ASSESSING PRIVATE PRACTICE OPPORTUNITIES: AN INTRODUCTION FOR NEW PHYSICIANS

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Some physicians entering practice for the first time may choose to "go solo," but a growing number are opting to join a medical group. According to an American Medical Association (AMA) survey, choice of practice setting has changed significantly over the past 30 years, with 3 times as many physicians in medical group practice in 1996 (32%) compared with 1965 (11%) [1]. In a more recent AMA survey, 49% of non–federally employed physicians reported being in a medical group practice setting [2].

Limited information is available regarding the specific practice choices of physicians entering the workforce, but the trend to join a group practice appears to be strengthening. The AMA's 1996 resident survey indicated that a majority of new physicians entered private practice that year, most of whom joined a medical group practice. Of the 7628 respondents to the survey, 67.3% reported finding clinical practice positions in their specialty or subspecialty, 15.5% found academic positions, 5.0% found clinical positions in other specialties, and the remainder had "other plans" or were still looking for employment; of those who entered clinical practice, 72.2% joined a medical group and 8.4% joined a staff model health maintenance organization (HMO) [3]. In another survey of physicians who completed an internal medicine–pediatrics residency between 1986 and 1995, 90% of the 1005 respondents indicated that they were in a group practice, compared with only 10% who reported being in solo practice [4]. Finally, in a 1999 survey of 300 primary care residency graduates, most indicated a clear preference to be in a single- or multispecialty group practice setting over other practice options (Table 1).

Residents currently preparing to enter the job market have probably heard that the "real world" of clinical practice is full of predatory malpractice lawyers, threatening government agencies, all powerful health insurance companies, and financially struggling physicians. The grim economic news is particularly troubling, given the state of debt in which many physicians find themselves at the completion of training. Many newspapers report that physician groups are going bankrupt and cite "inadequate reimbursement rates," "excessive utilization," and "internal conflicts" among the reasons for the financial failure. New physicians can, however, prevent similar problems from developing in the practice settings they select. Although it is unlikely that new physicians can avoid contact with or have a major impact on the legal, regulatory, and insurance worlds, there is no reason why they should not be financially successful.

Avoiding financial disappointment in private practice begins with making an informed choice about the specific setting in which one will practice. This requires an understanding of the defining features of various practice types and an appreciation for how practice settings compare. It is also important to assess specific factors that have been found to impact the financial success of medical practices, such as leadership, governance, financial control, and office management.

Consider the following scenario in which 2 residents are about to enter private practice:

> Dr. Connor and Dr. Rhodes, both in their final year of residency at University Medical Center, decided to join medical group practices after completing their training. Both considered other options, such as solo practice, government organizations (eg, the Armed Services, the Indian Health Service), research, and teaching; like many other residents at University, however, they chose medical group practice.
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> Common factors led to this decision by both physicians. Both have more than $150,000 in education-related debt, and both were convinced that they would earn substantially higher incomes in a group or solo practice than they would in any of the other available options. Solo practice was ruled out after the physicians heard of the many complex issues faced in practice today; both physicians were concerned about dealing with these issues alone. In addition, neither wanted to work the long hours that they perceived

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Table 1. Residents' Self-Reported Preferences for Practice Setting

Solo practice	4%
Partnership	15%
Association	2%
Health maintenance organization	1%
Hospital employee	8%
Single specialty group	31%
Multispecialty group	25%
Outpatient clinic	8%
Other or no preference	6%

NOTE. Results of a 1999 survey of 300 residents entering primary care. (Adapted from Summary report: 1999 survey of final-year medical residents. Irving [TX]: Merritt, Hawkins & Associates; 1999.)

would be required by solo practice. Thus, medical group practice seemed to be the best option.

Upon completion of internal medicine training, Dr. Connor joins Community Medicine, a small medical group practice founded in 1978 by 2 of the 6 current members, Dr. Ewing and Dr. Lynch. Community Medicine is a busy urban internal medicine practice with a single location. It belongs to the local physician hospital organization (PHO), Community Hospital PHO, which also includes 3 other small medical group practices, 50 solo practitioners, and Community General Hospital. Community Hospital PHO has a major contract with Community HMO.

Community Medicine offers Dr. Connor a 1-year employment agreement with the following terms:

- $120,000 annual base salary
- A bonus to consist of 40% of annual billings above $120,000
- A profit-sharing program providing her with a 5% share of the group's overall profits
- A leased luxury automobile

Dr. Connor is pleased with the terms and also with the news that Community HMO has agreed to pay 20% higher fees to the practice in the coming year.

Upon completion of general surgery training, Dr. Rhodes joins Metro Clinic, a large multispecialty group practice with more than 100 physicians and 10 office locations. Metro Clinic was established in 1948 as part of Metro Health Plan, a staff model HMO that provided services only to patients who were members of the HMO. In 1996, the Clinic became independent from the HMO and began to provide services to a broad range of patients, including individuals not belonging to the HMO.

Metro Clinic offers Dr. Rhodes a 1-year employment agreement with the following terms:

- $175,000 annual base salary
- A bonus of 25% of annual billings above $180,000, adjusted for withholds and bad debt
- A profit-sharing program providing a share of Metro Clinic's overall profits up to 20% of his base salary
- Free membership in a fitness club

Although Dr. Connor and Dr. Rhodes considered several personal factors when choosing a practice setting, were their choices truly well informed in terms of helping them meet their financial goals? To make an informed choice, what should a physician know about a practice opportunity? This article introduces new physicians to the basic characteristics of solo practice and the most common forms of medical group practices and suggests factors that should be considered when assessing a practice opportunity.

Practice Options

A new physician who has chosen private practice over other options for initial employment has further decisions to make: Start a solo practice? Join a group practice? If the latter, what size and type? Being aware of how these practice options differ is important for making an informed choice. Table 2 compares solo practice and the major types of group practices (small, medium, large) in areas such as ownership, typical method for physician compensation, average income, and average workload [1,2,5,6].

Solo Practice

In a solo practice, one physician provides all the appropriate clinical services required by his or her patients, which fall within the scope of that physician's training and experience. In addition, the solo practitioner is accountable for all management duties required to operate the practice successfully. These duties include, among others, supervising office staff, billing (accounts receivable), paying bills (accounts payable), and ensuring that necessary supplies are available (inventory control). A solo practitioner may hire an office manager or an outside company (referred to as a *practice management service*) to perform these duties. Nonetheless, the physician is solely accountable for ensuring that these and all other duties critical to the running of the practice are accomplished.

Table 2. Important Comparative Features of Different Practice Types

Feature	Solo Practice	Group Practice		
		Small	Medium	Large
No. of physicians	1	3 to 9	10 to 49	≥ 50
Specialty mix				
Single specialty	—	78%	22%	0%
Multispecialty	—	22%	78%	100%
Average pretax income	$150,000	$192,000 to $230,000	$192,000 to $230,000	$192,000 to $230,000
Percentage of revenue from				
Medicaid and Medicare	36%	37%	37%	37%
Managed care*	≥ 50%	≥ 50%	≥ 50%	≥ 50%
Typical compensation method	FFS	FFS	Salary	Salary
Average workload, hr/wk	60	50	50	40
Governance model	None	Partnership	Partnership	Corporation
Percentage of practices owned by physicians	Most	76%	76%	52%

FFS = fee for service. (Data from [1,2,5,6].)

*Refers to all forms of managed care programs, including health maintenance organizations, preferred provider organizations, and point-of-service plans.

Although solo practice has purportedly been growing out of favor, in 1996 approximately 68% of practicing physicians were in solo practice [1]. Physicians considering this practice option should carefully weigh the risks involved. Generally speaking, a new solo practitioner faces an overall higher risk (financial, business, lifestyle) compared with a physician joining an existing group practice. On the financial side, a solo practitioner must borrow money to purchase office equipment and to provide operating capital during the practice's start-up period. Business risk also is involved, as a solo practitioner must make all business decisions associated with running the practice and may have no experience and minimal training in this area. Physicians attempting to set up solo practices in areas of high managed care penetration are at particular risk, because they usually cannot afford to obtain the legal, actuarial, and other consulting services required to properly evaluate managed care contracts and may agree to unfavorable terms. Finally, the financial returns for solo practitioners who "make it" in the business world typically are less than those enjoyed by group practitioners. In 1997, physicians in solo practice earned 32% less after taxes compared with physicians in medical group practice [2]. On the plus side, however, a solo practitioner has much greater control over practice operations than do members of a group practice.

Most solo practitioners own their practices. However, managed care market pressures have led many hospitals to purchase local physician practices under the belief that the action is necessary to maintain the number of admissions and outpatient visits required for the hospital's ongoing financial success. The methods used in these purchases generally result in physicians receiving a "good deal." A typical case would begin with a hospital measuring the net income generated by a practice to establish a purchase price. Net income is determined by calculating the average annual fees collected by the practice over the past several years (referred to as *average annual billings*), subtracting practice expenses, and multiplying by a factor that varies among locations and specialties. In addition, the hospital typically guarantees a minimum income equal to the physician's average income over the previous 2 or 3 years. For example, hospital A offers to purchase physician B's practice for $300,000. This price is based on calculating physician B's average annual billings less expenses ($150,000) and multiplyiing by a factor of 2. Hospital A also guarantees physician B a minimum annual income of $150,000 for the next 5 years. This is a good deal for physician B because the income guarantee lasts several years and is not linked to the actual income produced by the practice after it is sold. This practice-purchase strategy has resulted in financial windfalls for many real-life physicians as well as the recognition by hospitals that the strategy is very costly.

Medical Group Practice

A medical group practice can be simply defined as 2 or more physicians practicing in a setting in which all revenue and expenses associated with the physicians' practices are shared and a single set of financial records is maintained. A more formal definition of medical group practice, developed by the AMA, is as follows: "The provision of health care services by 3 or more physicians who are formally organized as a legal entity governed by physicians, in which business, clinical and administrative facilities, records, and personnel are shared and the practice goals, objectives, and values are commonly defined. Income from medical services provided by the group are treated as receipts of the group and distributed according to some prearranged plan" [1]. The AMA definition is used in much of the available research and survey data on medical group practices.

All medical group practices are not alike. Major points of differentiation are size (number of physicians), physician specialty mix, and network model (ie, the association between the practice and other important organizations such as insurance companies, HMOs, hospitals, and other physician practices).

Small group practice. The AMA defines a small group practice as a medical group practice consisting of 3 to 9 physicians; approximately 87% of group practices in the United States are small [1]. Typically, all physicians in a small group practice are in the same specialty or subspecialty (eg, family practice, internal medicine, cardiology, plastic surgery) [1,2]. An advantage of focusing the practice on 1 clinical specialty area is that all physicians and other staff members (eg, nurses) in the practice typically use the same tests, treatments, and procedures; therefore, the practice may be able to standardize processes and supplies and operate more efficiently.

Medium-sized group practice. These medical group practices are defined by the AMA as practices consisting of 10 to 49 physicians; approximately 12% of medical group practices in the United States fall into this category [1]. Most often the physicians in a medium-sized group practice are in a few different specialties or subspecialties; a common model combines primary care physicians (eg, family practitioners, internists, pediatricians) with the specialists to which they most commonly refer patients (eg, cardiologists, gastroenterologists, general surgeons) [1,2].

Large group practice. Large group practices (ie, practices consisting of 50 or more physicians per AMA definition) account for less than 1% of group practices in the United States [1]. Virtually all large medical group practices are multispecialty, and many are true integrated delivery systems that may own hospitals, ambulatory surgical centers, pharmacies, and other health care facilities and services (eg, nursing homes, home health agencies, ambulance companies). Several large medical group practices were formerly known as staff model HMOs, such as the Kaiser Permanente Medical Groups (CA), FHP International (now merged with Pacificare but originally a large staff model HMO in the Southwest), and Harvard Community Health Plan (MA). Others not having a staff model HMO origin include Mayo Clinic (MN), Ochsner Clinic (LA), Geisinger Medical Group (PA), Lahey Clinic (MA), and Cleveland Clinic (OH). An integrated delivery system has the potential to offer care at the highest level of quality and efficiency because it contains all major elements of the health care system and can mandate processes that minimize treatment errors, omissions, and redundancies.

Joining a group practice offers some risk protection over starting a solo practice. There are no start-up expenses, there is no need to spend time learning how to run the practice, and other group members are helping to bring in revenue. Generally speaking, larger group practices offer a greater degree of financial stability. In addition, a large group practice may represent a significant percentage of the local physicians, giving the group negotiating leverage with managed care companies. For example, if 50% of the physicians in community D belong to group D, any managed care organization planning to do business in community D will most likely have to contract with group D. This gives group D the negotiating leverage to demand higher reimbursement rates or other desired objectives.

Office sharing. Another way that physicians practice together in the same location is through office sharing. In this setting, physicians share only expenses, office space, and office staff; they do not merge practice revenues, share common goals, or adhere to a governance model. Physicians in an office-sharing situation are not bound in the significant ways in which physicians in a medical group practice are connected. In the author's experience, medical group practice promotes the development of standard policies and procedures that typically lead to improvements in overall group function. For example, using a common medical record format makes it easier for office staff to process and review medical records and helps physicians and staff avoid potential documentation errors. The outcome is improved quality because of better documentation and improved efficiency (with reduced costs) because less time is required from office staff.

Table 3. Characteristics of Network Models

Network Type	Control	Mission	Financial Backer
Third party payer IPA	Third party payer	Provide services to third party payer's members	Third party payer
Physician-controlled IPA	Physicians	Ensure business success for physicians	Physicians
Hospital-controlled IPA (PHO)	Hospital control or joint control by hospital and physicians	Ensure business success for hospital and physicians	Usually hospitals

IPA = independent physician association; PHO = physician hospital organization.

Network Models

Networks are contractually defined relationships that exist between individual practitioners or medical group practices and insurance companies, HMOs, and other physicians or practices. In order to gain permission to bill and receive payment directly from an insurance company or HMO, a physician or group must participate in that insurance company's or HMO's network. Networks also provide a variety of services on behalf of the physicians and medical group practices belonging to the network, including contract negotiation, physician credentialling, and discounts on office supplies.

When a physician joins a medical group practice, he or she also joins the network or networks to which the group belongs. Network membership is an important factor to consider when joining a practice. Given the increasing number of people who belong to managed care plans, managed care networks are vital sources of patients for most practices.

A single practice may belong to several networks. For example, it may belong to network A because this permits payment by HMO A for services delivered to patients from HMO A, and it may belong to network B because this permits payment by HMO B for services delivered to patients from HMO B. For most physicians and medical group practices, failure to belong to the appropriate network may forecast future financial problems. For example, HMO B may decide that it will contract with only 1 of the 2 networks in town. If HMO B has a large market share (as is the case with Aetna U.S. Healthcare in some locations), physicians in the network not selected by HMO B may have a reduction in patient volume because they will be unable to bill for services provided to patients belonging to HMO B. No hard and fast rules exist for determining which networks to belong to, but asking the members of a medical group practice to share how they make this determination may uncover management deficiencies. There is reason to be concerned if the group's members cannot demonstrate how they perform this analysis.

The most common types of networks are third party payer–participating physician networks, physician-controlled networks, and hospital-controlled networks (Table 3).

Third Party Payer Networks

Currently, most physician reimbursement for patient services is provided by insurance companies and government programs (eg, Medicare, Medicaid) [2], commonly referred to as *third party payers* (Table 4). Each third party payer has its own network of participating physicians who agree to certain conditions desired by the payer. In return, network physicians can bill for services provided to patients enrolled in the payer's program. These networks are called *participating physician networks* and are developed by the third party payer to accomplish goals desired by that payer, such as controlling costs and ensuring that it has the resources (ie, physicians) to provide covered benefits to patients.

To join such a network, a physician must be credentialled by the third party payer. This process is similar to credentialling performed by hospitals when granting admitting privileges to physicians and requires that the physician meet specific criteria, such as being board certified or eligible for certification and providing certified copies of original documents proving completion of medical school and residency training. Also, a physician typically must agree to certain administrative procedures when joining a third party payer's network, such as accepting payment rates set by the payer as payment in full even though the payer's rates may be less than the physician's usual billing rates.

A physician who does not join a third party payer's network cannot expect to receive payment directly from that payer. The physician may still provide services to a patient enrolled with the payer, but billing and payment

Table 4. Characteristics of Third Party Payers

Payer	Typical Physician Reimbursement	Contract with: Individual Physicians	Contract with: Physician Groups or IPAs	Use Participating Physician Networks
Medicare and Medicaid	Discounted FFS*	Yes	No	Yes
Health insurance companies	Discounted FFS	Yes	No	Yes
HMOs (commercial, Medicare, Medicaid)	Discounted FFS, capitation	Yes	Yes	Yes
Other federal programs (eg, CHAMPUS)	FFS	Yes	No	Yes

CHAMPUS = Civilian Health and Medical Program of the Uniformed Services; FFS = fee for service; HMO = health maintenance organization; IPA = independent physician association.

*Discounted FFS for Medicare and Medicaid takes the form of state and federally mandated fee schedules.

are handled directly between the physician and patient. The patient then attempts to obtain reimbursement from the third party payer but, depending on the payer, may not be eligible for reimbursement. Because patients often delay paying medical bills, this situation can lead to significant cash flow and accounts receivable problems for private practicing physicians. In the case of HMO patients, a physician may encounter further problems getting paid, because the HMO will not reimburse the patient unless the physician belongs to the HMO's network. A physician with a unique skill or reputation might be able to be financially successful without joining third party payer networks, as might be the case for a solitary neurosurgeon who practices in a small community in which patients require her services. However, this generally is not true for most physicians.

Physician-Controlled Networks

In contrast to third party payer networks, physician-controlled networks are developed to help physicians and medical group practices achieve *their* goals, which typically are different from the goals desired by third party payers. For example, a third party payer's desire is to control cost, and the payer's network may achieve this by getting physicians to accept lower than usual payment rates. A physician-controlled network might have the opposite goal—to negotiate successfully for higher payment rates from a third party payer to meet the physicians' desire for higher incomes.

Physician-controlled networks began as third party payer–participating physician networks. HMOs in New York (Mohawk Valley Plan) and Southern California (FHP International, now Pacificare) developed regional participating physician networks, which they named *independent physician associations* (*IPAs*). Over time, these HMO-developed and -controlled IPAs became increasingly independent from the HMOs. Similar trends in other parts of the United States led to the gradual appearance of more physician-controlled IPAs developing out of third party payer–participating physician networks. In fact, the term IPA as used today refers overwhelmingly to physician-controlled organizations.

A good working definition of an IPA is an organization that "brings physicians together for purposes of managed care contracting, credentialling, claims payment, and medical management while leaving them independent for purposes of owning and operating their practices" [7]. Most IPAs are associations of solo practices, but there is a growing trend to include both solo and medical group practices. The mission of IPAs is business success for all physician members. Most IPAs have full-time staff members who function on behalf of the IPA physicians. Typical functions performed by an IPA are credentialling for insurance and HMO networks, HMO contract negotiation, office management, and billing services.

Hospital-Controlled Networks

Many hospitals have developed IPAs that consist of the physician members of the hospital staff. These hospital-controlled and -financed IPAs are commonly referred to as *physician hospital organizations* (*PHOs*). Some PHOs are jointly owned and controlled by the sponsoring hospital and the PHO's physician members.

The mission of PHOs is to achieve the goals of both the hospital and the PHO physicians. These goals include

successfully negotiating with third party payers for higher reimbursement rates for the physicians and hospital and influencing physician referral patterns within the PHO to maximize revenue to the hospital. For example, it is illegal to reward physicians financially to influence referral patterns for regular Medicare patients; however, it is not illegal for physicians to join a PHO voluntarily and, because of this relationship, to preferentially use the PHO hospital. The same principle applies to referral to physician specialists. In the belief that belonging to a PHO will influence referral patterns, many hospitals have chosen to fund the development of PHOs. A second reason for PHO development is the belief that physicians and hospitals belonging to the PHO gain power when negotiating contracts with third party payers.

Factors that Impact the Success of a Practice

Many factors impact business success for physicians. Effective leadership is important regardless of practice setting or network model. Effective utilization management is critical if the physician practice or network is capitated. A clear governance model, good financial control, and effective office management also are important for business success in a typical medical group practice [8]. The following discussion briefly describes each of these business success factors to provide the reader with a frame of reference for further learning. A thorough examination of these factors is beyond the scope of this introductory article.

Effective Leadership

Good leadership is the ability to make effective and appropriate decisions and to instill common beliefs and goals in group members. Leadership is an elusive quality that is difficult to measure objectively. However, before a physician joins a medical group practice, he or she should ask other members of the group about the group's leadership. Any indication of dissatisfaction with leadership may be a sign of problems within the group that deserve further investigation.

Clear Model of Governance

Governance is defined as a consistent, documented method for assuring that physician members of a group practice are bound to group decisions. Ideally, a group's governance policy also 1) requires that group members have input into the decision making process, 2) creates opportunities for actively involving members in group processes and for defining accountabilities within the group, and 3) defines how group members may acquire increased levels of ownership or control.

Governance model and ownership criteria are important parameters to consider when choosing a practice setting; they define how important decisions will be made in a practice, who will make them, and how a new physician may gain control over and influence decisions made by the group [9]. A medical group practice's governance model usually is described in a formal legal document that should be readily available for review. Many governance models exist, and there is no easy means to determine which is best. It is more important to understand how the governance model used by a medical group practice works. The legal document describing governance typically contains a description of criteria for practice ownership. If a physician's goal is to become an owner and the governance document cites criteria that will be difficult to meet, this may be a significant obstacle to joining that particular practice.

Good Financial Control

Having good financial control requires that a group practice accurately account for important financial transactions, produce appropriate reports that track financial performance, effectively manage accounts receivable and accounts payable, and establish good cash control policies that reduce the risk of embezzlement. A medical group practice should routinely provide its physician members with financial reports to allow them to see how the practice is performing financially. Prospective members should request a review of such reports.

Adequate Capitalization

It is critical that a pratice ensure the presence of sufficient financial resources to support the practice during periods of new business development or lower than expected income and to allow for growth of the business. It is the author's experience that most medical group practices are inadequately capitalized relative to the typical financial risks they face. Medical group practices acquire capital by retaining earnings and not paying them out to physician members. The tendency for medical group practices to pay out as much income as possible to physician members limits their ability to acquire sufficient capital.

Effective Office Management

Effective office management involves oversight of office staff, inventory, billing, equipment maintenance, and facility maintenance, all of which contribute to improved office efficiency. Effective office management has allowed many medical group practices to increase net income despite lower revenues [10]. A simple way to evaluate the effectiveness of a medical group practice's office management is to ask to review a copy of the routine reports produced by the group. These typically are financially focused reports from the office management

staff (eg, cash flow statements, accounts receivable reports, bank balances). If these reports are produced on a regular basis—preferably monthly—and are relatively easy to understand, they are a good sign of a well-run and effective office management process.

Effective Contracting

Effective contracting is critical for the financial success of any medical group practice that obtains a significant amount of revenue from managed care [9,11]. Through effective contracting, a practice may better manage its relationships with third party payers to achieve its goals. For example, negotiating with a payer to obtain a higher fee for a particular service may require a multiyear strategy for contract negiotations. Because contracts are binding legal documents, they should be reviewed by a lawyer for legal and regulatory issues. Contracts also should undergo actuarial analysis to determine whether the financial terms are reasonable and strategic review of nonlegal and nonfinancial terms.

Effective Utilization Management

A practice must be able to keep utilization of services at or below target levels in situations in which a capitation reimbursement arrangement with a third party payer or contract terms give an outside party the right to withhold payment for services judged to be unnecessary or in excess of targets specified in the contract. For example, if a medium-sized medical group practice signs a contract with an HMO that capitates the practice for primary care, the HMO will pay a fixed fee to the practice each month to cover all primary care services provided to a defined population of HMO members. This group practice may improve its financial performance by implementing utilization management processes such as a demand management nurse who triages patient telephone calls to avoid unnecessary primary care office visits.

Recognizing the Signs of Success

How can a new physician judge whether a practice opportunity is a good bet financially? Although no one can predict the future with absolute certainty, a new physician can attempt to assess a group practice's potential for financial success using the checklist provided in Table 5. Consider how this assessment might have influenced Dr. Connor's decision to join Community Medicine and possibly could have led to a better outcome, perhaps similar to Dr. Rhodes' experience during his first year at Metro Clinic.

> At the end of her first year with Community Medicine, Dr. Connor reviewed her performance and found that her year's billings totalled $150,000. She anticipated receiving a $12,000 bonus. However, when the Community Medicine staff met 2 weeks later, Dr. Ewing told the group that no bonuses would be paid because the practice had lost money. As a result, expenses needed to be reduced, leased cars would no longer be provided, and salaries would be reduced by 10%. Shocked, Dr. Connor reminded Dr. Ewing of the terms in her contract and noted that she met the goal required to receive a bonus. Dr. Ewing replied that no money was available and that she should be happy her salary was not reduced further. Dr. Connor left the meeting wondering what she could have done to prevent this disappointing outcome. She met with the group's office manager to investigate further.
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> Dr. Connor discovered that the group did receive 20% higher fees from Community HMO; however, monthly payments were subject to a 30% withhold, which would have been returned at the end of the year if Community Hospital PHO had met its cost and utilization targets. Because Community Medicine did not meet any of the targets, none of the withhold was returned, resulting in a 10% net reduction in revenue. Dr. Connor calculated that the 30% withhold reduced her $150,000 worth of billings to $105,000 worth of net income. She had not even covered her own base salary expense of $120,000!
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> Dr. Connor asked to see the goals the group needed to meet to receive the complete withhold amount as well as the financial reports showing the group's monthly performance against these benchmarks. The office manager told Dr. Connor, "We don't know what the benchmarks are, and the HMO was able to provide no monthly reports, only a year-end performance report." Dr. Connor asked who had approved the HMO agreement and what she could do to get involved in the process. The office manager replied that neither Dr. Ewing nor Dr. Lynch was interested in the "business side" and had failed to attend PHO meetings regarding the HMO contract. The PHO had obtained a legal review of the HMO contract but no actuarial review. Because the group had no formal governance model, Dr. Connor had no right to expect further explanation or involvement unless Dr. Ewing and Dr. Lynch gave their permission. Completely frustrated by her experience, Dr. Connor went home wondering what had gone wrong.
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> At the end of his first year with Metro Clinic Dr. Rhodes also anticipated receiving a bonus; unlike Dr. Connor, however, Dr. Rhodes had reliable evidence

Table 5. Factors that Impact Group Practice Business Success

Factor	Criteria to Assess Quality and/or Strength of Factor
Leadership	Is a leader clearly designated?
	Do group physicians report that the leader is accessible and involved in important business decisions?
Governance	Is there a clearly documented description of the group's governance structure?
	Does the governance document stipulate:
	• How group decisions are made?
	• Who participates in making group decisions?
	• How input from group physicians is incorporated into decisions?
Financial control	Does the group hold regular business meetings for physician members?
	Does the group produce and issue regular (eg, monthly) financial reports for physician members?
	Does the group use a professionally trained accountant?
	Does the group have a cash control policy?
	Does the group receive monthly financial reports from third party payers regarding contracts that involve withholds, capitation, or risk sharing?
Capitalization	What level of capital reserves does the group maintain?
	Does the group analyze how much capital it should maintain for adequate growth?
Office management	Who manages employed staff?
	How does the group control inventory?
	How are billings and payments managed?
	Does the group conduct regular (eg, monthly, annual) reviews of staff performance?
	Are sample reports of staff performance available for review by prospective physician members?
Contracting	Does the group perform legal, actuarial, and strategic reviews of all contracts with HMOs?
	Who within the group is accountable for contracting?
Utilization management	Does the group have defined utilization goals?
	Is there a defined strategy for meeting utilization goals?

HMO = health maintenance organization.

that this would be the case. Metro Clinic functioned much differently than Community Medicine. Business meetings were held after office hours on the first Monday of each month, at which time financial and administrative staff presented information describing the performance of the Clinic's practice.

Early in the year, the Clinic discovered it was at risk for having Metro Health Plan not return its withhold because the Clinic was not meeting cost and utilization targets. The cost problem invoved the use of an expensive laboratory service instead of the lower cost service preferred by Metro Health Plan. The utilization problem—excessive surgical length of stay—was traced to the surgical department's practice of rounding on inpatients only in the early morning, before all laboratory and other test results were inserted into patient charts. If discharging a patient was dependent on the surgeon reviewing a test not yet on the chart, the discharge would be delayed until the following morning. When the Clinic managers presented this information to the Clinic physicians, the Clinic Medical Director organized work groups to recommend solutions.

At the next month's business meeting, the work groups presented their recommendations, which were implemented and led to the Clinic achieving the desired targets and receiving full return of their withhold. At each business meeting, Dr. Rhodes

received an individual report of his own performance, including an estimate of his bonus payment. For several months this estimate had been relatively consistent, giving him confidence he would receive a bonus at the end of the year.

Dr. Connor and Dr. Rhodes had very different experiences in their first year of practice with a medical group. Obviously, all physicians would like to avoid Dr. Connor's fate. Using the checklist presented in Table 5, it is possible to identify some of the factors that led to the different outcomes for Dr. Connor and Dr. Rhodes. Following is a brief analysis of what is known about the practices:

Community Medicine

- The group has weak leadership. Leaders do not even attend important business meetings of the Community Hospital PHO.
- There is no documented model of governance.
- The group has very poor financial control. Financial statements are prepared only at the end of the year, giving the group no opportunity to improve performance if necessary.
- The office is poorly managed. No monthly reports are produced and distributed to the group physicians, presenting information about the group's experience with their managed care patients and contracts.
- Managed care contracts are not adequately reviewed.

Metro Clinic

- The group has strong leadership. The Medical Director takes action to address laboratory and inpatient utilization problems while there is still time to improve performance.
- The group's governance model appears to work well, although no formal governance document is noted.
- The group has excellent financial control. Monthly financial reports are prepared, distributed, and reviewed with group physicians at formal business meetings.
- The office is well managed. Monthly reports are produced, distributed, and reviewed, which show perfomance of the overall group as well as individual physicians.
- Effective processes are in place to measure and manage utilization.

Had Dr. Connor assessed these business success factors prior to joining Community Medicine, she may have identified inherent problems in the practice and decided not to join the group. Alternatively, she may have joined the practice but been motivated to take action earlier by identifying her concerns to the group and suggesting that members work to correct the problems before they led to financial losses for the practice. Similar to a real life situation, information about all important success factors is not available for these 2 hypothetical medical groups. However, looking at what is known about them, Community Medicine appears to have significant deficits.

With appropriate consideration and careful assessment of practice opportunities, new physicians entering private practice should be able to make an informed choice and avoid major financial disappointment. The information presented here is intended to introduce the reader to some of the many characteristics of successful medical practices as a first step toward preparing for these decisions.

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