Private medical practice remains the model of health care delivery, but in many communities it faces new competition. As in the 1990s, integrated health care delivery systems (IDSs) and hospitals are buying medical practices to create communitywide care systems. However, today’s IDS leaders are more selective in hiring private-practice physicians and giving them incentives to perform.

Now it’s the physicians who tend to initiate hospital integration discussions. Why do medical groups want to join an IDS? Seven areas of performance can help you and your physician leaders judge the need to improve financial, operational and governance systems in your practice.

**Governance**
The old saying, “Ten docs, 10 sets of rules,” prevails in many medical practices. These groups’ physician owners refuse to empower their employees, view every compromise as a sacrifice of their individuality and recoil from unified systems or protocols. The result is a continuous state of crisis management. Governance degenerates into a struggle for physician buy-in for the simplest decisions. Leaders never make important decisions about where the practice should go.

Integrated practice, on the other hand, provides a structure for governance. Successful hospital-owned groups place elected physicians on a management committee. Smart system leaders listen to the physicians. The physicians understand that they are consulted as employees — rather than as co-owners. Decisions are made for the good of the whole.

**Management decision-making**
The pressures of today’s tight revenue picture mean that decisions made hastily or without broad support can backfire. This is especially evident when a practice has laid out large sums of capital, as when starting a new ancillary department. A group with poor governance can quickly fall apart if the venture runs deeply into red ink. The project’s naysayers may seek to flee the organization. Inadequate corporate documents only exacerbate the situation.

*continued on page 2*
Hospital systems have deep pockets, extensive business resources and broad investment experience. They’re adept at integrating ancillaries into their operations. Medical groups with underperforming ancillaries tend to look for a hospital partner to bail them out. But why would a hospital want to get involved with a fractious collection of individualists? Hospital leaders might figure they’re better off starting their own ancillary service and recruiting employed physicians to run it.

**Ownership cost**

Most physician-owned groups must recruit new doctors to remain viable. Unfortunately, many have set the cost of admission too high. Those that still base practice buy-in amounts on accounts receivable, appraised equipment value and related real estate ventures may find few takers. Similarly, the financial demands of funding physicians who want to leave, particularly when several depart in a short period, can overwhelm cash flow. These demands, often based on a buy-in agreement forged decades earlier, can even cause a group to collapse.

Such problems don’t exist in an IDS. The system owns the practice and provides the facility and the resources. Physicians develop an ownership attitude, but it tends to focus on steering their collective futures, not on guarding their retirement accounts and golden parachutes.

**Risk**

It takes capital to develop a medical practice. Physicians must contribute capital themselves or borrow it, or both. Some can’t bear to do either. Physicians employed by an IDS do not have to make investments. They can capitalize practice development, but they must understand long-term commitment, forge legal documents to support their agreement and guide their practice as a financially sound business.

**Practice profitability**

Private practices today experience severe margin pressures. Revenue after paying the staff, rent, insurance and so on may be insufficient to compensate physicians at market rates. This is particularly true when the group’s payer mix leans heavily to government-supported insurance, such as Medicare or Medicaid.

In contrast, hospital systems depend on physician retention, so they compensate doctors at market rates. This may prevent some owned practices from turning a profit, but it keeps the network together.
Practice culture
Success, opportunity and effective governance depend on a medical group’s culture. As an owner in a private practice, each physician has a say in determining its future, or at least his or her percentage of that future. This can lead to a “me first” attitude or the creation of special-interest groups that can eventually destroy an organization. In-fighting can also injure a group’s service orientation and reputation, and create problems with corporate and practice compliance.

Under an IDS, group culture is guided by the larger organization. The physicians are professional employees of the IDS — they either accept this notion or leave. An effective IDS must be physician-friendly, but ultimately it must exercise its power to act for its own interests and for the interests of the community it serves.

Practice size
Large medical groups have both market clout and financial strength.

Clout translates to brand acceptance, established patients and a referral base. It also helps them get favorable contracts with payers.

When big health care systems, either physician-led or IDS-owned, exercise control, size means the ability to optimize services. Smaller practices must worry about becoming marginal players.

Effective governance, culture keys to keeping a practice strong
As seen in these seven areas of performance, if a physician group does not develop a viable governance system supported by a reasonable physician culture, it may fail or, perhaps worse, struggle along with marginal performance.

The good news is that there is an alternative between withering away or joining an IDS. This middle road requires physicians to:

• Examine their roles in the community;
• Agree on a common vision of their practice; and
• Follow a strategic process to examine problems and alternatives.

Affiliating with an IDS is attractive to physicians who question the benefits of private practice. However, they should consider compensation, benefits, productivity requirements, record keeping, governance and financial reporting. They and the group’s administrator might consider a “prenuptial” agreement to detail what happens if things don’t work out.

Planning must also address practice dissolution, including ongoing obligations, responsibility for former employees, asset distribution and responsibility for carrying on the business.
Medical group practices are learning that temporary help can be a welcome and creative addition to the management team. When an administrator or other top-level executive resigns, an interim administrator can remove the pressure to find a quick replacement.

Why would a medical group ask an outsider to tend to its affairs after a top administrator leaves? Physician leaders know it can take months to find the right replacement. An interim administrator can keep the practice on course during that time. These seasoned professionals can do more than babysit a practice; they can look at how management and other structures may need to change and help create a game plan for the permanent administrator.

An interim administrator also can be the extra “pair of hands” that a practice might need to implement a new information system, clean up accounts or tackle other large projects.

The best fit
Key attributes of effective interim administrators include:
• A proven track record;
• Long-term experience in medical practice management; and
• A willingness to seek new challenges.

In a typical arrangement, the medical group practice supplies temporary housing, meal allowance and reimbursement for traveling back home every other weekend.

Salary will depend on the administrator’s experience. It may be higher on a monthly basis than what the permanent administrator will be paid. In the long run, the interim administrator can save money for a medical group by keeping its staff focused and its projects on track while leaders carefully recruit and vet the permanent replacement.

Fast start-up
My colleague in the MGMA Health Care Consulting Group, Nick Fabrizio, PhD, FACMPE, a principal, notes that the honeymoon period isn’t long for an interim administrator.

Within days of arriving, the interim administrator should take the pulse of the organization by meeting with key physicians and staff, he says.

“You have to be, by nature, a person who can hit the ground running and quickly determine the competencies and gaps of the organization and its staff,” Fabrizio says.

He also suggests that at the beginning of the engagement the practice’s top leaders list the outcomes they would like to see during the interim assignment.

“It’s good to make sure before the engagement starts that everyone has realistic expectations of what can and cannot be done in the short term,” he says. “Implementing a new practice management system in six months is one thing; thinking you will be able to change the compensation system in just 30 days is not realistic.”

Experienced help
Taking on new responsibilities and learning the culture of a new organization on the fast track seems daunting, but Jim Fajkus, FACMPE, says being a temporary has its advantages.

“You don’t feel the same amount of pressure because you know you’re not going to be there forever,” he says. “I look at it as a new adventure and a new way to help people.”

Fajkus resigned from his post as chief executive officer at a large multispecialty practice in Texas after an ownership change. He is one of a select but growing number of seasoned medical practice executives working with the MGMA Health Care Consulting Group to provide a sort of administrative locum tenens service to medical practices that need creative and skilled leadership for the short term.

If your group is in need of an interim practice administrator, please call the MGMA Health Care Consulting Group, toll-free 877.275.6462, ext. 1877, or e-mail consulting@mgma.com.
Orthopaedic Practice Management, March 2008

Coding Spotlight: Use the right codes for these confusing cases

Various CPT* coding rules, complex anatomy and frequent changes to codes and definitions often confuse coders in orthopaedics, says Cynthia L. Dunn, RN, FACMPE, Cocoa Beach, Fla.-based senior consultant for the MGMA Health Care Consulting Group. She gives these examples that can stymie coding staff, and offers the correct codes for each.

- Using code pairs
- Use proper terminology for the distinct regions of the shoulder
- Sorting out shoulder surgery codes

*Current procedural terminology

Unique Opportunities, March/April 2008

By Judy Capko

Reality Check for Joining a Group

Staff’s actions and opinions can tell you a lot about a practice you are considering joining. “Talk to support staff,” suggests Rosemarie Nelson, MS, an MGMA consultant in Syracuse, N.Y. They are at the heart of the practice, working in the trenches every day. What they know or don’t know about the practice’s plans to add another physician will also tell you a lot about how the practice communicates.

Conversations with referring physicians can also be helpful in forming your final opinion about a practice opportunity. “Engage folks in conversations about reliability, dependability and follow-through,” advises Nelson. Finances are a big consideration, including what and how you will be paid, productivity expectations and how a bonus is calculated.

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