial statements can be developed for the new entity. Since complete information is not always available, it is advisable to develop at least two sets of financial statements; one that shows a most likely scenario and a second that shows the worst case scenario. As the financial statements are reviewed, the group may also want to perform numerous sensitivity or “what if” analyses in order to evaluate the impact of changes to structure, services offered, physician compensation, and a range of other factors. The financial analysis will also need to account for the impact of legal issues including, but not limited to, tax, antitrust, liability, and Medicare and Medicaid fraud and abuse.

Once the financial and legal analyses have been completed a full cost-benefit analysis can be performed by each practitioner individually and by the group as a whole. The components of the cost-benefit analysis include the quantitative and, less easily measured, qualitative factors identified in Figure 1. Figure 5 provides and example of a framework within which to perform such an analysis to compare a number of affiliation options.

As long as the critical mass of interested physicians remains willing to commit the required capital investment at the conclusion of the cost-benefit analysis, the group can finalize issues related to structure, financial feasibility, legal and regulatory requirements, and timing of capital needs.

Once the decision to proceed has been reached, an operational action plan can be structured and implemented. The action plan will vary based on the structure selected but, in all cases, will focus on issues related to financial viability, governance, management, location, policies and procedures, cost allocation, and

Example of Criteria	Solo Practice	PHO	Service Organization
Increase Revenue	Minimal	Jt. Ventures-Minimal	Jt. Ventures-Minimal
Control Expenses	Low Potential	Group Purchasing	High Potential
Improve Contracting	Low Potential	High Potential	Moderate
Increase Market Power	Low Potential	High Potential	Moderate
Increase Long-Term Value	Practice Ownership	No Ownership	Ownership of Org.
Access to Capital	Taxable	Hospital Partner	Taxable
Maintain Control of Decision Making	High	Moderate	High
Maintain Independence	High	High	High
Increase Flexibility in Hours	Reduces Net Income	No Impact	Minimal Impact
Develop Standards of Care	Alone	In Related Contracts	Minimal

Figure 5. Framework for cost-benefit analysis, an example.

Group W/out Walls	Traditional Group	Foundation	Employment-HMO/Hosp
High Potential	High Potential	High Potential	Fixed
Moderate	High Potential	High Potential	Paid by Employer
High Potential	High Potential	High Potential	Through Employer
Ownership of Shares	Ownership of Shares	Ownership of Shares	No Ownership
Taxable	Taxable	Tax-Exempt/Grants	Through Employer
Moderate to Low	Moderate to Low	Moderate to Low	Low
Moderate	Moderate to Low	Moderate to Low	Low
Minimal Impact	High Potential	High Potential	High
Developed W/Group	Developed W/Group	With Group & Found.	Through Employer

revenue distribution. In order to keep the process moving at reasonable pace, it is important to define the expected timing for the completion of each task in the action plan and assign responsibility for each to one individual. In order to ensure continued viability, a system should be created to monitor key financial and other variables on a routine basis.

Understanding the potential pitfalls in this development process can help to enhance chances for success. In this regard, there appear to be five primary reasons for failure of the development process to reach a successful conclusion or for dissolution of the entity after a short period of time. Two of these were mentioned earlier: the organization was developed without defined objectives and rigorous financial analysis was not performed. The other three are (1) the development process did not include key participants, (2) the quality of control over services was not well structured, and (3) insufficient incentives exist for physicians to use the services offered by the new entity. The third factor was most prevalent among entities that did not become formal group practices.

The search by physicians for opportunities to improve the short-term performance and long-term value of their practices has resulted in the creation of a range of affiliation and group practice structures and changed the traditional private practice profile. The resulting ability to structure an environment that is optimal for each practitioner or group of practitioners can enhance the delivery of medical care and service to attract an array of individuals to private practice. In order for this evolution to be successful, however, the entities must be developed with thoughtful and detailed analysis and should be flexible enough to adapt to the continually changing environment.

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