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Strange Bedfellows

Physicians, Hospitals Both Need Partners But Distrust Each Other

Outside of health care, many people have difficulty understanding why hospitals and physicians have an unprecedented demand for capital. After all, according to figures reported in the journal *Health Affairs,* published by Project Hope, Bethesda, Md., the average physician earned $186,000 in 1994. Hospitals are part of a $400 billion industry, and typically have earnings of about 5%, or $20 billion.

But hospitals and physicians are worried about money for three reasons:

1. Earnings are stable or dropping,
2. Neither has much in cash reserves, and
3. Each needs capital to compete under managed care.

To be competitive today, physicians recognize that there is strength in numbers, which means they need to participate in an integrated group practice or a well-run IPA. Organizing a group practice or an IPA requires $5,000 to $10,000 per physician. This money will pay for lawyers and accountants, and the requisite six to 12 months of effort.

Once you've formed the group, even more money is needed. The Advisory Board Co., a membership organization in Washington, D.C., said in its 1995 publication, *To The Greater Good: Recovering the American Physician Enterprise,* that any organization managing a physician practice would need the following amounts for each participating physician

- $10,000 to acquire other existing practices,
- $5,000 to employ a professional manager,
- $10,000 to establish new practice sites,
- $2,000 to market the group, and
- $5,000 to establish the necessary information systems.

A physician group or management company, therefore, would need as much as $42,000 per doctor to be competitive. Surely, observers say, a person making almost $200,000 annually could set aside $42,000 to invest in the future. But many who have tried to raise money from doctors for physician-led HMOs or management service organizations (MSOs) have failed consistently to raise even $5,000 per physician.

Fund-Raising Failure

For many reasons, physicians resist efforts to raise capital — even to invest in their own future. For one, they tend to be risk averse. They are reluctant to sign personal notes on a risky enterprise, even their own. Also, they tend to trust themselves more than they trust physician leaders about how to invest money outside of the practice.

They are unaccustomed to reinvesting taxable earnings into their practices. At year end, they generally empty the coffers of cash to avoid taxation and to support a life style that often includes a second home.

Physicians have no tradition of investing in physician groups, and see little need to do so because most physicians who have been in practice for longer than five years have practiced under fee-for-service. Under this system, physicians generate capital by simply raising fees or increasing volume.

In addition, not all physicians make $200,000 annually. Many primary care specialists earn $80,000 to $120,000 annually and have little cash to spare. In a

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EDITORIAL

Wanted: Physician Entrepreneurs, Executives

Wanted: Physician leaders who have entrepreneurial skills and a successful record of risk-taking.

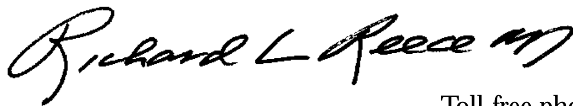
At a recent seminar on how physicians can acquire capital to succeed in managed care, all of the presenters were physicians. These speakers also were CEOs of practice management companies, had started management services organizations (MSOs), built information companies, and taken specialty start-up companies through the initial public offering (IPO) process. In the audience were two former physician educators, one a former dean of a medical school, the other the head of a department of family medicine. The two are now CEOs of new specialty start-up companies. One is in obstetrics and gynecology, the other in cardiology.

These physician leaders were a different breed. Some had MBAs. Some had worked in managed care and been trained on the job. Some had been through executive training programs sponsored by the American College of Physician Executives. Some had spent a lifetime at one organization. Some had held multiple jobs. Some had experienced multiple failures. Each one had a blend of medical and business training.

What linked each one is that each of these physicians is highly desirable in the job market today.

- Investment bankers are seeking strong physician leaders with credibility on the clinical and business sides of health care. Innovative physician leaders who can put together a profitable business are quite rare, investment advisers say.
- Hospital executives recognize that future growth will occur outside of hospitals. As a result, they are looking for physicians willing to be partners with hospitals in either vertically integrated systems or what are called virtually integrated systems.
- Managed care organizations want physician executives experienced in managed care and capitation strategies. Mary Frances Lyons, MD, an executive search consultant with Witt/Kieffer, Ford, Hadelman & Lloyd in St. Louis, says in the November issue of *The Physician Executive,* published by the American College of Physician Executives, Tampa, Fla., "Clients want to attract and hire physician executives who possess intangible skills — with and without MBAs. These intangible skills include the ability to educate other physicians to the new health care realities, a sales orientation emphasizing effective communication that focuses on patients and payers as customers, comfort with ambiguity, flexibility, tact, and sensitivity in negotiations."
- Only other physicians, particularly the clinical partners of these rising stars, have trouble accepting their peers as leaders. Typically, these clinicians want to know: How does the group pay this leader? After all, he or she is no longer producing clinical income. What are management, entrepreneurial, and leadership skills worth? How can a physician keep one's clinical skills sharp while working only part-time as a clinician?

In my experience, these matters are not usually resolved adequately, and the physician leader must either make financial sacrifices or leave for another career. But since entrepreneurial and leadership talent are not easy to find, physicians must learn to nurture rather than disparage the physician leader who sees the big picture and who tries to empower the group to move in the right direction. If physician partners don't want this new breed, the new corporate world of medicine will.



Richard L. Reece, MD
Editor-in-Chief
15 Banbury Crossing
Old Saybrook CT 06475-2362

Toll-free phone: 888/457-8800
Fax: 860/395-1512
E-mail: RReece1500@AOL.Com

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Publisher
Premier Healthcare Resource, Inc.
888/457-8800
E-mail: PHRinfo@aol.com
Publishing Address: Premier Healthcare Resource, Inc.
49 Van Doren Avenue
Chatham, NJ 07928

Editor
Joseph Burns
508/495-0246
E-mail: JoeBurns@CapeCod.Net

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group, high-income specialists typically will be in the majority. Being reluctant to support primary care physicians, they are likely to resist setting aside income for the practice.

The Profit Squeeze

Hospitals, conversely, have other problems that make setting aside capital difficult. For one, at least 80% of U.S. hospitals are non-profit, meaning they must raise most capital from bonds. Typically, money from bonds must be spent on facility improvements. Yet most hospitals today need capital to build integrated delivery systems, to acquire physician practices, to market their services, and to invest in information systems.

Daniel Beckham, president of the Beckham Co., physician and hospital consultants, in Whitefish Bay, Wis., says in the September-October issue of the *Healthcare Forum Journal,* published by the Healthcare Forum, a research organization in San Francisco, that for a hospital to build an integrated delivery system that includes physicians requires enormous capital. Hospitals should expect to lose $1 million per month for every 100 primary care physicians the system owns, says Beckham, a member of the advisory board of *Physician Practice Options.* Establishing a brand name identity may cost some systems another $1 million monthly, Beckham says. To build a first-class information system may require as much as 5% of operating revenue. Banks, for example, spend 10% on information systems.

Other experts have estimated that it may require $1 million to establish a physician-hospital organization, $10 million to set up a management-service organization, and $50 million to organize an integrated delivery system.

Given the constraints imposed by non-profit status, the only way hospitals can raise such cash may be to convert to for-profit status. Or, they could engage in a joint venture with a for-profit hospital company, such as Columbia/HCA. Hospitals also may start for-profit subsidiaries or find new capital partners, such as insurers or managed care organizations.

Uneasy Alliances

If a hospital has capital, physicians then face a potentially gut-wrenching choice between aligning with the local hospital, to which they are loyal, and an out-of-town physician practice management company (PPM), which likely has no ties to the community. Physicians may want their local hospital to succeed but may resist taking its capital because in the last five years, results of affiliations between group practices and hospitals have been mixed. Robert Bohlmann, head of management consulting services for the Medical Group Management Association, in Englewood, Colo., cites these five reasons for conflicts between group practices and hospitals:

Physicians have no tradition of investing in physician groups, and see little need to do so.

1. The group practice and hospital administrator often clash, and typically the group administrator leaves. This result disrupts the group's structure and sends a negative message to physicians that the two parties are struggling for control of the new entity.
2. Hospital administrators often do not understand that running a group practice requires different skills and is more complex than running a hospital.
3. Hospitals often overpay for physician practices. Physicians profit on the front-end, but those joining later suffer. The hospital's physician-recruitment efforts then may become uncompetitive and fail.
4. Physicians find that they had entered the deal to have access to capital to expand but become disillusioned when hospital capital dries up or when they are asked to assume financial risk or take reduced income to fund expansion of the enterprise.
5. Hospitals learn quickly that group financial margins are narrow, and hospital boards are reluctant to subsidize a division in which cost allocation has not been applied in the past.

"A medical group practice is an important component of integrated system development, but the nature of the beast does not make it a cash cow if physician compensation is to be competitive," Bohlmann says.

As a result of these factors, many hospitals simply don't have the capital to expand the groups they own, physician productivity drops, hospitals begin to lose significant money on owned physicians at annual rates of $20,000 to $100,000 per physician, and physicians begin to form their own groups. Dissolution of physician-hospital partnerships is becoming common.

In the West, physicians are saying simply that hospitals don't make good business partners. In an article, "Vertical Integration and Organizational Networks in Health Care," in the spring 1996 issue of *Health Affairs,* James Robinson, an associate professor of health economics at the University of California at Berkley, and Lawrence Casalino, a clinical assistant professor of family medicine at Stanford University and a family practitioner, said that since managed care aims to shift medical care away from acute inpatient facilities, organizing a delivery system around hospitals is illogical. Also, there are few advantages of integrated systems that cannot be accomplished through contractual relationships, they said.

These arguments may be true in the west, which is dominated by large IPAs. But they would not necessarily be true in places where IPAs are small and where less than 5% of physicians belong to groups of 25 or more. They would not be true either in places where primary care physicians make up less than 20% of the physician population and where hospitals still dominate in many communities.

The answer for physicians seeking capital may still lie, therefore, in hospitals. But if not, then physicians may turn to PPMs. The problem with this solution is that only one such company—PhyCor—has more than five years of experience acquiring practices. The question that remains unanswered is whether these new companies will decline once the market is saturated. In any case, since less than 5% of all groups are consolidated, the trend is just beginning. ■

COMMENTARY

Seven Trends to Watch in 1997

By Richard L. Reece, MD, Editor-in-Chief

By now, most physicians are familiar with health care premium and cost compression. Resulting in less income for the same labor, this phenomenon is likely to continue this year and into the next century, says Peter Kongstvedt, MD, a partner in the Washington, D.C., office of the accounting and health care consulting firm of Ernst & Young.

"The market place is not willing to pay ever increasing amounts of money for health care, and therefore it is pushing down on health care costs," Kongstvedt says. "As that happens, the amount of margin between the cost of providing health care and what the market is willing to pay gets compressed."

Pressure on premium and costs is being driven by managed care, which once was viewed as an alternative delivery system, but today is the mainstream method of providing health care. The need to respond to managed care trends and to understand the dynamics of current and future market pressures is creating a corollary need for physicians to consolidate and seek management expertise, both of which are increasingly unavoidable market realities.

"A lot of physicians don't like to think of their work as taking place within a market and subject to market forces, but, unfortunately, it is," says Kongstvedt. "With the tremendous forces at work in the health care market place today, higher levels of professionalism are required in physician management activities, in managing the office, managing the finances, managing the contracting, and, not to be diminished at all, managing the medical delivery itself."

Seeking Stability

Physicians can understand the dynamics of the market by realizing that "all provider cultures are stability-seeking cultures, and the health care market is a change-seeking market," he explains. "If you burn up all of your energy trying to resist change, you will not succeed. You will wear yourself out. If you recognize that the health care market right now is change-seeking, you can then learn to adapt and to thrive on it.

"Today's market has been called permanent white water, and the best white water river guides don't fight the current. They read the current and use it to their advantage. They don't fight it, and they don't bash into rock all day long."

Providers can learn to read market currents by seeking knowledge about managed care and by accepting an increasing degree of risk. In fact, many physicians are beginning to understand that their practices need to serve more members, rather than more patients, Kongstvedt says.

"Physicians can get into a lot of economic problems if they convert all their patients to capitation and don't enroll a number of members who are not patients," he says. "By definition, if these patients are considerably ill, they're going to cost more to take care of than any amount of premium will pay. That's what insurance is all about: You spread the risk. Therefore, physicians should seek a mix of the well and the unwell, and pay attention to the satisfaction of both."

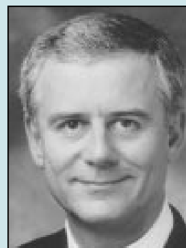
Here's an example. Patients being treated under capitation often complain that they cannot get an appointment when they call their physicians about routine care. "If a physician is relatively busy and a patient who is chronically ill and who has a lot of problems calls and wants to be seen, the physician always fits that patient in," Kongstvedt says. "But if a patient who's never been seen calls up and says he or she wants to schedule a physical or has a cold or a sore throat and wants to be seen, he or she will frequently be turned away. The problem is that under capitation, the premium for that patient with the cold is paying for the cost of care for the sick patient. Of course, you can and should provide good service to the sick patient, but you must also provide good service to the well patient."

"Today's [health care] market has been called permanent white water, and the best white water river guides don't fight the current. They read the current and use it to their advantage. They don't fight it, and they don't bash into rock all day long."

Getting Educated

Gathering information about such market realities is a first step in dealing with the problems inherent in assuming risk and in managing practices efficiently under managed care, Kongstvedt says. Toward that end, he has identified seven market pressures or trends that he anticipates will continue through at least this decade. They are

- Payers of commercially insured populations will continue to seek lower health care costs;
- Managed care organizations will continue to grow and to consolidate;
- Large, well funded hospital systems will increase their ability to reduce costs, perform efficiently, and practice package pricing while purchasing market share;



***Peter Kongstvedt, MD,** FACP, is a partner in the Washington, D.C., office of Ernst & Young LLP, and a member of the advisory board of* Physician Practice Options. *The leader of the managed care strategy and medical management practice for Ernst & Young's Managed Care Group, Kongstvedt is responsible for leading and assisting consulting engagements in managed care strategy and operations. He is a frequent lecturer and writer on managed health care, and a board certified internist. He is the editor and principal author of* The Managed Health Care Handbook, *third edition, Aspen Publishers, Gaithersburg, Md., 1996.*

- Well run physician organizations will become increasingly prevalent as physicians continue to seek ways to operate more efficiently;
- Government entitlement obligations will continue to exacerbate budget problems;
- Government regulation will grow; and
- Consumers and purchasers will demand increased accountability and improvements in health care quality.

1. Pressure from Payers

Employers' health insurance cost increases have moderated slightly over the past two years, and they have fallen for those workers enrolled in managed care plans. As a result, employers continue to foster enrollment in HMOs and PPOs by making such plans financially more attractive than traditional indemnity care. At the end of 1995, 71% of U.S. workers were enrolled in managed care plans, according to Foster Higgins, benefits consultants in New York.

Large employers, such as IBM, Pfizer, and Sears, have formed purchasing alliances, giving them increased market clout. The National Business Coalition on Health, an organization in Washington, D.C., that serves coalitions of businesses formed to help reduce health care costs and to improve quality, has more than 100 members nationwide.

These employer groups do not necessarily want to limit access to providers or to channel all business to a single provider or group, but they will contract with quality-oriented, cost-effective managed care organizations and risk-assuming provider groups, Kongstvedt says. They also will contract with what are called centers of excellence for high-cost procedures. As a result of high volume, such centers have experience, good outcomes, high quality care, and may offer lower costs than other providers.

Moreover, employer demands for more choice have made standard HMOs more complicated and have resulted in what Kongstvedt says is the "resurrection of open-access HMOs." Some health plans offered by United HealthCare, Blue Shield of California, and others allow members to see specialists without first going to a primary care gatekeeper, and, in some instances, provide HMO-like benefits with a copayment.

In addition to pressure to provide more choice, the average medical loss ratio in publicly traded HMOs went from 76.4% in 1994 to 80.6% in 1995, even as utilization has fallen. In California, which continues to lead the nation in the degree of utilization control, premiums dropped as much as 5% among some purchasers, and utilization continued to fall statewide. These trends mean costs rose and revenue fell.

A similar trend can be found in the East. From 1994 to 1995, premiums fell by 0.7% overall. In some markets, premiums dropped even more, for example, 5.6% in Philadelphia. Concurrently, inpatient days fell 12.7% and hospital rates were negotiated down by 4.2%. Hospital utilization may be stabilizing, however, Kongstvedt says. Average lengths of stay for acute-care patients in non-federal hospitals appear to be averaging about five days over the last few years.

2. MCO Growth

Since 1986, 18 publicly traded HMOs have been acquired by other health care entities, and recently large managed care organizations have merged with indemnity insurers. Simultaneously, the national

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network of state and regional Blue Cross and Blue Shield companies has been moving into managed care. Since it insures 65 million covered lives, the Blues plans, in effect, are the nation's largest health care system. Of that number, just under 50%, or 31 million Blues enrollees, are in some form of managed care. The Blues also have recognized that there is strength in numbers, having announced several consolidations (such as Blue Cross of Western Pennsylvania's merger with Pennsylvania Blue Shield) and joint agreements such as the one in which Blues plans in New England have signed a joint marketing agreement.

Managed care also is expanding horizontally, Kongsvedt says. Many PPOs and other managed care plans are seeking HMO licenses, and the number of provider groups accepting risk is rising. By offering managed workers' compensation and managed Medicare and Medicaid programs, MCOs are opening new lines of business. While such diversification increases market share, it also can raise administrative costs. If so, any increase in cost will result in increased premium and cost compression on providers.

3. Hospital Systems

In 1980, only about 18% of U.S. hospitals were part of a hospital system. By 1994, that proportion had increased to 60%. The result was a 10% decrease in patient care support personnel, a 17% decrease in general support personnel, but a 72% increase in general administrative personnel. A paradox inherent in the growth of large hospital systems has been that although many physician-hospital organizations, hospital-based management services organizations, and integrated delivery systems were formed or purchased by hospitals to strengthen their negotiating positions with managed care organizations, premium and cost compression has continued. Geographical dominance notwithstanding, many hospital systems have discovered that in negotiations with MCOs, health care has remained largely a buyers' market.

"It's unfortunate that a lot of hospital systems paid a lot of money for physician practices, after which productivity fell like a rock, and they've had some financial problems because of it," Kongstvedt says. "A lot of success in PHOs actually depends on the motives and skills of the participants more than the structure. The structure is just a vehicle, just a set of tools. It's really the skills and desires of the parties that will make it work. I think when physicians are pure employees, that's not an optimal situation."

4. Physician Organizations

Physicians form groups for several reasons, Kongstvedt says. Among them are reducing the cost of care, the possibility of receiving on-the-job training from colleagues, and increasing the quality of care. Other, perhaps more important reasons, involve access to capital and to information systems.

> **"That's what insurance is all about: You spread the risk. Therefore, physicians should seek a mix of the well and the unwell, and pay attention to the satisfaction of both."**

"And one other reason is that in a group, physicians have better business management. All health care providers are under pressure to control administrative costs by increasing automation and electronic connectivity," Kogtvedt says.

To bring administrative costs under the current level of 10%, physicians need to seek efficiencies in groups. "In particular, young physicians just coming out of training or physicians early in their careers are being heavily affected by consolidation," Kongstvedt says. "It's very difficult to come out of training now, heavily in debt, and simply hang up your shingle as a physician or in a small group. There are exceptions to that, of course, particularly in rural areas. But in most metropolitan areas in which managed care is rising, the economic forces are compelling physicians toward consolidation."

More is at stake than simple market share, however. "If consolidation is done solely for marketing clout, then there are going to be as many problems as solutions created because the economic forces at work are very powerful," Kongstvedt explains. "Physicians need to work together in reasonably sized organizations, whether they're medical groups or another form of organization. And, they need to do so, not just for purposes of market access, but also for genuine improvements in efficiency, administrative capabilities, the ability to use electronics and information more effectively, and to lower the cost of care while improving access and quality."

Increasingly, physician practice management (PPM) companies are becoming a powerful market force, he says. "There are all varieties. Some PPMs are getting very large, but there are plenty of small ones as well. There are organizations that are local physician-driven operations, but they function like a PPM. The overarching issue is the professionalization of all aspects of management."

At one time, many physicians managed their own offices or had their offices managed by a part-time accountant or family member. "That is no longer true," Kongstvedt says. "The truth is that solo primary care physicians, specialists, and small physician groups are becoming an endangered species."

A recent survey of almost 16,000 residents in 4,369 medical programs in the 1993-94 academic year showed that among respondents, as many as 10% could not find full-time positions, Kongstvedt says. Primary care physicians did not have any trouble finding jobs, however. In response to the tightening job market, specialists are forming physician groups, and even becoming case managers, he says.

5. Federal Budgetary Pressure

As state and federal Medicaid expenditures rise, many states are seeking waivers from the federal Health Care Financing Administration to implement managed Medicaid programs. The need for such programs is obvious to state officials whose Medicaid costs rose from about $50 billion in 1988 to more than $120 billion in 1993. Also, Medicare HMO enrollment has grown from 1.7 million enrollees in 1987 to 3.7 million in 1995.

As governments spend more money on managed health care, they are spending less on traditional indemnity care. In other words, shifting public programs to managed care results in more premium and cost compression on providers, Kongstvedt says.

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6. Government Regulation

As the number of public patients in managed care rises, state and federal politicians have felt pressure from consumers and the media to write new laws and rules regulating health care.

As a result, the federal government has mandated that health insurance for workers should be portable, and some states have started to regulate how much providers can spend on medical and administrative costs. The federal executive branch is easing its antitrust restrictions on doctor networks, while increasing anti-fraud efforts, especially among HMOs. Many state governments are placing limits on the amount of risk an integrated delivery system may accept without obtaining an HMO license.

At the same time, a number of states have passed laws concerning access to health care, including laws that affect whether health plans can limit physician panels, called any-willing-provider laws, and laws regulating how long new mothers must remain hospitalized after delivering a baby. This year, Congress will take up legislation on how long a woman can be hospitalized after a mastectomy. The number of such laws increased six-fold between 1993 and 1996, Kongstvedt says.

7. Accountability

The demand for external accreditation continues. The National Committee for Quality Assurance, an organization in Washington, D.C., that accredits health plans, and other credentialing organizations are increasing their efforts to review and accredit health care providers. Eight states require external review and accreditation, and many large employers and labor unions will not contract with HMOs unless they are accredited.

In closing, Kongstvedt points out that despite the many concerns and media attention on health care, consumer satisfaction with the quality of health care and with managed care in general, remains high. Some 59% of consumers said in a recent survey that the trend to managed care is good and should help to contain costs successfully, he says.

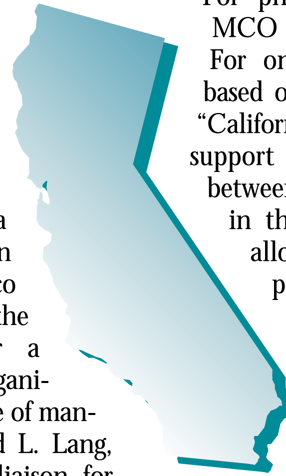
The lesson for physicians is that managed care is not likely to be regulated out of business anytime soon. And like a river guide in white water, physicians should learn to read the currents. ■

CASE STUDY

California Physicians Form a New Health Plan

First of two parts

Seeking to help doctors control their economic destiny and to maintain their presence as a force in health care, the California Medical Association has started California Advantage Inc., a managed care organization (MCO). Based in San Francisco and organized in January 1995, the MCO is designed to offer a statewide, physician-directed organization that provides a wide range of managed care options, says Howard L. Lang, MD, a physician shareholder liaison for California Advantage.



"Without an economic identity, the physician's professional identity diminishes, leaving the physician as nothing more than an economic commodity in the marketplace," says Lang, a board-certified Ob-Gyn from Greenbrae, Calif.

For physicians, Lang believes the MCO offers significant advantages. For one, decisions about care are based on what's best for the patient. "California Advantage is designed to support the central relationship between the physician and the patient in the delivery of health care by allowing physicians to exercise professional judgment that serves the patient, with minimal intrusions and encumbrances of third parties," he explains. "We believe that the delivery of health care must be determined by using a medical model rather than a corporate business model."

The founding of California Advantage is based on four principles adopted by the CMA in 1994:

1. The organization is philosophically dedicated to maximizing the percentage of premium spent on the delivery of health care and minimizing the portion spent on administration, overhead, and profit.
2. The organization, including governance functions and all medical management and utilization review processes, is directed by physicians.
3. The organization discloses financial information necessary to assess the organization's performance to all physician-shareholders.
4. The organization allows all CMA member physicians to participate if they meet certain qualification requirements.

"We believe that the delivery of health care must be determined by using a medical model rather than a corporate business model."

Three Health Plans

California Advantage offers three commercial health plans: an exclusive provider organization (EPO), a preferred provider organization (PPO), and a point-of-service (POS) plan, all through the state Health Insurance Purchasing Cooperative. "In the future, we plan to offer individual plans to consumers, and plans for worker's compensation, medical savings accounts, and Medicare products," Lang says. An author and lecturer on many aspects of medical practice, health system reform, and physician responses to managed care, Lang is a past-president of the CMA and is currently an alternate to the AMA's House of Delegates. In addition, he served from 1986 to 1992 as chair of the AMA's Hospital Medical Staff Section.

California Advantage has more than 7,200 physician-shareholders, and 800 more have applied to participate, Lang reports. In addition, the provider networkincludes 17,000 physicians affiliated with

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the California Foundation for Medical Care, a statewide network of PPOs in San Mateo, and 320 hospitals. Licensed throughout the state, the MCO has providers in 55 of the state's 58 counties.

> **"The focus in any health care delivery system should not be on hospitals or HMOs, but rather on the physician-patient interaction, and in order to serve that relationship best, the delivery system must be flexible."**

For comparison, 60,000 physicians practice in California, and 35,000 are members of the CMA. To become a physician-shareholder, a physician must belong to his or her county medical society and to the state medical association and must buy at least one share of stock (at a current price of $1,250) and pay a $250 credentialing fee.

The MCO is designed to allow physicians to retain their professional role in the delivery of health care while also being flexible enough to provide what the market requires, Lang say. "We believe that what the marketplace requires today is a physician-centered organization that can provide quality care at the best cost."

A Changing Market

Perhaps more than that of other states, California's health care market has been shaken deeply by managed care, Lang says. "There has been an increasing amount of dissatisfaction among both physicians and patients with some managed health care plans as evidenced by an increasing number of patients and employers opting for choice and access rather than the narrow, restrictive requirements of traditional HMOs," he explains. "The market is shifting toward a demand for access, choice, quality, and less intrusion on the physician-patient relationship. As an organization designed to meet these demands, California Advantage is entering the market at a good time and should therefore be successful."

One significant sign of change in the California health care market is how vertically integrated health plan models, such as Kaiser Permanente, are struggling. At one time these models were considered the best health care delivery system. But today many large staff-model HMOs, including Kaiser, which consists of the Permanente Medical Group, the Kaiser Foundation Health Plan, and several hospitals, are fighting to cut costs to win back market share lost to smaller competitors, such as group practices.

"Several years ago, vertically integrated systems, where aspects of the health care delivery system have common ownership, were considered to be the ultimate, and Kaiser was the paradigm of that model," Lang comments. "It's clear today, however, that these vertically integrated systems aren't working. In particular, Kaiser has experienced a great deal of turbulence." At the same time, hospitals have become "a dead weight under managed care," Lang says, "and therefore, Kaiser is beginning to shed its hospitals and reconsider its vertical integration concept."

The *Healthcare Forum Journal*, published by the Healthcare Forum, a research organization in San Francisco, reported in its September-October 1995 issue that large vertically integrated health care organizations have not been able to produce care at a lower price or demonstrably superior quality than their smaller, less integrated competitors.

"In the managed care environment, at least in California, the focus is on creating value in the delivery of health care services," Lang explains. "Value is defined as maximizing quality, maximizing patient service, and maximizing patient access, while minimizing per-patient costs."

If smaller, more nimble organizations are ready to step into the market and deliver higher quality, increased patient satisfaction, and lower costs, they may have a competitive advantage, Lang explains. "It seems that vertically integrated systems have not been able to do that. What's emerging is a concept called virtual integration, a virtual company, if you will, where services can be contracted, instead of having common ownership with a management system or an insurer. This allows each component of the delivery system to do what it does best and to provide the flexibility to meet the changing demands of the marketplace."

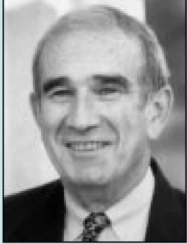
> **"California Advantage is designed to support the central relationship between the physician and the patient in the delivery of health care services by allowing physicians to exercise professional judgment that serves the patient with minimal intrusions and encumbrances of third parties."**

In closing, Lang explains how the new MCO's philosophy fulfills this market need. "California Advantage believes that the focus in any health care delivery system should not be on hospitals or HMOs, but rather the focus should be on the physician-patient interaction," he says. "In order to serve that relationship best, the delivery system must be flexible. One of the problems that the Kaiser system is experiencing is that, because of their vertically integrated structure, their flexibility has diminished."

[Next month: Lessons learned.]

Lessons from Minnesota

A Specialty Practice Thrives in a Market Dominated by Managed Care



Harold B. Kaiser, MD, *is a specialist in internal medicine with Allergy & Asthma Specialists, PA, in Minneapolis. He has been affiliated with Allergy & Asthma Specialists since 1966. A member of the advisory board of* Physician Practice Options, *Kaiser is a clinical professor of medicine at the University of Minnesota Medical School. An active member of the staff of the Abbott-Northwestern Hospital, Minneapolis Children's Hospital, North Memorial Hospital, and the Riverside Medical Center, Kaiser has written extensively for books, magazines, and other publications on asthma, corticosteroids, and the health care system. This interview was conducted by Richard L. Reece, MD, editor-in-chief.*

Q: *Since you've been practicing for a number of years now in Minneapolis, an environment some consider the most mature of managed care markets, what are physicians' options in that market?*

A: We've been in managed care for about 10 or 15 years. And that's a plus and a minus. The minus is that it's all managed care, the individual practitioner doesn't have much to say, and fees are falling.

The plus of being in this slowly maturing market is that we've had 10 years to deal with it. We've learned to cope and to compromise. We've learned how to operate and to say 'no.' Here, we don't have to decide our future in 15 minutes, as people in Southern California and some areas of the East do. Managed care can be tough on an internal medicine group in a suburban area. When a large managed care organization (MCO) suddenly plants itself, you may find that one-third of your patients are gone the first of the year.

For many of us here in Minnesota, managed care has been like that. It has created a different environment, but it's still a nice way to make a living and a nice profession.

Q: *Could you describe your practice for us, please?*

A: We have a four-man practice of internists with an allergy subspecialty. The reality in this subspecialty-oriented community is that most of our practice is allergic disease, allergy, and clinical immunology. This puts us in a spot of being a referral practice and a sub-specialist.

As referral practitioners in a market that has 78% managed care, we encounter different situations. Some of our agreements with the MCOs, HMOs, PPOs, or independent practice associations (IPAs) are fee-for-service less a percentage. Capitation is surprisingly just coming into this market. I know capitation is supposedly the wave of the future, but in Minneapolis it seems to be working without capitation or with minimal capitation for now. But in the large groups, capitation is coming and I suppose it'll come to us once in a while.

> **"The pundits are right: The sub-specialists are at risk. Some people are leaving town because they could not make a living as a sub-specialist."**

We belong to several HMOs, PPOs, and MCOs. Our general philosophy is, we join everything that we think is reasonable and see what shakes out.

Q: *The conventional wisdom holds that medical sub-specialists will be de-selected or excluded from these networks. Apparently that hasn't been your experience.*

A: You're right but you're not all right. In our situation, the de-selection process is not as aggressive as it is in some areas, such as Southern California. We're aware of the fact that you don't need 29 plastic surgeons, or 29 allergists, or 29 urologists in an HMO that has 150,000 members, or even 600,000 members. We're trying our best by being active, visible, and by doing a good job.

The pundits are right: The sub-specialists are at risk. Some people are leaving town because they could not make a living as a sub-specialist. But in our particular situation, we're doing okay along with most of the other sub-specialists.

Q: *Do you have to supply these managed care organizations or health plans with any outcomes information about the efficiency of your practice?*

A: Not as yet, but we try to be pro-active in this area by measuring our own outcomes. For example, asthma is a sexy disease now. Everybody wants to cut down on asthma ER visits and asthma hospitalizations and there are good medications available for it. We're collecting our own data on our own outcomes, and we hope to show that we're both medically very good and cost-effective. We're also surveying our practice using satisfaction surveys.

Q: *What steps are you taking to measure outcomes and patient satisfaction?*

A: We have found, as others have, that it's very difficult to measure quality quantitatively. It's easy to tell when the X-ray clears or when the broken bone heals or when someone dies. Those are good end points. But in terms of patient satisfaction, it's hard to measure how you're doing exactly. But patient satisfaction as a measure of quality care is topical right now, so one of the things that we do is collect data about how we are doing with our patients. What we collect are data about what patients think about the general office attitude. We want to know if patients think they were treated respectfully, did they have enough time with the doctor, were things explained clearly, were preventive measures discussed,

and is 24-hour phone advice available? These sort of issues are usually made up into a questionnaire, which may be generic, or it may be very specific for a very specific practice.

These questionnaires are given to a representative sample of our patients, and then we simply see how we're doing. It gives us a couple of things. It gives us a measure of how we're doing in areas we can be proud of and other areas that may need some attention. And, also, when we collect these data, those numbers give us something that we can take to managed care or to umbrella organizations to show we're not only doing a good job, but we're measuring and reporting that we're doing a good job.

In general, we look pretty good to ourselves. We're delighted to find that we are doing a good job with our patients. They like our office, the waiting times are reasonable, and they're quite happy with the physicians. In addition, we think we do a good job medically, too.

We do this from time to time. We do not do it continuously, but every year or two.

Q: *You were making a distinction earlier between patient satisfaction and outcomes. Are you measuring outcomes as well?*

A: We try to measure outcomes, but those are harder to measure. We need more hard data for outcomes. We can measure outcomes by how often our patients wind up in the emergency room, how often our patients are hospitalized, and some other harder data. But those data are hard to come by because those numbers do not always come from us. It may come from someone else, for example, the emergency room. Also, our patients don't always come back and say, 'I got well. Check off box X.'

Quantitative outcomes are difficult to measure in an office setting and that's one of the things that medicine is dealing with now. How do you measure clinical results? What benchmarks do you have? We always think we do a good job, but we wish we had better tools to measure our results quantitatively.

Q: *Speaking of better tools, many managed care organizations are using guidelines today, particularly for treating patients with chronic conditions, such as asthma. What's your approach to guidelines?*

A: Guidelines seem like a good thing and probably they are. But at this stage in the game, there isn't enough data on enough diseases to really nail that down. For example, in our literature, there's evidence that care of asthma by asthma specialists, whether they be pulmonologists or allergists, is more cost effective. They get well faster, they stay out of the ER, and are hospitalized less. The same is true with patients who have acute myocardial infarctions and also patients with diabetes. The problem is that someone with an MBA who's controlling 35,000 lives, may be following guidelines and saying, 'No, you've got to see your family doctor first.' He may be married to a philosophy that doesn't check out in reality for certain diseases.

I think that bringing a rational order to the treatment of medicine is always a useful goal, and guidelines have and will make a contribution. But they are not the be-all and end-all. They are guidelines. They are not etched in granite. Sometimes they may be self-defeating by being too rigid.

Take, for example, the new long-acting bronchodilators that are available today. To get them, you have to see a specialist. To see a specialist, you have to get a referral from a family doctor. Well, if the family doctor doesn't think the referral is indicated, you can keep the patient away and not let the patient have the benefit of this new and very effective medicine for a long period of time. That wouldn't have been the case if the patient had seen the specialist immediately. Requiring patients to see a gatekeeper or primary care doctor may or may not be cost effective for many diseases, but for some diseases it's definitely not cost effective.

This is not a simple business. Organizations are different and patient populations are different. And, specialists not only have a role in specialist consultations for their specific medical expertise but also we should consider that it may simply be cheaper and better for patients and for health plans in the long run to let patients with complex diseases be handled by specialists who do the work regularly and who experience has shown have become more cost effective at it than family doctors.

Q: *The business coalition in Minneapolis, called the Buyers' Health Care Action Group, has said it wants to deal directly with hospitals and physician networks and that it wants to cut out the HMOs. Do you think that's an important movement?*

A: The business coalition has 23 large employers and represents 250,000 beneficiaries and 10% of the Twin Cities market. Whenever they speak, we have to listen, or at least try and overhear. There's some rebound and backlash against the organization of medicine here.

The first go-around was to sign up members to get market share. Then the next go-around was to get the lowest cost per member per month. Now quality is being talked about. In addition to quality the businesses are saying, "We don't want our members bouncing between insurance plans every year and a half where they have to change primary physicians and their medical relationship." So maybe there's a better way to do it. I know that they're talking about bypassing insurance organizations. Ideally, if you can cut out the 23% administrative cost and give it back to either the patients or the physicians, that's great. It's like in a war. I don't want to get killed while my side wins the war, though.

So we're observing it. I don't know how or if they're going to pull it off, but that's one of the issues we're watching closely. In this market, we find we have to watch many things like that very closely. ■

"It may be cheaper and better for patients and for health plans to let patients with complex diseases be handled by specialists who do the work regularly and who experience has shown have become more cost effective at it than family doctors."

The Compelling Logic of Information

By Carl Schramm, PhD

Editor's Note: With this column, Physician Practice Options *introduces a new service for physicians. The Information Systems column aims to help physicians and practice managers to understand how advances in practice information can help them manage more effectively and to develop the information needed to survive under capitation and other managed care payment arrangements. Occasionally, the column will be accompanied by a review of a vendor's information system, and Greenspring Advisors notes that the firm may have an economic interest in companies reviewed here.*

By now every physician appreciates that as part of the drive to consolidate physician practices there is a strong need for information. While this fact is widely known, there is little agreement about just what new information is needed. This confusion is due largely to the novelty of having to manage in a world dominated by what might be called "nonrecourse capitation contracting." Capitation payment is without precedent. Nonetheless, many practices are being formed to take insurance risk under such arrangements. And most are operating dangerously because they do not have an information strategy. Without an effective, well designed approach to managing information, any group of physicians assuming financial risk under these conditions could be devastated.

An example makes the point. Recently our firm was asked to examine a contract already in place between a physician's group in Connecticut and a large HMO. As often happens, the group had 10 business days to accept the HMO's proposal for "all in" capitated risk or watch the business go to competitors. While the physicians' lawyer and accountant signed off on the deal, the clinic manager had no sense of whether the contract made economic sense. Since he had no unit costs, no marginal cost model, and no comparative data, he could not evaluate the contract adequately. For all he knew, it could be a death sentence to the practice or a solid basis for profitable growth. As it turned out, the contract put the physicians at risk for a great deal more than the per capita fees would cover. It forced the doctors to overprice services where they had price discretion (a risky strategy) to make up for certain losses in other areas under the contract.

Such situations are new to physicians who have practiced as one-person business entities. Payers are using their power to channel patients and to insist on capitated payment, thus forcing physicians to assume financial risk for large groups of patients. Since these payers find capitation attractive for many reasons, the trend is not likely to be reversed.

Therefore, as the example shows, physician managers must understand their practices' internal operations from a risk perspective.

The first and most obvious step in this process is to develop an information strategy, just as a group would develop a business strategy. This strategy should involve identifying what information resources the group needs to survive.

The world of health information systems can be unsettling. Soon after a physician group understands that information is somehow important, the group suddenly may be making decisions about how much memory its net server needs to run the plan's management software. Thus, an information strategy is critical to a group's ultimate survival and threfore needs to be articulated clearly.

Information strategy is based on a simple view: data are gathered to become information; information is valued because it can lead to knowledge; knowledge is necessary to change behavior. The successful practice bases its information strategy on the premise that it must change its behavior. Its information strategy, therefore, presents the practice with a profound reality: The practice exists to be managed into something that it is not but wants to become. The importance of this observation cannot be overstated. The group practice that does not exist to change itself will embark on an information strategy that will not help the practice accomplish its goals. It is not uncommon for groups to use their information resources to make contracting decisions that are putting the practices at long term risk.

The clinic manager had no sense of whether the contract made economic sense. He had no unit costs, no marginal cost model, and no comparative data to use in evaluating the contract.

Data Strategy

The components of a data strategy involve four functions that any group must be able to accomplish. The group's data strategy must involve

1. Gathering all pertinent data from its doctors and other sources including lab results, medications, and selected hospital information;
2. Transmiting the data to the processing site;
3. Analyzing the data in the context of the group's strategy (in other words, it must translate the data into information);
4. Reporting the data so that they become a knowledge asset to physicians who intend to make changes in their behavior.

In order to accomplish these goals, the information strategy must rely on data

(Continued on page 12)

***Carl Schramm, PhD**, is president of Greenspring Advisors Inc., a consulting firm in Towson, Md., that specializes in health information technology for physicians' practices, insurers, pharmaceutical companies, Blue Cross plans, and venture capital funds. He also is a member of the advisory board of* Physician Practice Options.

Figure 1: Physician Information Systems

Data type	Collection	Transmission	Analysis	Reporting
Internal	Physician develops data.	Office sends data to group's information center.	Data are analyzed for compliance and for expected outcomes.	Information helps practice conform to internal and external norms.
External	Consultants or information systems vendors collect data.	Information systems vendors transmit data to central facility.	Internal and external data are compared to show variance from norms.	Outcomes and patient-satisfaction scores are reported.

internal to the practice as well as external data assets that will operate as norms or benchmarks. Figure 1, Physician Information Systems, shows four functions and two data sources needed to deliver the knowledge necessary to conform individual practitioner's behavior to the group's overall business strategy.

The figure provides a reference for any discussion about health information. The physician manager can see, for example, that while the technology behind a hand-held data device that records physician decisions may be attractive, the data are only as good as their port of entry. The device does not let the group act upon the data, nor will the device improve upon the data. In order to conform to the group's information strategy, the data must not only be collected and transmitted to a data facility, but analyzed and presented to the physicians in a form that is actionable. Since transforming the data into useful information is a much more useful function, it is therefore likely that a more sophisticated data-entry tool is needed.

The figure also is useful when considering the various physician information system vendors. Most vendors fall into one of the eight cells in the matrix. Vendors providing normative data, for example, do not own primary data from physician groups. Organizations that transmit data seldom analyze data. And organizations that conduct patient satisfaction suveys rarely link the data to physicians' clinical actions. Therefore, the practice manager cannot turn to one vendor for a complete solution. While many vendors purport to offer all the information support needed, none actually does.

Lacking a ready-made solution, each clinic manager must develop a unique data strategy for his or her group. A group in Texas may prefer to scan patient encounter forms for data entry, while this strategy may be rejected by doctors in Pennsylvania who prefer direct computer entry. The system of analysis for a group of cardiologists is likely to be more advanced than that of another vendor providing analysis software for Ob-Gyns.

The market is fragmented. To make a group of physicians happy and productive while working under a self-imposed information regime, the system must be tailored specifically to the group's needs. ■

Information Vendor Review

LifeRate Systems Inc., Edina, Minn.
Provides outcomes analysis to cardiology and asthma practices

LifeRate's product is used by cardiology practices and asthma specialists to evaluate their internal quality. The company establishes a data capture capacity in each of its practice sites. Its customers look to LifeRate for an electronic patient record that makes all data uniform at entry. Physicians might not actually do the data entry. But all patient information is electronically screened to ensure uniformity of data elements and the quality of the data pool. As data are absorbed into the practice's data base, the system prepares information on physician performance. As part of its philosophy, LifeRate concentrates on measuring outcomes. Thus, the cardiology practice using LifeRate's system can make an empirical case with its payers that its covered population is being well treated.

Many cardiologists have had a hand in designing the LifeRate system and its customer base includes several distinguished cardiology practices.

Like many analytic companies, LifeRate has had a slow start. Customers have had problems in data entry. However, recent focus by management on improving customer satisfaction, and the utility of the LifeRate product in a capitated environment is promising. The company has the resources, including seasoned management, to improve its performance. It has become a customer-friendly vendor.

One lesson to be learned from this and similar companies is that the emergence of the electronic medical record (EMR) is more likely to be observed in data firms supporting specific sub-specialists rather than those serving physicians in a general clinical setting. Companies selling only EMRs for application in any clinical setting are finding that broad-scale implementation is extremely difficult. Indeed, it is difficult to predict which generic EMR companies will be around in five years.

Specialty Care

In a survey, InterStudy Publications, in Minneapolis, asked HMOs to specify the percentage of total reimbursements covered by each of four reimbursement methods (figure 1).

Figure 2 shows the percentage of HMOs that have developed disease management programs versus the percentage of HMOs that have actually implemented the programs. Figure 3 shows the percentage of HMOs that have cut costs after implementing disease management programs.

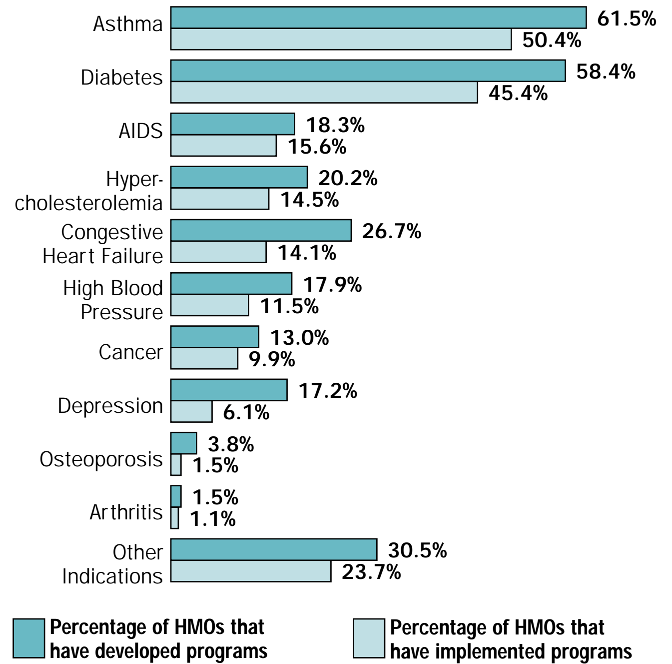


Figure 3: Disease Management and Cost Cutting

Healthcare Service	Percentage of HMOs that Cut Costs	Responding HMOs
Emergency room visits	74.0%	50
Hospital admissions	73.7%	57
Specialty care visits	48.8%	41
Diagnostic testing	34.4%	32
Home care	33.3%	36
Primary care visits	28.2%	39
Pharmaceutical prescriptions	25.5%	47

Figure 1: Average Percentage of Specialty Services Reimbursed Using Different Methods

Specialty	FFS or Discounted FFS	Capitation	Relative Value Scale	Salary
Average for all specialties	46.0%	28.6%	24.5%	1.1%
Allergy and Immunology	42.3%	30.9%	23.3%	3.5%
Anesthesia	50.3%	24.8%	24.3%	0.6%
Cardiology	46.7%	27.4%	24.7%	1.2%
Dermatology	45.4%	28.6%	24.8%	1.2%
Emergency Medicine	49.9%	25.9%	23.2%	1.0%
Endocrinology	46.5%	28.1%	24.2%	1.2%
Gastroenterology	44.9%	29.2%	25.1%	0.8%
General Surgery	45.8%	28.3%	24.9%	0.9%
Hematology and Oncology	47.2%	26.7%	25.3%	0.8%
Infectious Disease	47.7%	26.1%	25.9%	0.3%
Nephrology	48.2%	26.1%	25.0%	0.7%
Neurology	46.8%	26.5%	25.7%	1.0%
Neurosurgery	47.6%	27.3%	24.7%	0.3%
Obstetrics/Gynecology	43.6%	29.4%	25.0%	2.0%
Opthalmology	44.4%	30.0%	24.7%	0.9%
Orthopedics	43.8%	30.9%	24.6%	0.7%
Otolaryngology	45.6%	28.6%	24.7%	1.1%
Patholgy	45.1%	30.0%	23.7%	1.2%
Plastic and Reconstructive Surgery	46.8%	27.2%	25.4%	0.6%
Psychiatry	40.7%	36.4%	21.9%	0.9%
Pulmonary Medicine	46.6%	28.7%	23.6%	1.2%
Radiology	43.3%	31.8%	23.7%	1.2%
Rheumatology	47.0%	28.8%	23.4%	0.8%
Thoracic Surgery	47.3%	26.9%	25.5%	0.3%
Urology	45.1%	29.0%	24.9%	1.1%

Note: Percentages do not total to 100 due to rounding.
Source (for all charts): The InterStudy Competitive Edge: HMO Industry Report 6.2, InterStudy Publications, Minneapolis, 1996.

Physician Seeks a Capital Source

Dear Practice Options Q&A

My practice is in an advanced managed care market, penetrated heavily by senior and commercial HMOs. Last year, our primary care group of more than a dozen physicians broke off from our local hospital-based IPA. We found that it was driven too much by the need for revenue for specialists, the hospital, and by HMOs. We now have office-based primary care doctors, use capitated specialists, and have captured more full risk contracts than our old IPA ever had. We made a profit within six months. Ours is a primary care equity model. Our new IPA is hooked together by our HMO business, our utilization and quality assurance programs, and our shared risk. Since we're still practicing solo or in small groups, the infrastructure is in place and I believe solo primary care physician groups, such as ours, are more competitive on price, quality, and patient satisfaction. But we require capital to hire the best managed care expertise and to buy the best information system. Can you direct me to a capital source?

Seeking Capital

> **"Since we're still practicing solo or in small groups, the infrastructure is in place. But we require capital to hire the best managed care expertise and the best information system. Can you direct me to a capital source?"**

Dear Doctor,

The whole world of capital-lending to doctors is looking for integrated groups like yours with a positive economic track record, experience in managed care, and able to consummate deals with a single signature. Your only drawback is that most companies are reluctant to do business in mature markets where premiums continue to drop and margins are narrowing. Nevertheless, your group sounds as it if would be attractive to a physician practice management firm or a venture capitalist. Undoubtedly, you have received such inquiries. In addition, we would refer you to two members of our editorial board: W.L. Douglas Townsend Jr., managing director and CEO, Townsend Frew & Co., LLC, investment bankers specializing in health care, Durham, N.C.; and Brooks G. O'Neill, managing director, Piper Jaffray Inc., Minneapolis.

Physician Practice Options welcomes questions from readers. Write to Richard L. Reece, MD, editor-in-chief, 15 Banbury Crossing, Old Saybrook, CT, 06475-2362. Or, call our toll-free line at 888/457-8800.

Dear Practice Options Q&A

I'm in a very successful 12-man cardiology group in a mature market. We're very ambitious and would like to go public as a cardiology practice management company.

Going Public

Dear Doctor,

A genuine skepticism exists about the sustainability of specialty practice management companies. In mature markets, large buyers tend to consider specialty carve-out companies as regressive and tending to re-fragment the health care market. Specialty companies sometimes find that they form a company, create a product, and no one is interested. The fact that many publicly traded specialty companies suffered paper losses last summer further fuels such skepticism. Also, your group may be too small to attract much interest. Most physician groups or collections of groups should have at least $50 million in annual revenue.

Having said that, the cardiology market, at roughly $125 billion, is huge and has caught the eye of Wall Street. A publicly traded company, MedCath, is currently on the market, and others anticipate going public. You would be well served to discuss your interests with venture capitalists. You might also attend investment conferences sponsored by such firms as Bear Sterns, Paine Weber, Piper Jaffray, and Cain Brothers, and network among your fellow cardiologists.

> **Specialty organizations sometimes find that they form a company, create a product, and no one is interested.**

Dear Practice Options Q&A

I'm in a 26-member primary care group in the South. As we expand, we need capital for information systems and practice acquisition. We're currently talking to Columbia/HCA, the owner of our local hospital, about getting capital. Should we consider other capital sources?

Evaluating Capital Sources

Dear Doctor,

Yes. You should consider a physician practice management company, which would have none of the encumbrances of a hospital. Hospitals are not always desirable as sources of capital because conflicts can arise when hospitals need to fill beds while managed care forces doctors to reduce hospital stays. (See "Strange Bedfellows," page 1.)

Having said that, you should remember that Columbia/HCA is no ordinary hospital chain. Nationwide, Columbia/HCA is pursuing an integrated delivery strategy that includes making physicians financial partners. You're doing the right thing by talking to Columbia, but be sure to explore other options as well. ■

Analysis Shows Benefit of 48-hour Maternity Stay

Since a Connecticut law requiring a 48-hour stay for mothers and newborns went into effect in June, the number of newborns returning with complications has dropped, according to an analysis of hospital discharge data by *The Connecticut Post,* a newspaper in Bridgeport. Reported maternity stays were longer at each of the 31 Connecticut hospitals that have maternity wards, the Post said.

From June 1 through Oct. 31, for example, Griffin Hospital in Derby had 28 babies return with jaundice, 37% lower than the number of newborns who returned in the same period in 1995.

Comment: *After the law went into effect in June, maternity patients at Bridgeport Hospital were staying three full days, compared with 2.3 days the previous June. At Milford Hospital, new mothers stayed 2.8 days in August, compared with 1.7 days the previous August.*

Health Plans Try to Quiet Controversy Over Outpatient Mastectomies

Trying to quell a controversy over outpatient mastectomies, the American Association of Health Plans, a trade group in Washington, D.C., has recommended that health plans allow an overnight stay for women who have a breast removed for cancer.

HMO decisions to sanction outpatient mastectomies has created outrage among cancer surgeons, patients, and their families. Congresswoman Rosa DeLaura, D-Conn., plans to introduce legislation this month to require a 48-hour stay for any mastectomy patient who wants one.

In August, two Connecticut health plans, ConnectiCare and CIGNA Healthcare of Connecticut, adopted guidelines recommended by Milliman & Robertson (M&R), actuaries and health care consultants in Seattle, that mastectomy be done on an outpatient basis, according to *The Wall Street Journal.*

Women dread such surgery because it often causes pain, disfigurement, and damage to self-esteem. Traditionally, such patients have had a two- or three-day hospital stay because pain requires intravenous medication and wounds need to be drained. Many hospitals keep patients for two or three days, but some women prefer to go home as soon as the anesthesia wears off. Women's groups and the American Cancer Society support this option.

About 7.6% of mastectomies performed on Medicare patients in 1995 were outpatient procedures, according to HCIA Inc., a health care data analysis firm in Baltimore. In 1991, only 1.6% of Medicare mastectomy patients had the procedure done on an outpatient basis, HCIA said. HCIA could not say how many of these procedures were done for HMO patients.

The M&R guidelines suggest that even radical breast surgery can be done on an outpatient basis. Richard Doyle, MD, a senior consultant with M&R who wrote the guidelines, says outpatient care is intended for routine, uncomplicated cases. Oral medications are usually sufficient for pain relief, and family members can be trained to empty a drainage pouch, he says. Patients suffering emotional trauma often are happier at home, he adds.

Lee Newcomer, MD, chief medical officer for United HealthCare, in Minneapolis, has said his company had a policy requiring outpatient surgery for mastectomy, but reversed that policy after recognizing the emotional issues involved. "Some battles just aren't worth fighting," says Newcomer, a member of the advisory board of *Physician Practice Options.*

Comment: *As managed care covers more Americans, protests over cost-cutting methods have grown. In response, Congress passed legislation last year guaranteeing a 48-hour hospital stay after a routine vaginal delivers and equal benefits for mental illness.*

HMOs Refuse To Accept Malpractice Risk

HMOs prefer to shift financial risk to physicians and hospitals and do not want to accept a consequences of that risk — malpractice liability, according to *The New York Times.* HMOs, which care for 59 million Americans, are telling courts they cannot be held accountable for medical malpractice, asserting in court that malpractice claims against them are preempted under the Employee Retirement Income Security Act (ERISA) of 1974, *The Times* said.

Under ERISA, the HMOs say they are administering employee benefit plans, not practicing medicine, and they contract with doctors and hospitals as independent contractors. They further argue that patients must sue doctors, not health plans.

Comment: *The fact that HMOs promise to provide high-quality care by choosing the best doctors and hospitals and that they refuse to authorize tests, procedures, and hospitalization they consider unnecessary is irrelevant, the HMOs say. In considering the HMOs' claims, the U.S. Department of Labor said that using ERISA as a mechanism to strip protection against medical malpractice is paradoxical, since ERISA is designed to protect workers.*

More Doctors Move Toward Unionization

Physicians at Thomas Davis Medical Center in Tucson, Ariz., are scheduled to vote on affiliating with the American Federation of State, County, and Municipal Employees union. Reacting to changes fostered by managed care, Keith Sherman, an internist at the hospital, says doctors need unions to have more negotiating clout to dictate employment terms.

In October, Local 45 of the AFL-CIO, the First National Guild for Health Care Providers of the Lower Extremities, announced that it had formed the first national union founded by physicians for physicians. Physicians have been unfairly made the scapegoat of perceived problems in health care, Local 45 said at the time.

The AMA views doctors' unions cautiously.

Comment: *Although there is no widespread movement among physicians to unionize, perhaps that attitude will change as more doctors become employed by hospitals and HMOs.*

NEWS AND COMMENTARY

Harvard Pilgrim, a Staff-Model HMO, Restructures

Staff-model HMOs, such as Kaiser Permanente, in Oakland, Calif., and Harvard Pilgrim Health Care, in Boston, are struggling. Facing slow growth and competition from IPAs, both plans recently asked doctors to work longer hours for the same pay.

For years, these plans had the lowest premiums in their regions and grew rapidly. Then medical staff grew complacent, competitors undercut premiums, and enrollment dropped. Membership in Harvard Pilgrim peaked in 1993 at 300,600 commercial subscribers and 9,300 Medicare enrollees. Since then, growth in Medicare enrollees has kept overall membership stable, but commercial subscribers have declined to fewer than 285,000. The Harvard plan employs 106 more total staff today than it did at its peak. This year, the plan faces a deficit of $10 million on a budget of $530 million, according to *The Boston Globe*.

Such closed-panel HMOs clearly are on the wane, and currently care for less than 2% of all HMO subscribers. The delivery model has shifted to networks of independent practitioners. Staff model HMOs are battling consumer perceptions that they offer an anonymous brand of care with a limited choice of doctors and a narrow geographic reach.

Comment: *The salaried system sheltered doctors from the vagaries of the market, and now salaried doctors will have to become more productive because their compensation is contingent on meeting budget targets. Also, Harvard's doctors will face what's called internal competition, which allows subscribers to change providers within the network of 16,000 office-based physicians.*

A Toll-free Line for Physicians
888/457-8800

Our mission at *Physician Practice Options* is to be a practical information resource for physicians seeking to thrive in health care. In a search for new practice options, physicians are asking themselves a variety of questions, including:

- Should I sell my practice?
- Should my colleagues and I form a physician organization?
- Where should I go to get capital?

We willingly make ourselves available to answer any and all such queries from readers. If we don't know the answer, we have vast resources at our disposal and will refer you to the appropriate expert.

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Richard L. Reece, MD
Editor-in-Chief
Physician Practice Options
15 Banbury Crossing
Old Saybrook, CT 06475-2362
Phone: 860/395-1501
Fax: 860/395-1512
E-mail: RReece1500@AOL.Com

Joseph Burns
Editor
21 Stone Wall Lane
Falmouth, Mass. 02540
508/495-0246
Fax: 508/495-0247
JoeBurns@CapeCod.Net

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