PHYSICIAN PRACTICE
OPTIONS™

January 1998

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

Five Trends to Watch in 1998

Physician practice management companies will continue to grow significantly in influence in the coming year, and this trend will be one of the most dramatic changes physicians can expect in 1998. In particular, these companies will move to consolidate specialists, affording them more market clout.

This prediction is one of five major market trends identified by members of the Advisory Board of *Physician Practice Options*. The board also identified three trends that will have less significant effects on physicians (see sidebar, "Three Other Trends to Watch in 1998"). The five trends the board outlined as the most important trends physician will face in 1998 are

1. Physician practice management companies (PPMCs) will continue to acquire and partner with physician groups. The number of PPMCs doubled from 20 to 40 in 1997, and strong growth is possible again this year.
2. Dissatisfaction among physicians will lead them to seek a greater role in how health care is delivered, and dissatisfaction among consumers will force legislators to set more limits on managed care.
3. The Balanced Budget Act of 1997 will have a significant effect on physicians. Seeking to control federal health care spending, Congress passed the legislation to restrict Medicare reimbursement growth and to create new organizational options for physicians and hospitals.
4. HMO costs will rise in 1998, meaning physicians' pay will be cut as health plans seek to contain costs.
5. Physicians will gain more power in their dealings with physician-hospital organizations (PHOs).

PPMCs

The growth of PPMCs is a major development for all physicians, but particularly for specialists, says Peter Kongstvedt, MD, a partner in Washington, D.C., with Ernst & Young, accountants and health care consultants. "The growth of specialty PPMCs will consolidate specialists," he says. "That means a network of specialists will be represented by PPMCs and will have risk-based contracts with managed care organizations. The specialists who become part of larger groups will have an increased amount of market clout, while those who are not part of a PPMC will have diminished market clout."

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> ***— Peter Kongstvedt, MD, Ernst & Young***

PPMCs assumed new stature in October when the nation's two largest PPMCs—PhyCor Inc., in Nashville, Tenn., and MedPartners Inc., in Birmingham, Ala.—announced their intent to merge. Scheduled for completion in the first quarter of this year, the merger will mean that 5% of the nation's physicians, or more than 35,000 doctors, will be represented by a single company, giving them a degree of market power unprecedented in health care.

Under managed care, PPMCs have become a viable practice option for nearly 8% of U.S. physicians, or more than 56,000 doctors. To remain independent in this environment, physicians need capital to hire management talent, to invest in

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EDITORIAL

Wanted: Your Comments, Opinions, Suggestions

This issue marks the beginning of our third year of publishing *Physician Practice Options*. In keeping with our goal to continuously improve the newsletter, we begin this year with two invitations to readers.

First, we are assembling a panel of regular readers to serve as "reader reactors." These readers will fill out a brief form after each issue is published explaining their reactions to the content of the newsletter.

We are assembling this panel so that we can generate a regular source of feedback. As professional writers and editors for the newsletter, we have many ideas, a stellar advisory board, and innumerable sources of information at our disposal. But even with all these going for us, we cannot possibly know exactly how all the issues we cover affect practicing physicians, and we want to gauge the value and utility of our articles in a systematic and timely fashion. Although we have received an extraordinary number of calls on our toll-free phone number from readers asking questions, seeking information, and offering feedback, we would like to increase that level of interaction with our readers.

Here's how our reader reactors would work: After each issue is published and mailed, we will send a brief survey that includes the headlines of the articles appearing in our most recent issue. We will ask the reader reactors if they have received their copy of the newsletter, if they have read it, and to tell us their opinion of each article they read. We may follow up with a phone call to ask a reader to elaborate on the comments. Then, we will compile the data in a report to our writers and editors on the value and utility of each article.

Among the questions we seek to answer are

- Were the articles useful to you in your practice?
- Were they of sufficient depth to offer insight but also readable enough so that you could easily understand the meaning?
- Did we leave anything out?
- What other topics should we cover in future issues?

How we send the survey—by fax, e-mail, or regular mail—would be at the preference of the reader reactor. All we ask is that it be completed and returned promptly.

Our second invitation is similar in nature. We are seeking story ideas from readers, particularly case study articles and successful marketplace strategies. For an example, see the Case Study on page 3, "To Fend Off Outside Interests, PCPs Form a Group Practice." We invite readers to write articles themselves, or we have professional health care writers who can conduct interviews and then write the story.

We believe that when writers and editors work closely with readers in developing editorial content, not only does the quality of the newsletter improve, but we are able to deliver more of the information physicians need to succeed.

How to Reach Us

If you would like to be a reader reactor or have a story idea, you can call me directly at the toll-free phone number below. You also can write to me, or send me an e-mail or a fax. No matter how you respond, your comments are welcome.

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Physician Practice Options is published monthly by Premier Healthcare Resource, Inc., Parsippany, N.J.

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Subscription Price: $220 per year, 12 Issues
Issue Price: $25 each

CASE STUDY

To Fend Off Outside Interests, PCPs Form a Group Practice

Managed care has forced many health care providers to form partnerships. Gateway Medical Associates, a group practice of 18 primary care physicians and four nurse practitioners in Exton, Pa., is one example. Gateway formed its group with the help of a local hospital because the physicians were seeking an alternative to selling their practices to any of several acquisitive health systems from outside of Exton.

"We decided to form a group because of what we saw happening in our area," says Geoffrey M. Burgess, MD, Gateway's president and one of its founders. "We didn't want that to happen to us. As individuals, our interest in forming Gateway was to remain self-governing. Jointly, our interest was to become the preferred primary care group in Chester County."

Gateway is a group practice without walls (GPWW), in which physicians aggregate their practices into one professional entity, under a single tax identification number, but continue to practice in separate locations. Such groups usually are owned and run by member physicians. Formed in May 1996, Gateway has 10 sites throughout Chester County, which is about 25 miles west of Philadelphia and which has a population of about 400,000 residents.

The physicians who formed Gateway were concerned about the potential for market dominance that could result from the purchase of medical practices by integrated delivery systems (IDSs) from outside the county. Such organizations as the University of Pennsylvania Health System and the Jefferson Health System, both in Philadelphia, and the Allegheny Health System in Pittsburgh, were buying up physician practices in Chester County, says Burgess. An IDS is a system of providers, often including one or more hospitals, organized to offer a broad range of health care services.

In 1993 and 1994, the three large health systems purchased about 40 private practices in Chester County, says E. Christian Hansen, Gateway's executive director. "Those practices were purchased outright, and the doctors were given five-year contracts," says Hansen. "After their contracts run out, the doctors who sold their practices will be at the mercy of the system, their salaries may rise or fall, their positions may be eliminated, or they could be replaced by a recent medical school graduate at a lower salary. Some doctors in this area didn't want that kind of arrangement, seeing it as an economic hazard and a threat to their professional independence. They wanted an alternative."

Autonomy Preferred

In 1994, Burgess and other primary care physicians (PCPs) began meeting to discuss forming their own, self-governing group. "We were concerned about loss of professional autonomy," Burgess says. "The organizations that were coming in were buying all the assets of the practices they purchased. The doctors were receiving salaries and incentive payments. And, under the terms of the sales, the organizations that purchased these groups would make all business decisions, including the hiring and firing of personnel within each practice. We wanted to create a group that would be physician-owned and physician-governed. We wanted to create our own business plans and manage ourselves."

> "We decided to form a group because of what we saw happening in our area. We didn't want that to happen to us."
> — *Geoffrey M. Burgess, MD, Gateway Medical Associates*

In addition to the issue of professional autonomy, the 18 Chester County PCPs meeting to discuss group formation were concerned about the economic advantages the large IDSs would have in Chester County if many physicians sold their practices. Forming their own group could allow them to compete effectively with those systems, Hansen reasoned. "Large IDSs are often well capitalized and well positioned in a market to exert economic clout," he says. "It is to their advantage to purchase a critical mass of physicians within a market area, and then negotiate rates with regional payers. They can go to payers, such as employers and HMOs, and negotiate contracts that are more economically advantageous than physicians can who are in individual practices. Forming a self-governing, physician-owned GPWW helps to level the playing field, allowing physicians in that group to benefit from group purchasing discounts and lower administrative costs, and we hope it enhances revenue through improved access to managed care capitated contracts. It creates economies of scale impossible to achieve in private practices and allows physicians to maintain their incomes and compete with physicians whose administrative needs are met by the system that bought their practice."

The physicians discovered that their concerns about market dominance by large systems from outside the county were shared by a local hospital, Chester County Hospital (CCH). The president of CCH, Perry Pepper, met with the physicians and offered to help.

Self-preservation

The hospital wanted to maintain a level playing field. "I suppose it was a form of enlightened self-interest," Pepper explains. "Our area has traditionally been composed of individual practitioners and small groups of two to three doctors. If outside integrated systems purchase a large number of those practices, those doctors could be encouraged to make referrals to hospitals the systems

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>
> ***— E. Christian Hansen, Gateway Medical Associates***

(Continued from page 3)

own or with which they have economically advantageous contracts. We didn't want to see that happen. We have a commitment to community access and community service, and we didn't want to see health systems from outside the county pulling heath care resources out of the region."

Traditionally, health systems attempt to dominate a market by purchasing physician practices, Pepper says. "For some of these large systems, the whole point of buying physician practices is to channel patients to their institutions. Popular targets for some systems are ancillary services. By encouraging physicians to use the system's ancillary services, the system can see some return on its investment in owned practices. And that's especially true in managed care. Profit is made through the directed use of ancillary services, such as lab work or prenatal care," he says.

Conversely, community and nonprofit hospitals have lower profit margins than larger IDSs have. For smaller hospitals, some services, such as home care, are particularly fragile economically. Pepper comments, "If large systems were able to draw away even a relatively low number of patients from those services, by encouraging their physicians to refer only to their own facilities, that might mean we could no longer afford to provide such services locally. We did not want to see that happen. The entire system of local health care delivery begins with physicians having independent choice."

For physicians to remain independent and to compete successfully with large systems, they need to work in unison, Pepper says. "If they do not maintain their local focus, it adversely affects all of us," Pepper explains. "We wanted to see these doctors come together and develop their own strength within this county. Our focus in helping them organize was to maintain our bond to the community. That bond is the only reason this hospital exists."

In 1995, CCH hired Partners Consulting Group, of Minneapolis, to conduct educational seminars on group formation possibilities. Since the effort was aimed at all physicians in the region, CCH did not ask Gateway to pay for the cost of the seminars, nor did the hospital expect that once Gateway was formed, it would use CCH's services rather than the services of any other hospital, Pepper says.

"The hospital apparently understood the importance of local physicians maintaining their independence," says Gateway's Hansen. "That kind of forward thinking is unusual, in fact, enlightened from an administrative point of view. Most hospitals want to own physicians, not help them to be independent."

Multiple Sites

Gateway physicians operate in 10 clinics throughout the county, and each functions as a separate profit center. Gateway's annu-

Group in 10 Offices Seeks to Improve Efficiencies

The primary care physician members of Gateway Medical Associates, a group practice without walls of 18 primary care physicians in Exton, Pa., work in 10 separate clinics. To improve clinical coordination, Gateway is examining the possibility of replacing its current system with three new types of delivery clinics that will enhance clinical integration, including

Consolidated clinics, which would provide the "ultimate in one-stop shopping," says E. Christian Hansen, Gateway's executive director, by combining many highly used services under one roof. For example, Gateway plans to consolidate four offices staffed by solo practitioners into one clinic, in which the physicians would handle geriatric care, internal medicine, nutrition, and social services. Such consolidated clinics would be located on the campus of local hospitals to provide access to existing ancillary services, such as radiology, laboratory, and physical therapy. Each clinic would have evening and weekend hours.

Family clinics, which would provide typical primary care services at convenient locations, such as shopping areas. They would house two to three providers, and include blood testing services but not the broad range of ancillary services available at the larger sites. Each would offer evening and weekend hours.

Specialty clinics, which would provide typical primary care services specifically to underserved areas or future high market growth areas, as opposed to the family clinics, which would specialize in family care in convenient locations. The specialty clinics would be staffed by one or two physicians.

Currently, Gateway's administrative staff includes an executive director, an operations manager who manages all nonclinical staff, and an administrative assistant. Centralized administrative functions, such as payroll, accounts payable, budgeting, billing, and accounts receivable, are contracted to a management services organization, Integrated Medical Management, in neighboring Malvern, Pa.

al budget is about $6 million, Burgess says. Of that amount, administrative costs account for about 60% of income. All income goes into a common pool, and the group's members share a common tax identification number as a public corporation. Once administrative costs are met, funds are distributed to the individual clinics based on the amount of revenue each one generates. Physicians are paid a salary, and bonus payments are tied to each clinic's profitability.

"As yet, we are not a fully integrated model," Burgess says. "If we were, profits would go into a central pool. We are examining the possibility of a more centralized compensation system, with profitability tied to the performance of the entire group, but we haven't reached that point yet."

In Gateway's service area, the group has about 50,000 patients, or 12.5% of the market total. About 10,000 of its patients are enrolled in managed care plans, primarily those offered by two managed care organizations, Aetna U.S. Healthcare, of Hartford, Conn., and Keystone Health Plan East, of Philadelphia. Given the level of managed care enrollment, revising the physician compensation system is one of Gateway's current priorities, Hansen says. "Most studies show that when a group's revenue from managed care exceeds 30% of total income, it is time to re-evaluate its traditional fee-for-service-based compensation system," he explains. "As we continue to accept a larger percentage of capitated contracts and move toward global risk, we need to develop new methods to distribute revenue."

Looking Forward

"Managed care is an increasingly important factor in this market and a key ingredient in Gateway's recipe for growth," Hansen continues. "As with most primary care providers, we have a hard time generating excess capital to fund future growth." After analyzing managed care utilization data and hospitalization and specialty costs for the group, Hansen has concluded that accepting more of the financial risk of delivering care provides an opportunity to enhance revenue.

As it accepts more managed care risk contracts, the group will need to revise its financial incentive system and develop programs to improve the health of its patients through home health care, social work programs, and nutrition and patient educational programs, Hansen explains.

In addition to revising financial incentives, the group wants to move toward more clinical integration. "During our first year of, operation, most of our efforts were focused on establishing financial integration with networked information systems at all of our sites," Hansen explains. "In our second year of operation, we are moving toward clinical integration. At a minimum, clinical integration provides for referrals from one Gateway office to another. Enhanced integration will involve the coordination of expanded hours, specialized product lines (such as geriatric and adolescent medicine), and coordinated coverage, which would include a hospitalist." A hospitalist is a physician who handles all hospital care.

Hansen believes clinical integration has the most potential to help the practice grow and to reduce costs. "We want to develop the clinical integration that will allow us to capture a larger portion of the region's managed care market," he says. "Unfortunately, the existing revenue and expense allocation system of returning funds to separate profit-and-loss centers does little to encourage that." ■

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> **"Because there are fewer choices, at least in the short run, the feeding frenzy that has gone on for the last three or four years in practice acquisitions will slow down."**
>
> ***— Nathan Kaufman, The Kaufman Group***

(Continued from page 1)

information technology and ancillary businesses, and to manage capitation profitably. Physicians also need assistance in negotiating complex contracts with managed care organizations (MCOs). Most practices cannot do all of these functions without help. Seeking funding, physicians borrow from banks or other capital sources, obtain capital from hospitals, or get capital and management resources from a PPMC. Since PPMCs offer so many services, they are an attractive option for physician groups of all sizes.

Moreover, PPMCs may have a positive effect on the quality of care delivered, says W.L. Douglas Townsend Jr., managing director and CEO of Townsend Frew & Co., investment bankers in Durham, N.C. "Creating consumer satisfaction has to be the result of a merger of business and medicine if such mergers are to work," he says. "Medical groups that distinguish themselves with quality and service will be the survivors in the long run. To maintain quality, physicians will need to continue to make capital investments in systems and infrastructure." One of the best ways to do so is to form an alliance with a PPMC, he says.

The number of PPMCs providing services to physicians, doubled in 1997, reaching 40, according to some estimates. While such growth in the number of organizations may not occur again this year, there is little doubt that all PPMCs will grow substantially in size simply by partnering with and acquiring more practices.

Also, some PPMCs may merge with or acquire competitors, as PhyCor and MedPartners are seeking to do. Since the two companies had competed aggressively for physician practices, the merger may slow competition for physician groups, says Nathan Kaufman, president of The Kaufman Group, in San Diego, a division of Superior Consultant Co. "The consolidation of PPMCs, like the MedPartners and PhyCor merger, will reduce the number of options that physicians have," he says. "And because there are fewer choices, at least in the short run, the feeding frenzy that has gone on for the last three or four years in practice acquisitions will slow down."

Dissatisfaction

Another significant issue this year will be physician and consumer dissatisfaction with the limits of managed care. Last year, complaints about managed care were commonplace. Congress and state legislatures considered bills aimed at limiting the reach of HMOs; physicians opposed HMO gag rules; and consumers sought and received wider access to specialty care. This year, consumers and physicians are likely to continue to attempt to assert control over the health care system, and, as a result, MCOs will reevaluate the way they do business.

> **"Physicians ... abdicated leadership in health care, and there is a movement now to regain that leadership. Either we become employees and mope, or we move on and find options."**
>
> ***— Richard Liliedahl, MD, Milliman & Robertson***

"From working with physicians nationwide, I think physician dissatisfaction with medicine today and with what we as physicians in this country are doing professionally is a big issue," says Richard Liliedahl, MD, a consultant with Milliman & Robertson Inc., actuaries and health care consultants in Seattle. "What physicians perceive has happened in health care is that they have abdicated leadership, and there is a movement now to regain that leadership. Either we become employees and mope, and that is a choice everybody has, or we move on and find options."

Edward B. Hirshfeld, vice president of the American Medical Association's Health Law Department in Chicago, agrees. "Physicians in solo or small group practices are extremely distressed right now, and few policy makers, the public, or the other interest groups involved—such as hospitals, insurance companies, and HMOs—realize how unhappy they are," Hirshfeld says. "That anger and disenchantment are going to find an outlet. Where that outlet will be is unpredictable. It would be great if these physicians could direct their anxiety into forming new networks capable of managing risk and satisfying the consumer, capable of taking control back from HMOs and other institutions, but they badly need leadership in that area.

"Someone physicians respect has got to show them the way," Hirshfeld continues. "Otherwise, that anxiety may show itself destructively, and we may wind up with a division between the physicians who have embraced managed care and those who have not." Currently, physician dissatisfaction is one factor driving the growth of PPMCs, the merger of physician groups, the formation of integrated groups, and the rapid creation of specialty networks and specialty groups, he says.

While physicians will continue to struggle with change brought on by managed care, they will be unsuccessful if they attempt to return to the previous system

Three Other Trends to Watch in 1998

After identifying five trends that will dominate physician practices this year, the Advisory Board of *Physician Practice Options* also recognized three trends that will have less significant effects:

1. The trend toward consolidation,
2. The movement to eliminate gatekeepers, and
3. An increase in federal fraud investigations.

Consolidation. Most physicians now believe they must be part of a medical group to survive financially in markets in which managed care has a large presence. But what kind of group should they form or join? Should it be a multispecialty group that offers one-stop shopping for buyers, but may involve squabbling among primary care physicians and specialists for income distribution? Or should it be a single-specialty group in which members can agree on practice guidelines and on how to best manage major chronic diseases?

Whichever option physicians choose, group formation will continue at an accelerated pace. "The jury is still out as to whether multispecialty or single specialty is the way to go," says W.L. Douglas Townsend Jr., managing director and CEO of Townsend Frew & Co., investment bankers in Durham, N.C. "But group formation clearly is going to have to continue in the future. Today, only about 35% of physicians are in groups of more than three doctors, so physicians are still in a very fragmented industry. Physicians will have to consolidate into larger groups."

Gatekeepers. Patients want specialists when they're sick, and they want the best. Payers and politicians recognize these facts because their employees and their constituents tell them so. In response, managed care plans are beginning to promote open access plans, even if the care in these plans costs more than that of the traditional narrow-access HMOs. Companies promoting open access plans include United HealthCare, in Minneapolis; Oxford Health Plans, in New York; and Foundation Health, in Rancho Cordova, Calif.

"The elimination of gatekeepers is the trend of the future," says Harold B. Kaiser, MD, a member of Allergy & Asthma Specialists, in Minneapolis. "It's been established that nobody likes the gatekeeper. Patients don't like them, and specialists don't like them. Studies show that at most they save only 3% or 4% over allowing patients open access to any physician or any specialists they want. That's a cheap price to pay for patient satisfaction, and many of the managed care organizations are coming to see it this way."

Physician gatekeepers still have an important role, albeit a changing one, says Richard Liliedahl, MD, a consultant with Milliman & Robertson Inc., actuaries and health care consultants in Seattle. "We won't see the elimination of PCP gatekeepers as much as we will see an increased number and variety of so-called open-access managed care models," he explains. "Several types are emerging. Some allow long-term referrals without preauthorization for specific diseases, such as congestive heart failure. Others allow open access to specialists except for specific diagnoses, and a third type allows for a first-time visit to a specialist and then all follow-up visits through a PCP. We will see more of these models emerging and no doubt others as well."

Fraud investigations. The issue of compliance with Medicare regulations will change profoundly the level of financial reporting and claims tracking for any service venture that receives government reimbursements, says Jacque Sokolov, MD, CEO of PSO Development Corp., in Los Angeles. "Historically, we just didn't need to track the revenue streams at a level of detail that is currently being requested of certain organizations as it relates to these current fraud investigations. There are multiple academic medical centers being evaluated for inappropriate billings. There's also the huge review of the for-profit Columbia/HCA. As physicians enter into direct contracting relationships with the federal government, such as what happens when PSOs are formed, we are going to see a much greater level of scrutiny."

before care was coordinated by large organizations aiming to control spending, says Lee Newcomer, MD, chief medical officer of United HealthCare Corp., a large MCO in Minneapolis. "Many physicians hope health care will revert back to a system dominated by solo practitioners and fee for service," Newcomer comments. "That is unrealistic. Managed care as it has been practiced, especially limited-access managed care models, may not survive, but the industry will not return to the style of medicine practiced 20 years ago."

Actually, friction and turmoil are inevitable, given that so many physicians are facing so much change so quickly, says Michael B. Guthrie, MD, executive vice president and director of the Center for Clinical Innovation, a division of Premier Inc., in San Diego. "I interpret dissatisfaction to be a reflection of that turmoil," Guthrie says. "But I think it's going to stimulate constructive change. The alternatives physicians are looking at will be judged in the context of how they feel about current market changes and how they feel about the practice options that are presenting themselves."

Consumer dissatisfaction. Like physicians, consumers are dissatisfied with managed care. By some estimates, there were more than 1,000 bills introduced in state legislatures to limit the ability of managed care plans to dictate how care will be delivered. In addition, President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry has prepared the Consumer Bill of Rights and Responsibilities. Among other rights, the bill supports giving consumers a choice of health care providers, access to emergency care, full participation in medical decisions, and a fair and efficient process for resolving complaints. The commission's final report is due to the president on March 30.

Largely because consumers have

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> **"Few policy makers, the public, hospitals, insurance companies, or HMOs realize how unhappy physicians are."**
>
> ***— Edward B. Hirshfeld, AMA***

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demanded more open access to specialists, longer hospital stays, and access to expensive life-saving technologies, HMO profits have declined in the past two years. In addition, consumers have demanded wider access to care outside the hospital and access to alternative practitioners, among other demands.

In reality, consumer dissatisfaction is somewhat distorted by the national press and broadcast news outlets, comments Kongstvedt. "In general, consumers are relatively satisfied," he says, "but there are enough of them who aren't satisfied that a lot of legislation is being considered at the state level and some at the federal level."

Dissatisfaction with health care can be a two-edged sword, offering opportunities and pitfalls for physicians. The AMA's Hirshfeld says, "There will continue to be a sympathetic audience for increased regulation. That, in turn, will increase health care costs. It's hard to predict how all of this will play out, but it presents potential perils and opportunities for providers. One potential peril is that providers will be lumped with HMOs in the consumers' eyes as not giving them what they want or need. One potential opportunity here is for providers to form networks and organizations focused on reducing cost while maintaining quality, and keeping patients feeling well served at the same time. If physicians don't succeed in that, there's going to be a continued and rising disenchantment with health care systems, which may lead to an unpredictable outcome itself. The last few times we saw that, in the early 1970s and in the late 1980s and early 1990s, it resulted in market-based solutions. But the next time it might not be resolved in a market-based solution. It might mean more government control."

More state and federal health care legislation could mean health care costs will rise. If costs rise, physician payments may be affected adversely. Also, cautions Kongstvedt, greater governmental intervention easily can become micromanagement of health care. "While some physicians initially applaud this, it is one of those situations in which you must be careful what you wish for," Kongstvedt explains. "Physicians believe consumer dissatisfaction will mean the public will want to return to the old system of health care, but the shift to managed care that has occurred in the last 20 years is irreversible. Consumer dissatisfaction will mean that patients will demand more accountability, better access to specialists, and an increased role in determining how much and what types of health care they should receive."

> **"It would be great if physicians in solo and small group practices could direct their anxiety into forming new networks capable of managing risk and satisfying the consumer, capable of taking control back from HMOs and other institutions, but they badly need leadership in that area."**
>
> ***— Edward B. Hirshfeld, AMA***

The Balanced Budget Act

Federal legislation passed last year may have a profound effect on physicians' practices in the coming years, according to some observers. That legislation, the Balanced Budget Act of 1997, restricts the rate of growth of Medicare reimbursements, makes it easier for patients to join Medicare-risk HMOs, and allows physicians to form provider-sponsored organizations (PSOs) without meeting state insurance regulations. As a result, the number of PSOs will increase dramatically, says Jacque Sokolov, MD, president of PSO Development Corp., in Los Angeles. "We will have least as many PSOs as we have Medicare HMOs by 2002, which is quite a few. There are 400 Medicare-risk plans today, and by the early part of the next century there will be at least 800 to 1,000. These new plans will mean that doctors and hospitals will be competing on a different playing field."

A more significant issue involves the success of integrated delivery systems, Sokolov says. Historically, many so-called risk-based organizations that were started by physicians and hospitals actually were operating under discounted fee-for-service arrangements, he says. "Now, as a result of the Balanced Budget Act, the federal Health Care Financing Administration (HCFA) will make it worthwhile for physicians and hospitals to accept risk contracts. Since some 30% to 50% of a physician's revenue may be coming from his or her Medicare sources, physicians will find a way to succeed in that structure the way they have succeeded with other structures."

Under the act, the opportunity for physicians willing to handle Medicare-risk contracts is significant, says Brooks G. O'Neil, managing director for Piper Jaffray Inc., investment bankers in Minneapolis. But the opportunity may not lead to overnight success, he cautions. Since PSOs will need to win Medicare-risk market share from HMOs, physicians could lose a significant source of current business if HMOs cut them off when they begin to compete under PSO arrangements, O'Neil explains. Therefore, it may be difficult in the short term for PSOs

> **"Managed care as it has been practiced, especially limited-access managed care models, may not survive, but the industry will not return to the style of medicine practiced 20 years ago."**
>
> ***— Lee Newcomer, MD, United HealthCare Corp.***

to contract with HCFA directly until enrollment reaches a level such that PSOs will have enough patients to succeed without worrying about losing business from a competing HMO, O'Neil adds.

When forming PSOs, physicians may choose to partner with hospitals, O'Neil says. "Hospitals will be an important component of the arrangement," he explains. "However, hospitals will not be the drivers of these relationships. In the long term, well-organized and well-managed physician groups and HMOs will continue to hold the upper hand in the negotiations with hospitals."

Rising Costs

Looming in the background of all of these trends is the ominous threat that HMO premiums may rise by at least 5% in 1998, more than twice as much as wages and inflation have been rising, according to some analysts. Milliman & Robertson's *Health Cost Index,* a quarterly report on cost trends, said in December that costs rose by 0.8% in the quarter that ended in September 1996 over the year-earlier period. "Since the fall of 1996, higher hospital outpatient, physician and prescription drug prices have helped to drive up costs substantially," the report said. Cost increases should intensify rapidly this year and are expected to be 5.9% by June, the report said.

Says Hirshfeld, "It's been widely reported that HMOs are seeking substantial premium increases, meaning they will look to providers to find ways to keep costs contained. Employers and HMOs' other customers will object to rising costs. If costs rise too much, the pressure will be on providers to find ways to contain costs. There's no question that doctors will be asked to reduce fees, and utilization controls will probably be more stringent."

An increase in HMO costs, and a resulting increase in health care purchasers' premiums, will mean that alternatives to managed care, such as direct contracting between purchasers and providers, may become more attractive, says James B. Nuckolls, MD, CEO of Carilion Healthcare Corp., in Roanoke, Va. "It will also encourage the development of PSOs and regional provider networks."

Physician-hospital Relationships

Compared with any rapid rise in health care costs, the last trend—involving physician-hospital relationships—may go almost unnoticed. But for physicians, it could have a profound effect on how they practice in years to come. In the past five years, hospitals have purchased primary care physicians' practices and have lost heavily on those investments, losing $75,000 to $125,000 per physician per year, by some estimates. Hospital administrators obviously are dissatisfied with such losses, and many physicians in such arrangements feel as if they have become employees rather than colleagues. As a result, these relationships are unraveling.

"Hospitals have hit a wall with respect to acquiring physician practices," says Kaufman. "They have found that the return on their investment may not have been what they projected. In fact, they may be depleting their assets to the point where they need to reconsider their employment arrangements with physicians."

In cases in which hospitals are not losing money on the physician practices they have acquired, physicians may be dissatisfied. "If a hospital has acquired the proper physician practices, its bottom line may have gone up, but that has not meant increased income to the physicians," says Nuckolls. "Eventually some funds will have to come out of the hospitals and back to physicians' offices because health care is moving from the hospital to outpatient surgery to the doctor's office and eventually to the home."

One result of the deterioration of these relationships is that PPMCs have stepped in to woo physicians away from hospitals, promising they will help physicians capture revenue from ancillary services, such as outpatient surgery, imaging and laboratory, diagnostic testing, and other services traditionally provided in hospitals. This trend can result in an adversarial relationship.

"Every market is different," says Liliedahl. "There are certain markets where physician-hospital organizations are just beginning to form. But if these PHOs are going to be successful, then they will need to be far better organized than what we have been seeing. In developing PHOs, physicians will need to hold leadership positions and have an equity investment, or they'll fail as the earlier ones have failed," says Liliedahl.

Nuckolls predicts that hospitals may seek to form partnerships with physicians rather than purchase practices. "Physicians who want to build up their practice groups to stay competitive will need a significant amount of infrastructure, including the expensive information systems necessary for handling managed care contracts," Nuckolls explains. "That money has to come from somewhere, not just from payers. It requires investors. Therefore, physicians who do not want to sell their assets to PPMCs may prefer to partner with hospitals."

Such a trend is beginning among PHOs, says Liliedahl. "A second generation of PHOs is developing that isn't based on hospitals buying physician practices," he says. Under these new models, PHOs allow greater physician governance and physician equity. "They also allow for an increased role for primary care physicians, who have historically been patient advocates," Liliedahl says. "Too many PHOs now are dominated by specialists, and these tend not to be efficient and cost effective. PCPs need a stronger role in the provision of care within PHOs, which will allow for a conservation of resources and increased patient advocacy." ■

Single-specialty Companies Will Thrive, Says Physician-Turned-Investment-Banker

Jason M. Rosenbluth, MD, is a managing director of Volpe Brown Whelan & Co., investment bankers in San Francisco. He also is a managing director of the firm's private equity capital fund, Bedrock Capital Partners. In 1989, Rosenbluth became one of the co-founders of Health Data Communications, in Philadelphia. Health Data Communications is a venture-capital backed supplier of computer-based patient record systems. Later, Rosenbluth worked at Chi Systems, another company in Philadelphia that specializes in health care data management. A board-certified internist, Rosenbluth received his medical degree from Cornell University Medical College and has an MBA from the Wharton School of the University of Pennsylvania. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q: *What effect does the investment world have on the physician services industry?*

A: A huge effect. But Wall Street affects all entities—even nonprofit organizations—because raising capital is fundamental to most growing concerns no matter how they are financed. Lately, the health care industry has been moving toward a more business-oriented outlook—while holding individual organizations accountable to best practice standards. Even though this trend likely would be happening with or without the ups and downs of Wall Street, physician practice management companies (PPMCs) must base their consolidation on the market and repeatedly raise lots of capital, which highlights their vulnerability to Wall Street's whims.

Q: *There is a belief on Wall Street that physicians represent the third wave of consolidation in health care. The first was hospitals; the second was HMOs; now it's physicians. Is this true?*

A: Yes, to some extent. What's happening is physicians are rapidly moving from environments in which they practice in solo or small groups to a variety of more professionally run organizations—a large centralized group practice, a network, a physician hospital organization—the specific form doesn't matter as long as they're part of a large organizational structure. Over time, there will be a rapid movement in this direction simply because of the large number of physicians practicing. Later, a variety of forms are likely to emerge. One common denominator of the organizations that emerge will be that professional management will run many of the nonclinical aspects of care and will provide certain services, such as negotiating expertise and information systems, that are required to run any organized business. After that, it's just a matter of a format and what's most attractive to the capital markets and the physicians who are participating in them.

> "Since single-specialty PPMCs generally have higher margins than those oriented toward primary care, they're attracting more capital."

Q: *Before joining Volpe Brown Whelan, you were president and CEO of a start-up company that specializes in health data communications and that was later acquired by another data systems company. What did you learn from that experience?*

A: The health data company focused on developing computer-based record systems because the view 10 years ago, which is even stronger today, was that information technology and information sharing would be critical in health care. That was one thing I learned. Number two was that because we developed those programs specifically for large organized group practices and integrated delivery systems, we got a firsthand look from the inside at how those groups were organized and run. Personally, I had come from the fragmented traditional fee-for-service market. Therefore, I was intrigued that the physicians were highly motivated, they enjoyed the collegiality, and the quality of care was high. Also, their incomes were okay and they didn't have the burden of running a private practice. It appealed to me because it seemed that this was a you-can-have-it-all kind of situation.

Q: *On the subject of single-specialty PPMCs, about 40 such organizations are publicly traded now, and 40 more are in the queue. Of the 40 queued up, almost two-thirds are single-specialty-based PPMCs. What is their future and what do they need to be successful?*

A: These companies will become what I call product-line companies; that is, they will evolve by focusing on a certain dimension, such as a single specialty or a single disease category, until they grow large enough in both size and skill to go public. At some point, they will consolidate among themselves. Right now, for example, we're seeing the earliest stages of consolidation among PPMCs (as opposed to individual PPMCs going out to acquire or consolidate individual physician practices). After consolidating, the PPMCs

> "The specialists who are fragmented in terms of their practices are vulnerable, but those who can come together in local markets have an advantage."

> "It's not only more cost effective but also more beneficial on a quality basis to get a patient earlier and faster to the right specialist."

will maintain their product-line orientation. I equate these companies to the Procter & Gambles of the world, which produce certain brands of household products in separate business units, which basically are autonomous.

Single-specialty PPMCs will go where the money is. Take an oncology practice, for example. It doesn't take that many oncologists to have a leading market share in the largest markets in the United States. Whereas in primary care, it's impossible to get leading market share without consolidating a lot of practices in the market. Also, on the specialty side, one may have the ability to integrate a variety of procedural, technical, pharmaceutical, and ancillary services because the continuum of services that affect a cancer patient, for example, is substantial. By integrating these services, you remove the redundancies and the fragmentation. Also, you achieve economies of scale and can provide what is basically a carve-out to the payers. It's virtually impossible, however, to consolidate primary care in this way. That's one reason single-specialty PPMCs are attractive to investors. Another reason they're attractive to investors is that they involve high-margin businesses, and that, by itself, attracts capital. In any business, high margins are a magnet for capital. Since single-specialty PPMCs generally have higher margins than those oriented toward primary care, they're attracting more capital. Hence, you're seeing more new entrants.

Q: *Isn't it simpler to aggregate the single-specialty PPMCs than the primary care-oriented ones and to go public more quickly too?*

A: That's exactly what I'm saying. You have higher margins per doctor, so you need fewer of them to grow a big business. When you look at managed care, specialists who are fragmented in terms of their practices are vulnerable, but those who can come together in local markets have an advantage. Take a radiology group, for example, that covers all the counties in the San Francisco Bay area. The group has 70 or 80 radiologists practicing at multiple locations and the contracting is done by one entity. That organizational structure creates huge market leverage that is attractive to managed care payers because they have to deal with only one organization in order to serve the entire market. What you have is basic supply-and-demand economics. The single-specialty PPMCs are simply aggregating the supply side so they can get more on the demand side.

Q: *Do you believe specialists are regaining control as managed care plans seek to allow greater access to physicians?*

A: Basically, yes. We're all in business to make money, and HMOs need access to high-quality, high-volume, low-cost providers. When you look at the three or four leading cost centers in health care—and cardiovascular disease is number one—you can have primary care doctors screening people or controlling access to specialists, but over time, as evidence has shown, that system is not cost effective. In fact, health systems end up duplicating services. The patient ends up in a cardiologist's office anyway and often after more major complications have set in. It's not only more cost effective but also more beneficial on a quality basis to get a patient earlier and faster to the right specialist.

Q: *Is it easier to capitate specialists than primary care physicians?*

A: Yes, especially when you look at procedural-rate or case-rate contracting. Take a patient who needs open heart surgery, for example, where there is a defined beginning and a defined end to the services needed. If you take a particular diagnosis, like congestive heart failure, a physician may see one patient once a year, and another patient with the same condition once a week. So, it's the predictability factor that's the tough part in all this. The question is: Where actuarially do the risks lie and what supporting tools do I have to manage that risk better? When trying to set rates for chronically ill patients, it's often tougher to manage capitation because of factors such as the length of the illness, the services and procedures involved, and the cost structure. For specialty care, we could have a much better cost accounting system.

Q: *Given that, is it clear that single-specialty PPMCs have core advantages over multispecialty PPMCs? Is it also true that one will grow quickly at the expense of the other?*

A: I don't think it's at the expense of one over the other. But let's forget about PPMCs and look at the overall practice of medicine. Say you've got two groups in town: one's a large multispecialty group and the other, a smaller single-specialty group. The single-specialty practice could be a group of cardiologists, for example, but it could be any single-specialty group. The multispecialty group's staff can't possibly have all the ranges of subspecialties, since there are dozens within any given category. Look at radiology: There are something like 16 subspecialties. Because most multispecialty groups don't have that depth, they have to contract for it, internalize it (which they won't do because they generally won't have the volume to support it), or forgo it. In other words, they'll have a general radiologist reading a head scan that a neuroradiologist ordinarily might read. So, their level of expertise will be more

> "To maintain Wall Street's interest, a physician organization must have internal growth and must invest aggressively in disease management, in information technology, and in gaining local market power."

(Continued on page 12)

"We're at the earliest stages of evolution in terms of the total number of physicians becoming affiliated with PPMCs. Now, it's less than 10%."

(Continued from page 11)

shallow, although some specialty groups, by virtue of the economics of their situation, will be able to cover the areas of subspecialty they need to have.

In this example, physicians have another important issue to address. Single-specialty physicians prefer to be among others within their specialty. Cardiologists want to practice among other cardiologists; radiologists with other radiologists, and so on. Once you get into the larger multispecialty groups, there are always trade-offs among, say, the high-revenue-generating orthopedic surgeons and the high-volume primary care physicians. The specialists say, "I could be making more in another practice, and you primary care doctors keep talking about capitation or primary care medicine. All I want is to do is take more continuing medical education courses and delve deeper into my specialty." So, rifts can develop early in those relationships. Most of the larger multispecialty groups cover some of the bases well, but they're generally not centers of excellence in the true sense.

Q: *What you're saying is single-specialty groups have fewer political issues to sort out among their members. They have a common language and are more focused. Their practices are more conducive to developing guidelines. That's true, isn't it?*

A: Right. I try to draw as many analogies as I can from other industries. The multispecialty model is a conglomerate-based approach, which is not as focused as the single-specialty model, and thus those using it cannot allocate resources efficiently and take longer to make decisions in terms of allocating resources because of competing interests. When looking at guidelines, for example, you're much more likely to effect change with groups that have a smaller single-specialty focus and whose members are not competing for resources.

What will happen is what happened in the Japanese automotive industry. In Japan, the auto makers created a relationship with their suppliers in which they effectively ended up owning them over time. At the same time, they kept the businesses separate because the car makers knew they couldn't be good tire makers and the tire makers knew they couldn't be good radio makers, and so on. Yet their economic interests are tightly aligned. A supplier knows that if it doesn't have the Toyota account, it's out of business, and vice versa.

In the future, we will have a similar model for physicians. We will have many multispecialty groups with a primary care orientation that will control much of the dollars flowing into the system. These multispecialty groups will establish separate contractual or subcapitation arrangements with single-specialty groups. Many single-specialty groups won't have enough market clout to contract directly with a regional or local payer or a local hospital system. Therefore, they will need to go through a number of intermediaries. Some will get national contracts, but they will be the lesser part of the equation.

"Physicians need organizing power. They need capital. They need professional management. And they can't access those things themselves. So, they're going to have to partner up."

Q: *What will separate the single-specialty winners from the losers?*

A: For the near term, the single-specialty winners will be those that satisfy Wall Street investors because capital is everything. If you look at a physician group that is trading at $6 a share when it was well over $30 a share a year or so ago, you'll see that a vicious downward cycle happens very quickly. If a company misses its earnings estimates, it can't raise more capital, it can't do acquisitions, and it can't grow. The downward spiral accelerates until the company virtually disintegrates. We've seen that happen on more than a half a dozen occasions already.

To maintain Wall Street's interest, you must have internal growth that is not based solely on consolidations or laying out capital, but also on cash flow that you generate yourself. You must fund operations and capital expenditures through internal growth and you have to focus on margins. Also, you have to invest aggressively in disease management, in information technology, and in gaining local market power as opposed to acquiring a practice in every market in the United States.

From a business perspective, this strategy seems straightforward and simple, but execution is everything, and it's a very difficult business to execute. Many very opportunistic companies have sprung up, acquiring whatever practice was willing to be acquired without putting the proper infrastructure in place. They weren't investing heavily in information technology, disease management, or ancillary services, or developing local market share. Those companies have gotten themselves into trouble.

Q: *To close, can you tell us what to expect going forward?*

A: We're at the earliest stages of evolution in terms of the total number of physicians becoming affiliated with PPMCs. Now, it's less than 10%, and there are about 700,000 practicing physicians in the United States. We'll see more PPMCs go public, and several will be successful.

The major message here is that physicians need organizing power. They need capital. They need professional management. And they can't access those things themselves. So, they're going to have to partner up. It's a matter of which form will be the most successful. Capital plays a huge part now in all this, and will continue to do so for the foreseeable future, which shows what Wall Street's role will be for the next several years. ■

Bar on the Corporate Practice of Medicine Affirmed in Illinois

By Edward B. Hirshfeld, JD

Physicians seeking to steer through the turbulent trends in health care today may find that doing so is even more difficult after a recent ruling by the Supreme Court of Illinois. The legal issue involved affects how a group practice may affiliate with a physician practice management company (PPMC), a management services organization (MSO), or other lay entity. Specifically, the issue is the bar on the corporate practice of medicine. This legal doctrine is designed to prevent lay corporate managers from influencing the decisions physicians make about patient care. But as current corporate activity in medicine shows, the strength of this legal doctrine has eroded in recent years.

Lax Enforcement

The bar arises from state law. In most states, it was created by judicial cases finding that state medical licensing statutes allow only natural persons, not fictitious persons such as corporations, to be licensed to practice medicine. However, many of the cases upholding the bar are so old that their relevance has been questioned, and in many states, officials have not enforced it for years. In addition, numerous exceptions to the bar exist, such as the federal law that excepts federally qualified HMOs. Nine states—Alabama, Alaska, Arizona, Florida, Louisiana, Missouri, Nebraska, New Mexico, and Virginia—do not bar the corporate practice of medicine. In fact, some health lawyers consider the bar a viable legal doctrine only in the five states that have statutes affirming the existence of the doctrine and where the statutes are actively enforced: California, Colorado, Ohio, Texas, and Wisconsin.

In the Illinois case, *Berlin v. Sarah Bush Lincoln Health Center,* a physician broke an employment contract with a hospital on the grounds that it was illegal for it to employ him because corporations are legally barred from the practice of medicine. The hospital argued that the only cases that had found the bar in Illinois were very old, and that the passage of time and lack of enforcement had effectively nullified the doctrine. The lower courts disagreed, finding that the old cases were still valid, and that the employment contract was illegal. The case drew national attention because many hospitals and other corporations employ physicians.

Although the Supreme Court of Illinois reversed the lower courts and said hospitals are excepted from the bar and may employ physicians, it is clear from the decision that the bar applies to any other corporation that is not expressly exempt. As a result, *Berlin* has given new life to the bar in Illinois and perhaps other states as well, since the decisions of Illinois' Supreme Court are often influential and followed in other states. It should be assumed, then, that the corporate practice of medicine is still barred in all states except the nine states that do not have a bar.

PPMCs and MSOs are among the corporations that are subject to the bar. Medical corporations are not if they are owned and controlled by physicians. The bar on corporate practice, together with the bar on fee splitting, restricts the kinds of relationships that a group practice can have with these entities. The extent of these restrictions differs from state to state because the extent of the bar on corporate practice varies from state to state.

Exceptions to the bar often include—in addition to medical corporations—hospitals, HMOs, certain nonprofit corporations (such as medical foundations), medical school faculty practice plans, private employers that provide on-site health care services to employees, and private businesses not otherwise engaged in the practice of medicine that provide limited services for customers who are injured or become ill.

To avoid the bar on corporate practice when affiliating with a PPMC or an MSO, an entity should ensure that

- The entity provides only the facilities and support to enable physicians to practice medicine;
- All payments to nonphysician entities are for justifiable nonphysician services and expenses;
- Physicians control the treatment of patients, their fees and charges, their work schedules, the supervision of limited-license medical professionals, the kind of equipment used, and other aspects of medical office practice;
- Physicians own and control the medical records; and
- Physicians are not employed by these entities.

In addition, to the extent that a sale of assets by physicians or the sale of a medical practice (to another medical corporation or to an exempt entity) is involved in the affiliation, payments should not be based on actual or projected physician earnings. ■

The case of *Berlin v. Sarah Bush Lincoln Health Center* has given new life to the bar on the corporate practice of medicine in Illinois and perhaps other states as well, since the decisions of Illinois' Supreme Court are often influential.

***Edward B. Hirshfeld** is vice president of the AMA's Health Law Department.*

Financial Advisers Smooth Merger Process

By W.L. Douglas Townsend Jr. and Jill S. Frew

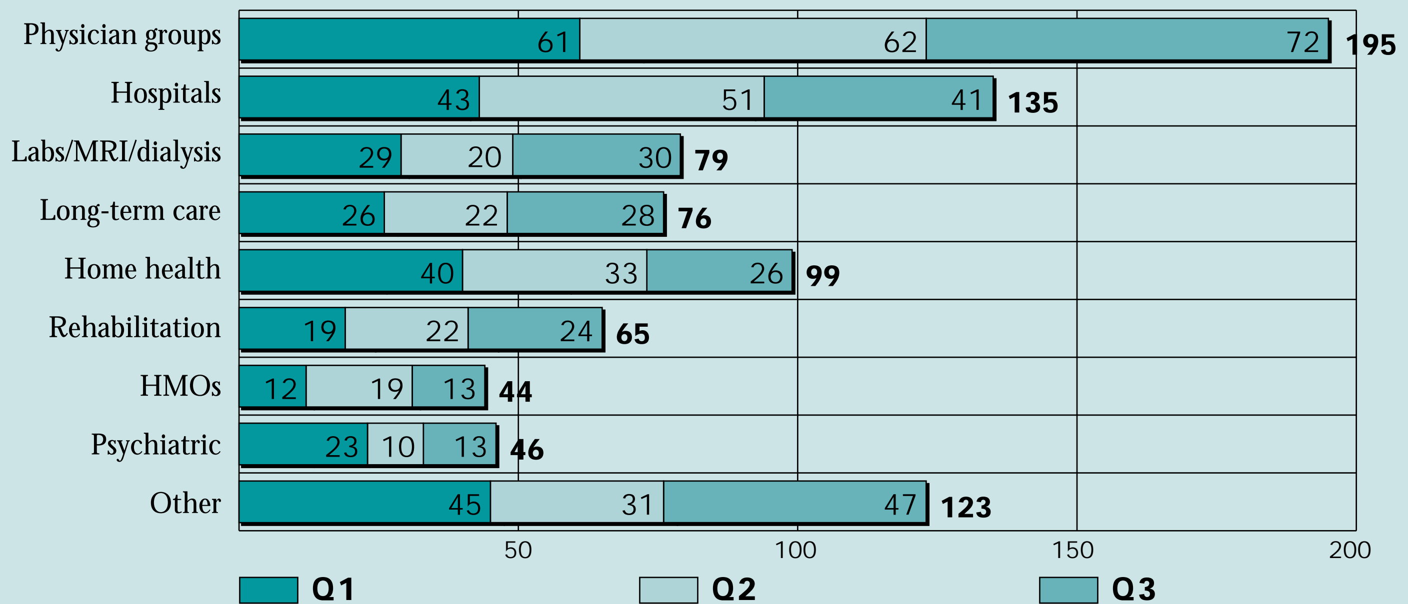
During the third quarter of 1997, health care companies announced 294 mergers and acquisitions, an increase of 9% over the number of mergers and acquisitions announced in the previous quarter.

Physician groups announced 72 transactions, or 25% of the total, and had more acquisitions than any other group. Small, independent physician groups were doing many of these deals, as managed care enrollment increased and they were forced to find partners in order to compete more effectively. (See table.)

Since small physician groups seeking to affiliate with a partner typically find themselves negotiating with seasoned acquisition professionals, many groups hire a financial adviser to represent them in a transaction. For a fee, a financial adviser provides services that include:

- Establishing objectives. An adviser helps the small group or physician clinic decide what to seek in a partner and to identify the clinic's goals and values.
- Collecting and analyzing clinic financial statements. The adviser reviews the value of the clinic's facilities, staff, and market strengths and weaknesses.
- Preparing an offering memorandum that explains information relating to the clinic's past and projected operating and financial performance, and that also reports on management and physician leadership, the clinic's strategy, and market trends.
- Identifying and contacting potential partners.
- Distributing the offering memorandum.
- Obtaining confidentiality agreements to ensure that prospective partners will not disclose information about the clinic to outside parties.
- Receiving, analyzing, and identifying the advantages and disadvantages of preliminary proposals.
- Selecting the partners for a final round of review.
- Organizing the final-round potential partners to conduct on-site due diligence and to provide an opportunity for clinic physicians to meet with physicians who have already affiliated with the potential partner.
- Receiving final proposals and assisting the clinic in choosing a partner.
- Working with the clinic's counsel to negotiate a letter of intent to close a deal between the clinic and its partner.
- Negotiating definitive agreements and closing the transaction.

Deciding whether to enter into a long-term affiliation with a partner is the most important decision an organization will make. To meet its strategic and economic goals, the organization needs a well-organized, disciplined process for assessing partnering alternatives. Experienced advisers can guide the organization through the process and help to ensure that it makes an educated, thoughtful, and financially sound decision. ■



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Washington State Oversees Physician-run HMO

Washington State Insurance Commissioner Deborah Senn is overseeing a managed care plan started by the Washington State Medical Association. The state's insurance department will oversee the plan until it has collected the $1 million in reserves it needs to meet the state's reserve requirement. The health plan, Unified Physicians of Washington, agreed to operate under a cooperative agreement with the commissioner. The agreement replaces a court order, under which the commissioner could have seized the plan and placed it in receivership, according to *State Health Watch*, a newsletter published in Yardley, Pa.

The plan was started in 1994 with $7 million in capital from more than 2,000 physicians and physician assistants. Last year, the company lost $5 million, and has been losing about $325,000 a month on operations, the newsletter said. At the end of 1997, it was about $1.5 million in debt and was trying to find a financial partner, the newsletter reported.

Comment: *The National Association of Insurance Commissioners (NAIC) has been reluctant to let provider-sponsored organizations, such as a health plan started by a state medical society, accept the financial risk of delivering care. The NAIC says such organizations are in the insurance business and need to meet the same capital and reserve requirements insurers must meet.*

Arizona Court to Consider Complaint Against Utilization Review Organization

After a medical director for the Blue Cross Blue Shield plan of Arizona denied permission for gallbladder surgery, the surgeon involved complained to the state Board of Medical Examiners and went ahead with the surgery. After reviewing the patient's records following the surgery, the health plan paid the bill.

In his complaint, the surgeon claimed that the rejection of the precertification request constituted medical incompetence by the utilization reviewer. The board investigated and issued a letter of concern to the medical director, saying he had made an inappropriate medical decision that could have harmed the patient. A letter of concern is a nondisciplinary advisory letter that is less serious than a reprimand. It simply states that the physician in question should modify his or her practices, according to William M. Mercer, consultants in New York.

The health plan sued to block the licensing board's action, saying the board had no jurisdiction because the utilization reviewer was not engaged in the practice of medicine or in patient care. One court ruled in favor of the health plan, but an appeals court ruled in favor of the board. The decision is being appealed to the Arizona Supreme Court.

Comment: *If the state supreme court upholds the claim, physicians and patients in Arizona may deluge health plans with complaints about treatments deemed not medically necessary. Also, the cost of utilization review may rise, reflecting the increased risk of such business, or claims payments will rise as more precertification requests are approved routinely, Mercer says.*

Two Reports Predict Increases in Health Conditions

Depression and alcohol dependency will rise sharply in the next century, replacing cancer as the most costly condition to be treated under the U.S. health care system, says a new report. Heart disease will continue to be the number one cause of illness, say researchers with the Institute for the Future, a research organization in Menlo Park, Calif. The forecast was commissioned by the Robert Wood Johnson Foundation, a medical philanthropy in Princeton, N.J.

The same researchers also predict that more than two-thirds of the U.S. population will be enrolled in managed care plans by 2010. Currently, about 50% of Americans are so enrolled. It is likely that there will be greater variety among health plans, and more plans will be managed directly by physicians and hospitals instead of by insurers, the researchers say.

Through 2010, health care costs will rise at an annual rate of about 6.4%, or slightly faster than most other prices, the researchers say. Given the growth of managed care and its popularity among employers and the government, it is unlikely that health care cost increases will rise at the 10% to 15% annual rates common in the late 1980s and early 1990s, researchers say.

A study reported in the journal of the British Diabetic Association, *Diabetic Medicine*, says that the prevalence of diabetes will nearly double within 12 years. Non-insulin-dependent diabetes mellitus (NIDDM) appears to be epidemic in many regions of the world, the journal says, and increasing longevity and changes in demographic age distributions will cause the number to rise sharply. Currently, about 2.1% of the population has NIDDM, a percentage that could reach 3% by 2010, the researchers say.

Comment: *In the future, physicians involved in patient care will rely on computers to share data and to standardize treatment processes nationwide, says the Institute for the Future. Patients may use the Internet to transmit from their home to their doctor blood pressure readings, for example, the institute says.*

NEWS & COMMENTARY

Management Companies Pay the Most

A new study shows that single-specialty groups and physician practice management companies (PPMCs) pay physician executives the most. The study by Cejka & Co., a health care consulting and search firm in St. Louis, shows that in 1996, physician executives in PPMCs and single-specialty groups earned $240,000. Physician executives in government jobs earned the least, having a median income of $126,000. The survey was done for the American College of Physician Executives, in Tampa.

The survey also shows that physician executives with advanced academic degrees earned higher pay than those without such degrees. Median compensation ranged from $160,000 to $240,000 for physicians without a master's degree. This range compares with $166,000 to $290,000 for physicians with an MBA and $192,000 to $240,000 for physicians with a master's in medical management.

The range of pay for medical directors was $175,000 to $227,500. Medical directors at large systems and those in PPMCs earned at the high end of the range.

Of the 3,912 physicians who responded to the 1997 Physician Executive Compensation Survey, some 55% were specialists. Yet primary care physicians (PCPs) dominated the ranks of physician executives, Cejka says. PCP executives earned a median salary of $175,000 versus a median salary of $200,000 for specialty physician executives. The physician executives with the highest median income were specialists, such as radiation oncologists ($350,000), neurological surgeons ($330,000), and cardiovascular surgeons ($300,000).

Comment: *As physician executives rise in the management ranks, they become more willing to link their income to a performance-related bonus, said Roger Rathert, MD, director of Cejka's Healthcare Executive Search Services. In the coming years, the income of more physician executives will be at risk under such arrangements, he said.*

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Editor-in-Chief
Physician Practice Options

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A Practical Resource to Succeed in Health Care

January 1998

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