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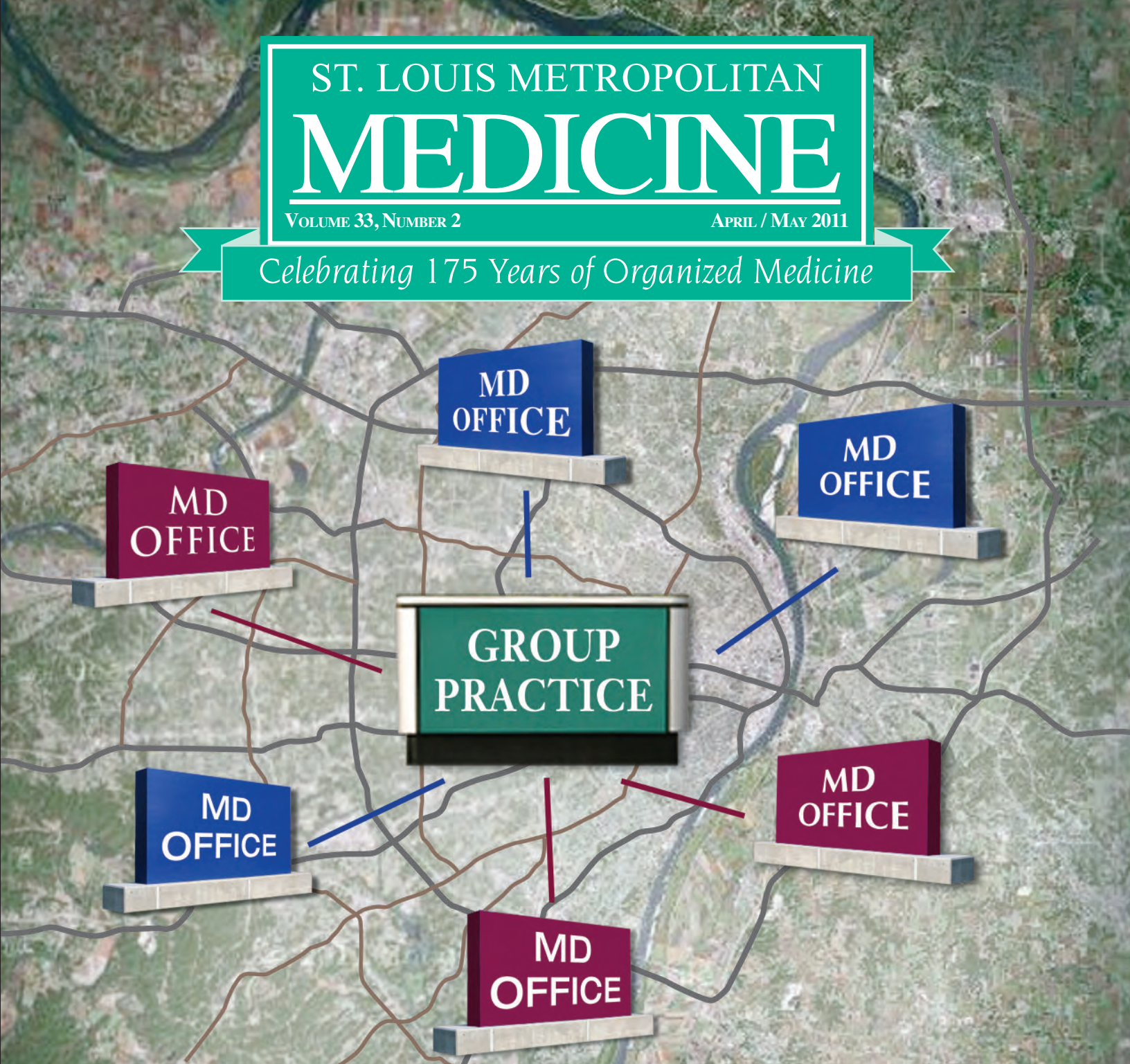

Physicians seek economies of scale in large practices...page 14

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Volume 33
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Cover Feature – Large Practices

Features

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Have you installed an EHR system?

In the next issue of *St. Louis Metropolitan Medicine*, we will profile practices that have installed electronic health records systems and share their experiences. If you have installed a system, please let us know! Please contact Jim Braibish, (314) 835-9883 or e-mail editor@slmms.org.

Super-Sized Medicine

Medical Society President
Thomas A. Applewhite, MD

> People may not remember the advice you give them; but, they will remember the way you made them feel. Medicine has always been, and should remain, a service-oriented profession.

Everyone knows that Wal-mart has changed the face of America. Mom and Pop stores and town squares all across the country have been replaced by the super-center. Banks and other independent businesses have been gobbled up by larger competitors with regional and sometimes national presence. The prices may be better at the superstores; but, what about the experience? How do they make you feel?

In this issue of *St. Louis Metropolitan Medicine*, we explore the similar phenomenon of ever larger medical groups, which are increasingly common in medical practice. Single and multiple specialty groups of sizes unheard of 20 years ago are now commonplace. The growth of medical practices has paralleled the increased size of hospitals and hospital systems and may be a reaction to them.

The advantages of large practices are political and economic. In order to preserve physician autonomy, many practices have merged and grown to avoid being bought out or pushed aside by larger competitors with more resources. Larger size allows practices to control a larger patient base; and, consequently, have more influence with hospital administrations and within their medical staffs. Size allows private practices a chance to be players in the national health care process when accountable care organizations form.

Larger groups have the resources to commit to the political process. Many such groups are influential in state and local politics. The recent tort reform initiative is an example where physician groups were key to influencing elections and, ultimately, supporting new legislation. Collectively, these practice groups can contribute more money and allow their leaders the time away from clinical work to be involved in the political process.

Economically, there are advantages to a larger scale of practice. Benefit packages such as insurance and retirement plans are easier and cheaper to negotiate for several dozen physicians, compared to a few individuals. Billing costs, office supplies and allied health staff can be shared with consequent reduction in cost to the individual physician. Large practices can afford subspecialty expertise, giving them a competitive advantage. Electronic medical records become more affordable if the cost is spread over more participants.

These are the advantages of super-sized medicine. Fundamentally, however, do these advantages threaten the personal touch that characterizes a service-oriented industry? In my opinion, at least potentially, they do.

Physicians may risk losing the very autonomy they are trying to preserve, to their corporate entity, rather than to the hospital. Rules and policies proposed by colleagues may vex an independent-minded partner. Some may work harder or longer than others, leading to feelings of inequity and, possibly, to production quotas.

Finally, care has to be taken for the independent physician not to fall into the practice of "factory medicine." The doctor-patient relationship should still be between one patient and one physician at a time. People may not remember the advice you give them; but, they will remember the way you made them feel. Medicine has always been, and should remain, a service-oriented profession. This privilege is what we should seek to preserve.

2011 Marks the Medical Society's 175th Anniversary

SLMMS is the oldest medical society west of the Mississippi

Executive Vice President
Thomas A. Watters, CAE

> "The stature of our group, since its early beginnings, has been unassailable. There was a time when membership in the Society was considered an absolute essential for any credible physician in the area."

In many ways, 1836 was not an extraordinary year. There were a few notable exceptions. Charles Darwin returned home to England after a five-year journey on the HMS Beagle, changing the future course of science. Samuel Colt manufactured the first pistol, but not quite in time to save Dave Crockett, who had arrived in Texas just in time to be killed at the Alamo. Congress formed the Territory of Wisconsin, Arkansas became the 25th state, Martin Van Buren was elected as our eighth president and Sam Houston was inaugurated as the first president of the Republic of Texas. But most significantly, at least from my biased perspective, the St. Louis Medical Society was born on January 7, "at early candlelight" as the original minutes report.

This year, we celebrate our 175th anniversary. We are the oldest medical society west of the Mississippi, and predate both the Missouri State Medical Association and the AMA. Remarkably, our history has been unscarred by a great civil war, two world wars, a worldwide economic depression, or any other of a host of hard times. We have operated continuously and tenaciously with only one major change in our structure. In 1979 the St. Louis Medical Society merged with the St. Louis County Medical Society to become the St. Louis Metropolitan Medical Society, and we function in that manner still today.

This is not to say there have not been trials and tribulations. Early minutes indicate that some meetings were adjourned "because (the) hall was too cold." Without a building or even an office, meetings in our early years were migratory and held wherever practical. The first president of the Society was Bernard G. Farrar, MD, recognized at the time as the most outstanding leader of medicine in St. Louis. A review of ancient rosters reads like a "Who's Who in St. Louis Medicine." The stature of our group, since its early beginnings, has been unassailable. There was a time when membership in the Society was considered an absolute essential for any credible physician in the area. No physician even considered not joining … if his credentials were good enough.

Early histories refer to the medical library of the Society as being "one of the best in the country, containing more than 30,000 volumes. The most valued part of that library is still intact today, and is on loan to the Bernard Becker Library at Washington University School of Medicine.

Through the years, the Society has had several locations, but most longtime members associate our old building at 3839 Lindell Blvd. as our original home. But in 2005 the building was sold and the Society moved to new offices in Creve Coeur, following the migration of most of its members to West County and its collection of new hospitals. The library, which at one time was an important part of St. Louis medicine, had paled in importance with the growth of the large and well-funded libraries of local medical schools.

A great deal of history was lost with the old building, and only a few select antiquities were retained. The new offices only had room for a few antique pieces of furniture and art pieces. And although we gave up the library we had maintained through so many years, we held onto the

best of it. We retained ownership of our rare book collections, namely, the Paracelsus Collection, the James Moore Ball Collection, and the Americana Collection. These are on long-term loan and can be viewed in the rare book archives at the Bernard Becker Library at WUSM. They are well-preserved and the subject of great research by scholars from all over the world.

This year, as we celebrate our 175th anniversary, we will make an effort through the journal to focus our attention on various facets of our history and the impact the Society has made on the St. Louis community through the years. SLMMS has a proud tradition of prestige and service, and it is important that we don't move forward so quickly that we forget our valuable heritage. In our next issue, you can look forward to a short history and update on our rare book collections – not only an important part of our cultural heritage but a significant financial asset for our Society as well.

What is Your Practice Worth in Today's ACO Marketplace? A Practice Valuation Will Tell You

Use assets, expected income and market analysis to arrive at value

By Kevin P. Summers, JD, CPA/ABV/CFF, ASA, CVA, CDFA, and Jerrie K. Weith, FHFMA, Anders Minkler & Diehl LLP

Kevin P. Summers

Jerrie K. Weith

Integration is the hottest buzzword in health care today. Large medical groups, independent hospitals and integrated health systems are all developing strategies to survive and excel in the future accountable care organization (ACO) world. And the ACO world is not possible without some form of physician integration – affiliation or employment.

If you are the owner of a physician practice and haven't been approached by a suitor yet, you will be! When that occurs, your suitor will most likely be conducting a "practice valuation."

What is a Practice Valuation?

A practice valuation is simply an independent financial assessment of the fair market value of your practice. To properly conduct a practice valuation, several documents may be requested, such as:

- Financial statements and tax returns for the last five years
- Charges, collections and adjustments for the last five years
- Aged accounts receivable summary as of the valuation date, aged current, 30 days, 60 days, 90 days and over 120 days
- Current listing of supply and drug inventories
- Current fixed asset report, including description, date purchased and original cost
- Current appraisals of fixed assets and real estate owned by the practice
- Accounts payable listing as of the valuation date
- Current fee schedule
- Compensation report by physician for the last five years
- Production report by physician and by CPT code for the last year
- Curriculum vitae for each physician

As you can see, you will be asked to provide highly sensitive documents. Even if you feel you know your potential suitor, approach this as a business decision. At a minimum:

- Request a confidentiality agreement or a non-disclosure agreement.
- Be prepared with your own list of questions important to your decision, including the entity's strategic plan and financial position regarding its employed physicians.
- Come to terms on a timeframe within which you expect negotiations to be completed and an offer to be made.

Fair Market Value

How is the fair market value of a practice determined? The three generally accepted approaches to valuation are as follows:

- Cost (or Asset) Approach
- Income Approach
- Market Approach

Cost (or Asset) Approach. The Cost Approach, sometimes referred to as the asset approach, is a balance sheet-based approach that analyzes the net asset value of the practice as of the valuation date. The net asset value of the practice is determined by subtracting the practice's liabilities from the fair market value of the practice's assets. The resulting value is deemed the fair market value of the equity of the practice on a 100% controlling interest basis. This method is appropriate for a practice that has little or no intangible asset value. Additionally, this method would be appropriate if the practice was:

- A start-up practice
- A practice with no history of earnings
- One considering liquidation

Income Approach. Under the Income Approach, the value of the practice is obtained through an analysis of the present value of the expected future financial benefits a practice will provide to its owners utilizing a discount factor that reflects the risks associated with obtaining those benefits. In general terms, the application of the income approach utilizes two critical inputs:

- An estimate of an ongoing, sustainable economic benefit stream
- An investor's required rate of return associated with the perceived risk of realizing that benefit stream. Ultimately this relationship can be expressed as:

$$\text{Value} = \frac{\text{Economic Benefit Stream}}{\text{Rate of Return}}$$

The income approach is one of the more financially sophisticated approaches, dealing with concepts such as capitalized cash flow (CCF) and discounted cash flow (DCF). But the essence of the approach is for the potential buyer to estimate the expected revenue stream if the buyer chooses to make this investment. Your valuation analyst can better explain the intricacies of this approach.

Market Approach. The Market Approach measures the value of the practice by comparing the practice to actual transaction data for similar practices. The direct company transaction method is based on the assumption that historical sales of controlling interests in similar practices provides useful benchmark multiples. This method can be implemented by identifying transactions where similar practices have been acquired and by analyzing:

- The size, financial and operating characteristics of the acquired company
- Its market and services
- The characteristics of the acquisition transaction.

The valuation analyst can obtain comparable market data by searching various transaction databases, such as Pratt's Stats.

When performing a practice valuation, the valuation analyst should consider all three approaches. If one or more of the approaches is not used, the valuation analyst should document the reasons why not all three were used.

Which Valuation Approach is Right for Your Practice?

Like most things in life… it depends. What is the purpose of the practice valuation? Does the practice have intangible value? Does the practice have a history of earnings? Have there been transactions of similar practices in the marketplace and is that data available for review? The valuation analyst will consider all of these questions, and more, in determining the approaches to utilize in valuing your practice.

In future articles, we will discuss each of the valuation approaches more in depth and provide specific issues that must be considered when valuing a medical practice.

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Payer Mix Impacts Revenue

Which payers reimburse at higher rates? Which require more staff time? Analyze payer results to help protect practice profitability

By Karen S. Schechter
Stone Carlie & Company, LLC

Karen S. Schechter

In their search for ways to increase revenue, providers often overlook the impact of their payer mix; i.e., the percentage of their charges and associated revenues that are represented by specific payers. Payer mix impacts operations, as well as revenue, and therefore, must be analyzed from several aspects, including but not limited to reimbursement, productivity, profitability and the employer presence. Once this analysis is complete, the next step is to develop and implement a strategy that will provide the practice with the opportunity to make the most profit.

The first step is to identify the practice's payer mix based on charges per payer for the past 12 – 18 months. Only look at payers that represent 80% of the practice's charges. Typically, this amount is represented by less than 10 payers.

Reimbursement

Reimbursement analysis may be performed several ways at several different levels. Once the top payers (by charges) are identified, the next step is to compare the payments from those payers, along with the percent of the total accounts receivable they represent.

Payer	% of Total Chgs	% of Total Pmts	% of AR
Medicare	35%	31%	40%
Payer A	20%	15%	20%
Payer B	12%	14%	25%
Payer C	8%	10%	12%

The preceding table provides a high-level look at the results of the efforts the practice is expending for patients from each payer group. In this example, Payer A comprises 20% of the charges, yet only 15% of the payments. Twenty percent of the accounts receivable comes from Payer A. This could indicate that Payer A is a slower payer than the other non-Medicare payers. This information should lead the analyst to the next step.

The next step is to perform the same analysis by CPT code for the top payers. The same method should be used: look at the CPT codes that generate 80% of the total charges for the practice over a period of time. Again, this should probably represent about 10 codes. If possible, use a report that matches payments one to one with charges; i.e., the payment reflects the actual amount paid on a specific charge, rather than a general figure of total charges for a period compared to total payments.

Productivity

Productivity is measured by the number of patients the provider sees and the associated services/charges. Generally speaking, the more patients seen, the more revenue is generated. However, the type of services provided also affects revenue. Therefore, it is important to review the physician's appointment schedule to identify ways to maximize revenue. To do this, look at the number of patients the physician sees each day. Divide this total by the number of hours worked each day. For example, if a physician sees an average of 28 patients a day and works an average of six hours a day (at the office), then the average number of patients seen per hour is 4.7. This represents 12.8 minutes per visit. Determine if the entire 12.8 minutes are spent on direct patient care, or on other administrative or ancillary tasks.

Next, look at the average visit time by payer to determine if certain payers have patients that take a longer time (most likely the older patients). The key is to maximize productive time – which may lead to establishing a schedule that balances patients by type of visit and payer, as well as making better use of clinical staff and technology to support the effort.

Profitability

In this article, profitability is being defined as revenue minus the billing cost. There are other costs to consider such as the expenses associated with clinical staff and supplies and medications. Typically, these costs are incorporated into the fee schedule.

The costs associated with billing and collections include more than the billers' salaries/benefits and the direct cost of the billing process. They may include:

- Front desk and billing/collection time and supplies
- Hardware/software
- Office space/equipment
- Telephones
- Other

It is important to note that these costs may vary tremendously by payer. It's often the "soft costs" associated with billing charges and processing a claim that impact the profitability of a specific payer. These may include:

- Transparency of and adherence to published fee schedules
- Denial rate
- Payment turnaround time
- Hassle factors: user-friendliness of insurance cards, ability to easily access information on the web, accessibility and knowledge of staff, number of reviews, response to appeals, referral/authorization process

A better indicator of the profitability of a payer may be seen by having the billing and collection staff track the amount of time spent dealing with any of the preceding issues. For example, one payer may pay 15% more than another payer does for the same CPT codes. However, the first payer may also have a higher denial rate, which means more time spent by the billers trying to collect on the money that is due to the practice. When this cost (or others) is subtracted from the profit of the first payer, it is possible that the second payer (that reimburses at a lower rate) may be more profitable than the first one.

Employer Presence/Patient Population

It is important to look at the demographics of the community. Are there large employers who contract with a particular payer? Even if the payer is not as profitable as others, it may not be prudent to stop participating in it. The challenge is that employers today tend to change payers more frequently than they did in the past. Therefore, keeping up with these changes may not be cost-effective. There are other community-based concerns that may enter your decision to change your payer mix.

Generally speaking, managing payer mix is an acceptable practice. This may be done primarily through scheduling and strategic networking with referral sources that participate in the most profitable payer plans. Tactics may include limiting the number of new patient appointment slots available for patients from a particular payer so its contribution to the payer mix will decrease. Another option is to increase the time intervals between patient appointments for those payers that are less profitable. For example, some practices may only allocate a few appointments a week for patients from less profitable plans. However, prior to implementing a new scheduling policy, it is important to review your managed care contracts to make sure that the practice is in compliance.

Networking with other providers who may refer patients in the more desirable plans is another important strategy. This may be accomplished informally, or by developing formal strategic alliances with other providers (including hospitals) and payers.

In conclusion, it is important for providers to be aware of their practice's payer mix. The appropriate payer mix can have a positive impact on the practice's profitability. However, doing so requires analysis and thoughtful consideration.

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Economies

Large multi-specialty practices grow as physicians face rising costs and flat or declining reimbursements

By Jim Braibish, Associate Editor
St. Louis Metropolitan Medicine

As physicians face complications of managed care, challenges in Medicare and rising practice costs such as electronic health records systems, some are turning to the economies of scale afforded by larger practices.

Large multi-specialty groups such as Esse Health, Patients First Health Care and Signature Medical Group have grown substantially in recent years and are poised for further growth. They offer a physician-owned alternative to joining a hospital system.

Jan Vest, CEO

Signature Medical Group

Signature Medical Group was founded in 2001 when physicians at Mid-County Orthopaedic Surgery & Sports Medicine and Premier Care Orthopedics joined to form the largest orthopedic physician group in the St. Louis area. Today, Signature has more than 80 physicians in 17 practices at 24 offices in St. Louis, St. Charles and Jefferson counties and Bolivar in southwest Missouri. Besides orthopedics and pediatric orthopedics, specialties covered include women's health, gastroenterology, allergy and immunology, dermatology, nutrition and imaging.

Signature is adding 12 more physicians in the next few months, and is looking to grow elsewhere in Missouri outside of St. Louis, said CEO Jan Vest.

Unlike Esse Health and Patients First, the practices in Signature retain their individual names and branding, such as The Healthcare Group for Women, Genesis OB/GYN and Gateway Gastroenterology. All are sub-branded as "A Division of Signature Medical Group."

"We believe that patients go to doctors, not to a corporate name," Mr. Vest said. "This enables us to interface on a local basis with each of our communities where we are located."

Physicians are shareholders and employees of Signature, which owns the practice and is named on all insurance contracts, Mr. Vest said. All offices are on the same information system, and the accounting process is centralized through a CFO and controller who oversee practice finances.

Other aspects of operation such as workflow process are left to the individual practice. "It's proven that people who are in charge of their workflow are more productive. We encourage local autonomy," Mr. Vest said.

"Our premise is that the physician-patient relationship is the most important thing as far as getting people well and keeping them well."

> "Our premise is that the physician-patient relationship is the most important thing as far as getting people well and keeping them well."

# of Scale

Patients First Health Care

Patients First Health Care was started in Washington, Mo., in 1998 when two primary-care practices merged to become an 11-physician group. Patients First now has 83 physicians at 21 locations. The group's footprint runs from St. Louis to as far west as Hermann and Cuba, spanning five east-central Missouri counties. They made a significant expansion into St. Louis County when the eight-physician Kirkwood Medical Group became part of Patients First on January 1. Patients First also has a four-physician office in Creve Coeur and a four-physician office in Eureka which also has an urgent-care center.

The group's 21 specialties range from internal medicine to allergy and immunology, to cardiovascular, dermatology, gastroenterology, general surgery, gynecology, hematology, plastic/reconstructive surgery, radiology, urology and more. Michael Rau, MD, of Washington is chairman of the board.

Patients First's headquarters and largest patient-care facility is a 194,000-square-foot building in Washington on Highway 47. The facility includes an outpatient surgery center as well as a cancer center, a diabetes and nutrition center, a heart and vascular center and a sleep center. In addition, the company is constructing a three-bed community hospital onsite to house overnight patients with anticipated opening this summer.

Patients First's office building and outpatient center in Washington, Mo.

Patients First is a physician-owned, physician-led organization, said Joseph Gubbels, CEO. "We operate as a group practice model whereby each doctor is assigned to a division which determines each doctor's compensation. There are two categories of physicians – employees and members. Employed physicians can be considered for membership if they have met predetermined criteria. Member physicians 'buy-in' to the company."

While such functions as IT, maintenance, accounting, marketing and human resources are centralized, much autonomy is left to the individual offices or "divisions," Mr. Gubbels said.

"What has made Patients First successful is the ability to retain, at the central level, the necessary decision making power but allowing doctors within certain required protocols to practice medicine in the manner they deem appropriate. Each division operates autonomously. The divisions are responsible for developing their own internal operating procedures which includes a compensation formula, overhead allocation, etc."

Based on current discussions, Patients First expects to grow to 95 physicians by the end of 2011, he said. "It is our belief that to be effective going forward the group will need to grow to 150 to 200 physicians. The company structure is in place to support such growth."

(*continued on page* 16)

Joseph Gubbels, CEO

PATIENTS FIRST HEALTH CARE

Websites

Signature Medical Group
www.signaturehealth.net

Patients First Health Care
www.patientsfirsthc.com

Esse Health
www.essehealth.com

Economies of Scale *(continued)*

Esse Health

Michael Castellano, CEO

In 1996, Esse Health was formed by the joining of Health Key Medical Group, which had been in operation for more than 20 years, and Beacon Health Care which started in 1994. The two groups shared the belief that an organized group of physicians could have a positive impact on the management and delivery of health care.

Today, Esse Health has more than 75 physicians at 28 locations in St. Louis city and county, St. Charles County and the Metro East. Unlike the other large groups, Esse Health focuses on primary care with physicians in internal medicine, family medicine, allergy and immunology, pediatrics and radiology. Each office is branded with the Esse Health name.

The corporate model of Esse Health is similar in that physicians own an equal share of the company, said Michael Castellano, CEO. The company handles insurance contracts, billing and collections. The main office also has a quality department that unifies clinical care and provides consistent quality metrics across the system, he added.

However, each office has its own manager and hiring decisions are made at the local-office level.

"We don't interfere with local office management," he said. "It goes back to our philosophy of being a physician-run group. We also don't have a lot of layers of management so we can protect independence at the practice level."

Esse Health hopes to recruit 10 physicians a year, with some of those replacing losses due to retirement. In seeking new partners, Esse Health looks for physicians who share common values. "Our mission statement states that we put the patient and physician at the center of health-care decisions. We try to get the patient to be accountable for his or her care. It takes time for a physician to practice that way – it's not for everyone."

Balancing Economies of Scale With Local Autonomy

Mr. Castellano says the large practice "offers the best of both worlds. Our physicians have the autonomy of a solo practice and the benefits of scale of the larger practice."

Mr. Vest of Signature said, "We believe the private practice of medicine is the most important structure that will provide leadership to reducing cost and improving quality as we move forward."

As a large practice, he said they can offer a lower per-unit cost while also developing systems of care that can help attract patients.

At Patients First, Mr. Gubbels said, "As a multi-specialty group, our physicians have control over what happens within their practice. And as an owner, they have a voice in their destiny. They enjoy the advantage of having electronic medical records at their fingertips, access to specialists as needed and the ability to provide diagnostic testing – all under one roof. Our St. Louis physicians in Creve Coeur and Sunset Hills are prime examples of many solo or small practices out there. They want to maintain some independence, they like our practice model and they benefit from the processes we have in place."

Weighing the Advantages

Financial uncertainty is a major driving force in physicians joining larger physician-owned practices or hospital-based practices, say area health-care consultants.

"Revenue streams are controlled by government payers and a managed care-dominated marketplace. They are flat, and in some specialties decreasing annually, while expenses are increasing," said Jerrie Weith, FHFMA, director of health care services for Anders Minkler & Diehl LLP. "Compensation becomes more stabilized when the physician is employed."

The $30,000-$50,000 cost of electronic health record technology is a challenge, she added. "It's hard to justify the return on investment, even if the doctor will qualify for the stimulus money paid out over a few years."

Overall, physicians seek economies of scale, better employee benefit programs for staff and themselves, less administrative hassle and income security, said Karen Schechter, director of health care services and practice management solutions for Stone Carlie & Company, LLC.

"There are so many 'unknowns' in the today's health-care industry. Some physicians may be willing to give up their autonomy and let someone else guide them along," she said.

In deciding what route to take, physicians should make a thorough, objective evaluation of their options, Ms. Weith said. "Don't make a decision out of fear."

Ms. Schechter added, "Not all physicians are made to work for larger practices and/or hospitals. I think there is still a place for smaller private practices. However, their ability to succeed will depend on their ability to keep their fingers on the pulse of their practices, respond quickly to changes associated with health care reform and to align themselves with other practices, ancillary service providers and hospitals in order to provide quality patient care and be reimbursed accordingly."