

PHYSICIAN PRACTICE OPTIONS™

February 1998

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

CONTENTS Features

Commentary
Failed PPMC Deal
Reflects New Realism 3

Market Report
New Models of
Development
Offer Insight 4

Interview
Physicians Will Need
to Balance Autonomy
With Accountability 9

Departments

Editorial
The Hazards of
Physician Consolidation 2

Health Care Law
PSO Regulations
Will Be Demanding 12

Capital Ideas
PPMCs Are Raising
Capital at a
Blistering Pace 14

News & Commentary 15

Group Struggles, then Succeeds, with Guidelines

By Robert Yetman, MD

As managed care becomes more widespread, physicians are encouraged to improve efficiency in many practice settings. Although capitation (especially for Medicaid patients) was not present in a significant way in the Houston hospital market until late last year, physicians and hospital administrators at the Hermann Children's Hospital in Houston had taken steps to become a more efficient organization several years earlier.

In 1994, the physicians reviewed the Healthcare Management Guidelines (HMGs) from Milliman & Robertson Inc., actuaries and consultants, in Seattle, and began using them in 1995.

Physician Leadership

Leading the review and implementation process has been a group of faculty physicians at the University of Texas-Houston Medical School. These physicians are using the HMGs to improve the way the medical school's pediatric physicians practice medicine at Hermann Children's, one of two teaching hospitals of the medical school. The physicians believe that by increasing efficiency in one setting, they can improve efficiency in both hospitals. They also hope the improvements in the hospital settings will benefit outpatient clinics, emergency centers, and home health programs.

Approximately 75 full-time faculty members and a score of local physicians practice

at Hermann Children's, a 150-bed, full-service children's facility in Houston. Many of the faculty members at Hermann Children's also practice at Lyndon Baines Johnson General Hospital, the second of the two teaching hospitals.

Initially, the physicians were impressed with how the HMGs handle actuarial issues, such as cost-benefit analyses in the use of hospital resources. The pediatricians learned, for example, that unnecessary hospital days were spent because certain services were not available on nights, weekends, or holidays. As a result, the hospital now avoids elective admissions on Fridays so that patients no longer need to wait through the weekend to begin tests or therapies.

Equally important, the physicians found the HMGs offer the best approach for addressing medical concerns, specifically appropriateness of care issues, because they are based on the best practices of pediatricians and hospitals nationwide.

When used correctly, the HMGs allow the physicians enough flexibility to apply a guideline to virtually any patient. A patient with pyloric stenosis (a narrowing of an opening in the stomach), for example, would be expected to go home from the hospital one day following surgery. Consistent delays beyond this predicted time span would be investigated.

(Continued on page 7)

Robert Yetman, MD, is associate professor of pediatrics at the University of Texas-Houston Medical School. He holds numerous directorship positions in community and general pediatrics, well-baby, and well-child clinics. Yetman is a distinguished teacher, writer, editor, and researcher in pediatric diseases, hypertension in children, and chronobiology. He received his MD from Louisiana State University Medical School in Shreveport and completed his pediatric residency at the University of Texas-Houston Medical School in 1987.

The Hazards of Physician Consolidation

"Take back control!" has become a rallying cry among physicians. Used in this way, "control" generally means forming organizations that can compete effectively with other health care providers, such as hospitals and managed health plans. Physicians have found they can compete by forming multispecialty groups, assembling regional specialty groups or networks, or establishing physician-owned outpatient units.

The problem with seeking more control is that it can lead to investigations on the grounds that such organizations are unlawful because they violate antitrust and antifraud laws and regulations. Therefore, before proceeding, it's prudent to ask how much control is appropriate, what kind of control is allowed, and how will competitors react.

These aren't idle questions, and they don't necessarily involve huge organizations. Regulators have warned a group of three ear, nose, and throat specialists in Iberia, La., that they may be inviting antitrust scrutiny simply by establishing an outpatient surgery center to compete with two local hospitals.

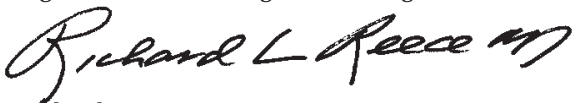
Robert Leibenluft, assistant director of the health care division of the Bureau of Competition for the Federal Trade Commission, says that the FTC will vigorously enforce antitrust laws if physicians form organizations that engage in price fixing, forestall managed care entry into a particular market, prevent other providers from entering a market, monopolize a market, and fail to take substantial financial risk. Generally speaking, "Physician networks would be in a safety zone if the network shared substantial financial risk and comprised, if it was an exclusive network, less than 20% of the market, and if it was a nonexclusive network, less than 30% of the market," Leibenluft says.

Edward Hirshfeld, vice president of the AMA's health law department, says antitrust scrutiny involves market concentration before and after a merger. The FTC may use the Herfindahl-Hirshman Index. Under this formula, regulators will square the percentage of market concentration figures so that a market concentration of 30% before a merger would be 900 and a concentration of 43% after a merger would be 1,849. If the index is less than 1,000 after the merger, the physician group likely would not be investigated; if it is between 1,000 and 1,800, it's likely the group would be safe; if it exceeds 1,800, it's likely to hear from the FTC. As of late last year, federal regulators had rejected only four of 48 proposals that had requested a review.

But this flexible attitude could change. Medicare regulators are becoming more vigilant, and as pressure to cut Medicare spending grows, claims of Medicare fraud and abuse could rise. Last year, an audit of the Medicare program found 14%, or \$23 billion, of Medicare funds entailed fraud and abuse. In response, Congress targeted \$104 million in 1997 for fraud and abuse investigations. By 2002, this figure will grow to \$250 million.

This year, the federal government is expected to add 300 investigators from the FBI and the office of the inspector general and 160 prosecutors and lawyers. Furthermore, revisions to the False Claims Act have encouraged whistle-blowers, who are entitled to between 15% and 30% of any funds recovered as a result of criminal convictions. Last year, the government collected \$300 million as a result of such convictions.

The lesson for physicians is: "Get advice from professionals familiar with these issues because Big Brother is watching—and acting."



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

Daniel Beckham
President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.

Michael B. Guthrie, MD, MBA
Executive Vice President, Director
Center for Clinical Innovation
Premier, Inc.
San Diego

Edward B. Hirshfeld, JD
Vice President
Health Law Department
American Medical Association
Chicago

Harold B. Kaiser, MD
Allergy & Asthma Specialists, P.A.
Minneapolis

Nathan Kaufman
President
The Kaufman Group
Division of Superior Consultant Co.
Physician and Hospital Consultants
San Diego

Paul Keckley
Chief Executive Officer
PhyCor Management Corp.
Nashville, Tenn.

Peter Kongstvedt, MD
Partner
Ernst & Young
Washington

Richard Lilledahl, MD
Health Care Consultant
Milliman & Robertson, Inc.
Seattle

Lee Newcomer, MD
Chief Medical Officer
United HealthCare Corp.
Minneapolis

James B. Nuckolls, MD
Chief Executive Officer
Carilion Healthcare Corp.
Roanoke, Va.

Brooks G. O'Neil
Managing Director
Piper Jaffray, Inc.
Minneapolis

Bernard Rineberg, MD
Physician Consultant
BAR Health Strategies
New Brunswick, N.J.

Carl Schramm
President
Greenspring Advisors, Inc.
Towson, Md.

Jacque Sokolov, MD
Chief Executive Officer
PSO Development Corp.
Los Angeles

W.L. Douglas Townsend Jr.
Managing Director and CEO
Townsend Frew & Co., LLC
Investment Banking
Durham, N.C.

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

© Copyright strictly reserved. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.

Publisher
Premier Healthcare Resource, Inc.
888/457-8800
E-mail: phrinfo@aol.com
Publishing Address: Premier Healthcare Resource, Inc.
Suite 300, 99 Cherry Hill Road
Parsippany, NJ 07054

Editor
Joseph Burns
508/495-0246
E-mail: joeburns@capecod.net

Subscription Price: \$299, 12 issues
Issue Price: \$25 each

Failed PPMC Deal Reflects New Realism

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

The failure of the merger of PhyCor and MedPartners has raised new questions about the two companies and about physician practice management companies (PPMCs) in general. On Jan. 8, the two companies called off their \$6.8 billion merger, and the stock prices of the two companies dropped to new lows.

"These new lows are no surprise," says W.L. Douglas Townsend, managing director and CEO of Townsend Frew & Co. in Durham, N.C., investment bankers that represent physicians considering PPMC affiliations. "MedPartners had short-term earnings problems while PhyCor was looking for long-term growth," explains Townsend, a member of the advisory board of *Physician Practice Options*. "PhyCor had no clue MedPartners would adjust its earnings so severely."

On Jan. 7, MedPartners had issued fourth quarter earnings, saying it was taking a \$115 million charge against earnings to consolidate its western operations. It also was taking a charge of \$30 million to discontinue some physician practices, and it projected 1998 earnings 30% short of what analysts had expected.

After Wall Street reacted negatively, MedPartners' CEO Larry House resigned on Jan. 16. He was replaced by Richard Scrusby, the chairman and CEO of HealthSouth Corp., a chain of rehabilitation and surgery centers based in Birmingham, Ala. Scrusby and House had founded MedPartners.

PhyCor also experienced problems after the break-up. On Jan. 13, PhyCor announced it was restructuring five clinics involving 320 physicians and was charging \$22 million against earnings. Comments Townsend, "Both companies are clearing ghosts out of their closets so they can get a fresh start for the new year."

In October, PhyCor, the nation's second-largest PPMC with 1996 revenues of \$1.5 billion, said it would acquire the much larger MedPartners, which had 1996 revenues of \$4.8 billion, in a stock swap valued at \$6.98 billion. PhyCor Inc. is in Nashville, and MedPartners Inc. is in Birmingham, Ala. The merger was designed to bring

together 35,000 physicians.

At the time, the proposed merger raised questions for physicians who were considering selling their practices to a PPMC. The fact that the merger has failed raises more questions: What differences between the two companies made them such a bad fit? What does the merger failure portend for physicians? Will PPMCs continue to grow?

One lesson from the failure is that the days of high price-to-earnings (P/E) ratios for PPMC stocks may be over. A high P/E ratio means traders have put a premium on the stock. "Right now the whole PPMC industry has a tight range of price-to-earnings ratios between 15 and 20," says Daniel Ratner, president of Physician Capital Corp., Wilton, Conn. "The PPMC market is consolidating. This consolidation will lead to stabilization, realistic pricing, and values filtering down. As a result, 1998 will be a down-to-earth year."

Another lesson learned is that the honey-

about selling out to for-profit PPMCs, and would prefer to remain independent. Many are finding that they can do so with the help of management services organizations and independent practice associations (IPAs).

A Difficult Business

For these reasons, PPMCs are difficult businesses to run, offering basically two ways to generate profit: by managing health care delivery effectively or by growing through acquisitions. MedPartners chose the latter and reported phenomenal growth. On Oct. 29, when the proposed merger was announced, MedPartners had just reported a 46% increase in profit and a 23% rise in revenue in the third quarter of 1997.

But in health care, when a public company grows through acquisitions, it must be careful to put away enough reserves to cover future claims. Since each public company has a strong incentive to keep reporting to Wall Street that it has had increases in prof-

"Both companies are clearing ghosts out of their closets so they can get a fresh start for the new year."

— W.L. Douglas Townsend, Townsend Frew & Co.

moon between physician groups and PPMCs may be over. Only 7% to 8% of all physicians currently belong to PPMCs, and even those observers who are optimistic about their future say no more than 20% of physicians will be in PPMCs within two years.

Most multispecialty PPMCs have learned that there is a limited number of existing integrated groups of 10 or more that are profitable and most of these are already affiliated with a PPMC, a hospital, or other organization. Future growth for PPMCs will come by managing groups of academic physicians or physicians affiliated with hospitals, or from building new groups by consolidating many smaller practices. The latter activity, of course, is time consuming and difficult because as much as 80% or more of physicians are practicing solo or in groups of two to 10. Most of these physicians are uneasy

and increases in revenue, it may be tempted to report cash from prepaid plans as profit rather than as reserves.

One final factor contributing to the collapse of the merger may have been the different styles of the two companies. PhyCor is cautious and conservative, acquiring only established medium-size to large groups dominated by primary care physicians. It has succeeded in secondary markets with low HMO penetration, and it prefers to avoid head-to-head competition.

MedPartners is bolder, preferring spectacular growth by acquiring large groups and services, such as a pharmacy benefit management company. It seeks competition in mature metropolitan markets, such as Southern California, and it embraces capitulation. In the end, perhaps the differences were too great to overcome. ■

New Models of Development Offer Insight

Physicians need to examine and understand thoroughly their local health care markets for many reasons. They may need to determine if their rates are competitive; they may want insight into whether they should affiliate with other physicians or with a local hospital; or they may seek to discern the future direction of a market.

Any such examination involves a variety of factors, including the influence of managed care companies, the number of physician networks and groups operating in an area, and patient demographics. Consultants and researchers develop models to understand how markets are behaving. A model represents reality in an organized fashion, “serving as a basis for comparison and a way to communicate,” explains Peter Kongstvedt, MD, a partner with Ernst & Young, CPAs and health care consultants in Washington, D.C. “One of a model’s most common functions is prediction.”

As managed care continues to penetrate health care markets, identifying the specific areas in which a market is unprepared for this trend is important to physicians, says Kongstvedt, who is also a member of the *Physician Practice Options* advisory board. A market that is not fully mature, such as Washington, D.C., can “offer terrific opportunities for providers,” he says. (See Figure 1.)

Often, market analyses involve examining linear models that illustrate one or more factors. Physicians are particularly interested in managed care activity in their markets, for example. But in seeking to understand one activity and its potential effect on their practices, many physicians and consultants do not recognize that many factors are intertwined and thus fail to see a local market in its entirety, explains Kongstvedt. “It is hogwash to say health care in this country, or in any specific market, is moving in discrete stages,” Kongstvedt says. “Health care is a particularly complex and unstable market phenomenon. A linear approach does not capture the rich variation of experience we are seeing in health care markets across the country.”

Therefore, physicians need a more sophisticated model of market development. Consultants at Ernst & Young have developed such a model. Called the spider diagram, or radar chart, the model helps physicians

describe the level of managed care maturity within local markets. Each market diagram is divided into 11 axes, and each axis is given a weighted score based on market research.

Market Anomalies

A common measure of managed care development is the amount of capitation within a specific market, says Kongstvedt. “Most linear models of managed care maturity equate highly mature managed care markets with nearly total capitation of providers,” he says. “But actual markets do not necessarily support that description. In Minneapolis, for example, managed care penetration is quite high, and the levels of sophistication in the application of managed care functions are quite high. But the levels of capitation there are not high. Instead, fee for service (FFS) and salary compensation methods are robust.” (See Figure 2.)

Another common determinant of managed care maturity within a local market is the types of provider organizations delivering care. In many linear models, the highest level of managed care is typified by highly vertical integrated health care organizations

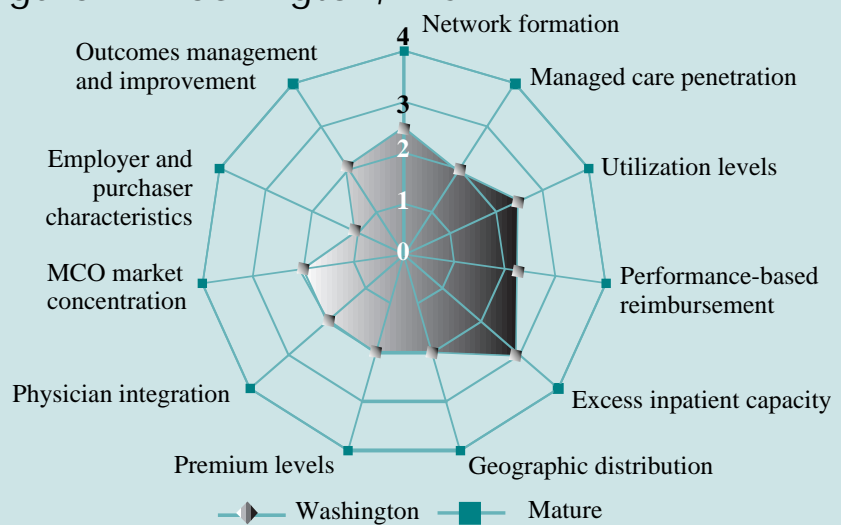
in which physicians, hospitals, and payer systems are part of a single organization. While such vertical systems may exist in some markets, such as Minneapolis, they are not common in other mature markets. In California, for example, many integrated provider organizations are not aligned with a single payer.

Some markets have a high level of managed care penetration, but premium rates have not yet declined. Some areas have relatively high levels of managed care penetration, but managed care is spread out over a large number of health plans, resulting in little payer consolidation.

“Each market is unique,” Kongstvedt continues. “There are market attributes that look like other attributes, but in no case will a market look exactly like another market.”

Moreover, markets evolve unevenly, depending on local and regional variables. “A good market model describes the local variables so as to allow physicians to make an intelligent estimate of where their market is going, to determine the complexity of the changes that are occurring so they can make informed decisions about their future,” Kongstvedt says. “The key to success is to understand how a market is evolving, and to develop a strategy

Figure 1: Washington, D.C.



All market attributes fall significantly within the outer ring, making Washington, D.C., a managed care market that is not fully mature. The market offers significant opportunities for physicians in integration and outcomes measurement.

Source: Ernst & Young, Washington, D.C. Figures based on 1996 data.

that is slightly ahead of that market. It is as dangerous to get too far ahead of a market as it is to fall too far behind it.”

Spider Diagram

To reflect market complexity more closely, consultants use the spider diagram to examine and to represent the influences providers and payers have on various markets. The provider axes are:

- Network formation,
- Physician integration,
- Geographic distribution, and
- Excess inpatient capacity.

The payer axes are:

- Managed care penetration,
- Managed care organization (MCO) market concentration,
- Employer and purchaser characteristics,
- Performance-based reimbursement,
- Premium levels,
- Utilization levels, and
- Outcomes management and improvement.

By itself, **network formation**, for example, can involve several complex variables. In immature markets, hospitals, physicians, and specialty providers are stand-alone entities. As the market progresses, single-specialty and multispecialty groups grow, physicians begin to join faculty-practice plans, and physician-hospital organizations (PHOs) form. Nonacute providers integrate, and risk-sharing begins across multiple types of providers. In the most advanced state, only two or three large systems are integrated and account for at least half of all managed care patients.

In the early stages of a market's development, physicians should assess the relative strength of the market's biggest payers. If their payers apparently will be losers in any consolidation, the physicians should move immediately to develop a stronger payer base.

Physician integration represents the level of integration involving physicians alone rather than physicians integrated with institutional providers. Immature markets have 10% or fewer physicians working in groups of five or more. In more mature markets, more than two-thirds of physicians are in large groups (of 25 or more), although not necessarily in one single group. If managed care penetration is low and there are numerous providers, physicians should organize so that when managed care penetration rises, they will be in a position to capture the business.

Geographic distribution involves providers' ability to deliver health care services across large geographic areas. **Excess inpatient capacity** reflects the number of unused beds in service. As markets mature, excess capacity is eventually reduced, so the higher the score on this axis, the fewer excess beds.

Managed care penetration is the care delivered by HMOs or POS plans. Simple discounted care offered through PPOs and managed indemnity plans are not considered managed care. If enrollment in commercial managed care plans is relatively high—35% or greater—but the Medicaid and Medicare sectors have low managed care enrollment, the market is still not fully mature. At its least mature, a market may have less than 10% of the population enrolled in managed care plans. At its most advanced, managed care may be mandatory for Medicaid recipients, and more than 60% of the commercial

(Continued on page 6)

SPECIAL INVITATION TO SUBSCRIBE TO

PHYSICIAN PRACTICE OPTIONS™

Our editorial focuses on:

- Moving from fee-for-service to capitation
- Looking at practice valuation
- Finding strategic partnerships
- Marketing and expanding your practice

A subscription to **Physician Practice Options**, (12 issues) regularly \$299, is now, for a limited time—\$225.

A savings of 25%
off the regular subscription price.

Simply send or fax the order form below to begin your subscription and get the information you need to succeed in health care. There's no need to send payment now; we'll gladly bill you next month!

PLEASE SEND FORM BELOW TO:

Physician Practice Options
PO Box 3000, Denville, NJ 07834-9218
or, for faster service, please call toll free:
888/457-8800 • Fax orders: 973/316-5989

Yes! Please send me a subscription (12 issues) to **Physician Practice Options**

Name _____

Address _____

City _____ State _____ Zip _____

PLEASE FILL IN THE FOLLOWING INFORMATION:

Bill me Payment enclosed

Medical Specialty: _____

Title: _____

I'm in a: Solo Practice Group Practice

If sending payment, please make check payable to: Physician Practice Options

(Continued from page 5)

population and over 40% of Medicare patients are in managed care plans.

Even 20% of physician revenue from managed care can cause significant changes in practice patterns, says Kongstvedt. "By the time a provider has 50% to 60% of revenue from managed care, it has made a complete change in practice patterns to the managed care model," he says.

MCO market concentration represents the number and organization of MCOs in a market. At its least mature, a market may have many MCOs, little differentiation among them, and none dominating the market. At its most advanced, a market has three or four dominant MCOs accounting for 80% of managed care enrollment.

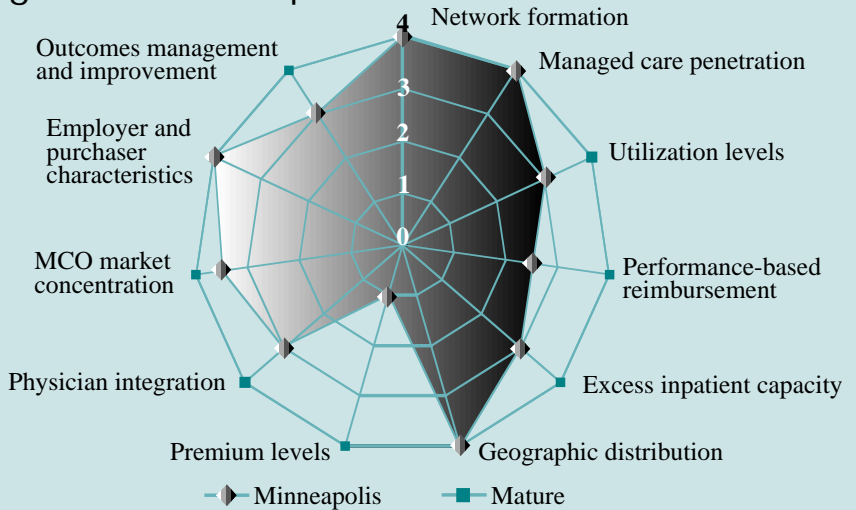
Employer and purchaser characteristics refers to employers but can include purchasing coalitions and government agencies that buy health care for beneficiaries. At its least mature, the purchaser base is fragmented even though some large employers may demand high discounts from health insurers. Later, employers band together to obtain more favorable pricing.

Performance-based reimbursement involves the level of pay for performance for physicians and risk-sharing among providers. In immature markets, contracting is done through discounted per diems, diagnosis-related groups (DRGs), and discounted FFS. In these markets, hospitals get little revenue from capitation. Physicians are paid primarily through FFS, and there may be simple primary-care capitation on a direct-contract basis, but it does not make up a large percentage of most physicians' revenue. As the market matures, hospitals get some revenue from capitation, and physicians receive higher levels of total revenue from capitation or other forms of risk-based reimbursement. In more mature markets, capitation becomes more prevalent. At the highest levels of maturity, reimbursement models are aligned completely with the financial and clinical goals of managed care.

Premium levels refers to premiums for commercial health care coverage. In the least mature markets, premiums rise faster than the rate of general inflation. As markets mature, premium rates rise more slowly, and in the most advanced markets, premiums are either flat or declining slightly.

Utilization levels is a measure of inpatient bed days per thousand covered lives (BD/K).

Figure 2: Minneapolis



While Minneapolis is a relatively mature market, premium levels continue to rise and the amount of performance-based reimbursement is low.

Source: Ernst & Young, Washington, D.C. Figures based on 1996 data.

In immature markets, commercial utilization is 350 BD/K and Medicare is over 2,500 BD/K. In the most advanced markets, commercial utilization is less than 180 BD/K and Medicare is below 850 BD/K. If utilization levels are high, it is only a matter of time before they start coming down. If providers start to lower utilization levels in a market still dominated by FFS care, however, they may suffer economically. Therefore, transition strategies are necessary. When a market is dominated by FFS contracting, it is a good time for providers to obtain risk-based contracts (such as capitation) and put serious effort into managing cost.

Outcomes management represents the level of sophistication in measuring and managing clinical outcomes.

Using the spider model to understand market dynamics allows health care providers and MCOs to plan and to execute for the future more effectively, says Kongstvedt. If integrated delivery systems are forming quickly in an area, for example, providers can use the spider models to estimate their chances for future success in a market dominated by such systems, he says. But in making that estimate, providers also should consider such factors as managed care penetration and employer and purchaser characteristics, he explains.

"All of these factors interrelate,"

Kongstvedt says. "It is not a linear world out there. There are no simple answers. A provider should not base its decisions about the future on a single market dynamic, but on a market overview. The farther out on a specific axis, the fewer opportunities there are within that specific area. Few opportunities exist for consolidation in a market that is already highly consolidated. But if the number of bed days is high within a local region, an opportunity exists to exploit that dynamic by offering services that reduce the number of bed days."

In closing, Kongstvedt believes physicians who have a full understanding of their markets will be in the best position to exploit any weaknesses in those markets. "Providers should look carefully at who are the most powerful personalities within their markets, the physicians and others who most seem to understand what is happening, and align themselves with them," he says. "Such alignments can create the force that drives a marketplace."

Once they are armed with the proper and thorough information, physicians have an opportunity to effect change in their markets. "Physicians have a major impact on how their market is going to look," Kongstvedt says. "Physicians keep thinking that the marketplace is pushing them around. Actually, they can do a great deal of pushing themselves." ■

(Continued from page 1)

Change has not come easily. Like physicians everywhere, the medical staff members have been concerned about how the business of medicine affects the practice of medicine. This concern is especially important in a teaching institution preparing a new generation of medical providers. The physicians also have been challenged by the unique and complex attributes of the pediatric patient. Naturally, the physicians were skeptical of outside influences that tell them how to practice medicine.

Professional Skepticism

Given these concerns, the physicians believe that health care management must be driven by physicians, the arbiters of quality in health care. Their enthusiastic support is essential to the success of our efforts. But gaining their acceptance and implementing the guidelines meant we would need to overcome physician resistance to change and we would need to answer legitimate questions about where such change will lead. In addition to clinical concerns, for example, physicians worried about the financial implications of improved efficiency. Would they lose their jobs? Would they erode their referral base by declining to admit patients inappropriately?

To address these fears, the physicians began to consider the opportunities available if the hospitals reached the expected levels of efficiency. By definition, efficiency means the hospitals would need fewer professionals to deliver the same level of quality care. If the hospitals need fewer professionals, perhaps the physicians then would be able to offer new programs and treat more patients. As physicians have realized that the guidelines are not necessarily restrictive, they have acquired a new freedom to improve the entire continuum of care. Our efforts to reduce hospitalization of asthma patients, for example, resulted in decreased inpatient but increased outpatient work for these same physicians.

Our solution to physician resistance demands a twofold commitment to ongoing education and critical evaluation. Education occurs through meetings, written messages, and one-on-one encounters. In practice, here's how it works: The HMGs are available to all physicians, including the attending physician on duty. Case managers

leave detailed notes in each patient's chart for the attending and other physicians regarding patient care issues. During daily rounds, case managers and physicians can discuss the guidelines as they apply to each patient under care, affording the opportunity for further clarification, if necessary. Such education of all providers helps physicians understand the intended purpose of the guidelines and their appropriate use.

Evaluation

Critical evaluation occurs continuously—during meetings, in one-on-one encounters, and in memos to physicians. During meetings, groups of physicians examine present practices and explore new approaches to care. In one instance, for example, physicians realized that patients being evaluated for congenital syphilis were being hospitalized for an unnecessary length of time because laboratory support was unavailable. After the physicians met with hospital administrators seek-

By improving efficiencies, the physicians are developing more appropriate methods of treating patients, such as with the case of the congenital syphilis patients. With each small improvement, physicians appreciate more fully the relationship between the business and the practice of medicine.

Cookbook Medicine?

Despite these advances, clinicians at Hermann Children's—like those at hospitals nationwide—have seen considerable variation in practice patterns. Using the HMGs is helping physicians to examine the roots of this variation. But reducing variation in practice patterns will be our most challenging issue because there are many physicians, each with his or her own idea of how each patient should be treated.

At the same time, the process of implementing the guidelines has shown that the HMGs are not intended to nullify the judgment of individual physicians. The guide-

Physicians worried about the financial implications of improved efficiency. Would they lose their jobs? Would they erode their referral base by declining to admit patients inappropriately?

ing to reduce the time needed to get lab results, length of stay declined.

Through such efforts, physicians now recognize that multidisciplinary teams are essential. Pleased to have excellent turnouts at monthly clinical focus meetings, the physicians also found that large groups of about 40 providers could be inefficient for decision-making, such as changing the timing of the laboratory tests or increasing the visibility of case managers. Therefore, the physicians brought together a much smaller group to attack specific situations and to meet on alternating weeks. Now that the physicians have both large and small committees—each promoting communication—improvements in efficiency have resulted. The large group can look at more substantial issues, such as patient satisfaction, while the smaller group can take a more focused approach by addressing such issues as the timeliness of lab results.

lines have an inherent fluidity. The term “goal length-of-stay,” for example, does not mean a patient should be discharged on that day regardless of his or her progress. Day one in the continuum of care calls for a set of expected criteria that must be met before the patient moves to day two. On day one, if the patient has not achieved the milestones outlined in the HMGs, the next day's progression will have its own timing, independent of the recommended goal. The patient with pyloric stenosis, for example, would be expected to be ready for discharge 24 hours after surgery. In reality, such a patient will go home only after tolerating full feeds, meaning enough normal nutrition to sustain life and to promote growth.

When implementing the HMGs, the physicians discovered that both subspecialists and generalists have misconceptions about the issue of consultations.

(Continued on page 8)

The guidelines have an inherent fluidity. The term “goal length-of-stay,” for example, does not mean a patient should be discharged on that day regardless of his or her progress.

(Continued from page 7)

Subspecialists initially viewed the HMGs as “cookbook medicine,” in which they would be shut out of consultations. Again, education helped physicians see that guidelines are not intended to replace consultations and that consulting appropriately is extremely cost effective. In the case of any infectious disease, for example, generalists now consult with specialists to determine the appropriate antibiotic and duration of therapy for a patient with an infection.

Conversely, generalists believed that subspecialists would “order everything in the book.” Again, frequent communication between the two groups has shown this impression to be mistaken.

The Teaching Process

Initially, faculty members were concerned that implementing guidelines would interfere with the process of teaching students and residents. In discussion among faculty members, the physicians agreed that students should learn about the guidelines, since the HMGs are becoming a more significant part of medicine today and can help students to consolidate into manageable bits the large amount of pediatric data. In many cases, students often are trained more easily than faculty.

In fact, resident and student physicians are playing an important role in developing efficiencies. One resident understood from daily rounds that discharge planning upon admission can be extremely important. The resident instructed that an intravenous catheter be inserted during an initial surgical procedure for long-term antibiotics for a new patient with a bone infection. Although, at the time, he was overruled by the surgical faculty member, the physicians now see that the resident was correct. The patient ultimately had to go back to the operating room for an intravenous line to be placed, extending the hospitalization beyond the anticipated guideline length of stay. Now, in similar cases, physicians try to place a long-lasting IV during initial surgery.

Such improvements can be found in many areas because physicians' efforts to become more efficient have had a positive effect on hospital services. The first area addressed—inpatient hospitalization—became an important area of focus. Among our patients, for example, the physicians have seen many cases of congenital syphilis, which require spinal fluid tests. Previously, the lab performing these tests was available only three days each week. It is now available every day. Also, ultrasound is now available seven days a week. Improving our ability to make the proper diagnosis quickly allows for earlier, more appropriate discharges.

Another improvement physicians have instituted is multiple rounds each day. The physicians are trying to refute the idea that patients who don't look well in the morning automatically need to stay another whole day, a way of thinking that might be called the “let's-just-watch-them-overnight” mentality. Between the morning and the afternoon, dramatic changes take place in pediatric patients. Many physicians have noted, for example, that any child seen in the playroom or with parents in the cafeteria is a prime candidate for discharge. The physicians also have agreed that evaluations and workups on otherwise stable patients can be done in outpatient settings and that discharge planning is so important it is now incorporated into the admissions process.

By itself, admissions can be problematic because the faculty physicians have little control over the emergency room or private attending physicians. Our ER Staff, for example, is overly aggressive and routinely gives a regular set of therapies to all patients. The physicians hope that collaboration among staff will encourage ER staff to consider other alternatives and not to admit unless appropriate. As an alternative to hospitalization, the physicians are promoting more clinics with extended hours so that patients can be observed rather than admitted automatically.

These changes are occurring despite ini-

tial resistance to the HMGs. Hermann Children's was like any hospital instituting guidelines: From the beginning, the faculty repeatedly insisted, “But our patients are different.” In general, pediatrics calls for its own care criteria, but, in fact, our patients are different because many come from dangerous homes. We are now seeing more cases of child abuse and neglect than we had in the past, and our patients frequently have inadequate or no caretakers at home. Since the social welfare system is failing to provide adequately for patients, the hospital has decided to hire a child protective service worker to address this need.

The pediatricians have come to view another provider who is not a physician—the nurse case managers—as partners in managing health care. In addition to playing an active role in guideline development, nurse case managers also are involved in decision-making and discharge planning. They join physicians on rounds and their resourcefulness has brought forth a variety of new efficiencies.

Nurse case managers also are monitoring faculty performance, tracking variation, and reporting outcomes. While labor-intensive, such data-gathering gives immediate feedback to the faculty.

Looking Forward

As we make these and other changes, hospital administrators and physician leaders have been gratified to see pediatricians modifying previous practice patterns, by increasing the use of home health care, for example. Moreover, we observe that the physicians have developed a respect for the HMGs and the manner in which they are authored. Milliman & Robertson has asked the physician staff to review the current HMGs and to comment on a new volume for pediatric care. As a result, the Hermann Children's physicians are leading the way, examining efficiencies and bringing together the business and practice of medicine in an appropriate and clinically meaningful manner. ■

Physicians Will Need to Balance Autonomy With Accountability



Michael L. Millenson is the author of *Demanding Medical Excellence, Doctors and Accountability in the Information Age* (University of Chicago Press, 1997). He also is a senior analyst in the Chicago office of the health care and group benefits practice of William M. Mercer, consultants in New York. As a long-time reporter for the Chicago Tribune, Millenson was one of the first journalists to write about the socioeconomic issues affecting medicine. While on a journalism fellowship in 1986, he began exploring issues related to medical quality measurement and management. He turned that interest into a book as a visiting scholar at Northwestern University with the help of an Investigator Award in Health Policy Research from the Robert Wood Johnson Foundation, a philanthropy in Princeton, N.J. A graduate of Washington University in St. Louis, where he studied history and economics, Millenson worked as a journalist in Washington, D.C., New York, and Fort Worth, Texas, before joining the Tribune. At the Tribune, Millenson was nominated for a Pulitzer Prize three times. He is a contributing editor to the health-policy journal *Inquiry* and has written for *Health Affairs*, among other publications. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q. First, let me congratulate you, Michael, on the recent publication of your book. What has been the response to it by reviewers and the public?

A. Prepublication reviews in *Publishers Weekly* and *Library Journal* were very positive, as was a recent review in *The New York Times Book Review*. I'm also pleased that many people who have read the book have commented on how readable it is. Within the profession, some of the most recognized names in the quality field also have been very complimentary, which is particularly gratifying.

The book began as a journalism project and became a combination of journalism and health services research. The academic books focus either on cost and access issues or are technical, but there was nothing that brought together all the different threads of quality measurement and management. As a result, I had to do a lot of intellectual hard labor. A book that is in some ways critical of physicians, as mine is, should be grounded in the medical literature, I believe. Many physician authors simply say, "I know this from personal experience." But if you're a nonphysician author who wants to be taken seriously, you have to ground both praise and criticism in the literature, which I tried hard to do.

Q. Turning to managed care and the current backlash against it, what is your opinion of the current nostalgia for the "Marcus Welby era" of medicine and how do you think the practice of medicine will change in the future?

A. There's a tendency in every profession to look back on and romanticize the good old days. The changes occurring in medicine today are tremendously painful and

"If a hospital improves the health status of the people who live near it, who's going to pay the bill? And if, as a result of being successful, fewer people are admitted to the hospital, who's going to pay for the loss of business?"

disruptive, but if the profession can concentrate on what happens to patients—and not unnecessarily confuse economic issues with clinical ones—the profession and patients will end up better off.

Q. George Halvorson, CEO of *HealthPartners*, a managed care organization in Minneapolis, sees the future of health care as a working partnership of buyers, health plans, physicians, and consumers, with the optimal result being the elevation of the health care status of the community as a whole. Do

you see that happening?

A. Yes, as long as we're careful with the definition of "community." If by "community," you mean a provider says to General Motors, "I'm going to be responsible for improving or maintaining the health status of your workers," that makes some sense. GM might pay for that. But at present, despite the puffy rhetoric, there is no economic incentive to improve the health status of an entire geographic community. If a hospital improves the health status of the people who live near it, who's going to pay the bill? And if, as a result of being successful, fewer people are admitted to the hospital, who's going to pay for the loss of business?

I have a chapter about what happens to a four-man group of family practitioners in Northfield, Minn., who did a terrific job of implementing practice guidelines and keeping people out of their office when those people didn't need to be there. The chapter is entitled: "The early worm gets the bird." This doctors' group went out of business. Under the discounted fee-for-service system, if you give fewer services, you get less money. If we want physicians to behave in

certain ways, it's critical that we reward them for behaving in those ways.

After that, we need to ask, "Are private health and public health coming together? Are physicians going to be responsible for maintaining health as well as treating sickness?" Yes, that is going to happen. But it will take some time and it will happen in ways that still need to play out.

Q. In your book, you often come back to the theme that the onset of the information
(Continued on page 10)

“If health plans compete on the basis of quality, they are doing something that helps consumers and patients. The profession should welcome and actively participate in this kind of standardization.”

(Continued from page 9)

age and accountability will result in a crumbling of the barriers separating physicians, patients, and buyers. Is that what you see occurring?

A. The old autonomy for individual physicians is changing to a new model in which autonomy and accountability are balanced. That is an enormous cultural change, and I give an example in my book. In the mid-1980s, John Burns, an internist who became medical director at Honeywell in Minneapolis, wanted a request for proposal (RFP) to be sent to the medical community that would say, “We’re buying health care services and here are some of our specifications.” Back then, for nonphysicians to put out any specifications for health care was considered a radical act. Today, RFPs are so commonplace that most corporate benefits managers can’t remem-

Q. When Burns became a medical director for Honeywell, he insisted that health care be treated as a cost of the corporation and be subject to specifications just as Honeywell’s other purchasers set specifications for any product or service they acquired for the company. That precedent has had a significant effect, hasn’t it?

A. It has. I think physicians getting involved in the purchaser side of the equation is actually good news. We need individuals committed to the pro-patient values physicians are trained in to be participating in purchasing decisions. Burns was active in the local medical society. He went to Honeywell because he saw first-hand that a lot of what doctors were doing in the name of patients was really meant to protect their own economic well-being. So he said, “We want to standardize and rationalize medical care, and I’m going to use the

A. Yes. We all know benefit managers and HMO executives who care about cost and almost nothing else. But the trend is for benefits managers to act on behalf of consumers and to look for high-quality, consistent care; that is, rationalization of care. Therefore, the credentialing that HMOs undertake routinely now because of the requirements of the National Committee for Quality Assurance are a pro-consumer action prompted by purchasers. Similarly, if health plans compete on the basis of quality, they are doing something that helps consumers and patients. The profession should welcome and actively participate in this kind of standardization.

Q. In the late 1960s, Paul Ellwood, a pediatrician who is often called the father of the HMO, said, “From now on, we shall talk in terms of the market rather than in terms of the old priesthood of doctor and patient.” Today, we talk in terms of the market, providers, and consumers. Is that the type of change you are referring to?

A. Partly. Ellwood was correct at the time in trying to break down the “priesthood” because there was a lot of bad medical practice being swept under the rug in the name of collegiality. A quick example from the medical literature of the early 1960s is a 98% rate of inappropriate tonsillectomies at a group of community hospitals. Moreover, for all the pious professions of disgust by doctors today about HMO greed, any objective historian looking at postwar medicine can find equal expressions of physician greed causing at least equal harm to patients. The professional societies tried to stop it and were largely powerless. It’s not a pretty history, which is why it’s been omitted by the official scribes. But that history led us directly to where we are today, so it’s important.

Q. You believe that these problems led directly and indirectly to managed care in a kind of counter-revolution?

A. Precisely. The television drama “Marcus Welby,” which some think personified the so-called golden age of med-

“For a profession that grew up as a guild holding information tightly to the chest, this is nothing less than a paradigm shift. Handled poorly, it will be a mess. Handled well, it will elevate medicine to a new and better level.”

ber when they weren’t around. Nonmedical organizations now specify what are essentially medical performance requirements. People forget the magnitude of some of the changes we’ve already seen.

The information revolution will go even further, making available to the public clinical pathways (already on the Internet), data on the performance of groups of physicians (available in California), and hospital clinical data (available for some procedures in some states). For a profession that grew up as a guild holding information tightly to the chest, this is nothing less than a paradigm shift. Handled poorly, it will be a mess. Handled well, it will elevate medicine to a new and better level.

power of the corporate dollar to do so.”

One point I stress in my book is that the greatest achievements and the worst failures of U.S. medicine have little to do with insurance arrangements, whether fee for service or HMOs. Instead, they emerge directly from the decisions made by health professionals. Doctors’ decisions will always be central to the future of medicine, and I believe doctors have to live up to the best ethical standards of the profession.

Q. You speak positively of corporate benefit managers as looking at situations in terms of facts, not emotions. You seem to believe that managed care and the benefit managers have both played a positive role by rationalizing care. Is that so?

“One reason HMOs look only at cost is because the medical profession said, ‘All doctors are roughly equal except for a few bad apples, and all the rest of us provide good quality care.’ If that is so, then why not just pick the lowest cost provider?”

icine, went on the air in 1969. In that year, there were highly publicized hearings in the Senate on Medicare fraud. Medicare had been in effect only since January 1966, yet one example of fraud involved family practitioners (the fictional Welby’s putative colleagues) who up-coded visits and added extra charges for psychiatric counseling. Medical care today is a lot better than it was back then, not simply because of technological advances, but also because the profession was profoundly ashamed and cleaned up its act.

Q. Many doctors have told me that HMOs operate in an environment of punitive secrecy, whereby doctors are excluded from networks but never told why. From the physician’s point of view, HMOs focus on cost management not clinical management. The doctors say that they have never received constructive clinical advice nor told how they might do things better. As a result, they more or less reject the notion that HMOs improve the quality of care. What are your thoughts on this?

A. One reason HMOs have been able to look only at cost, yet keep a clear conscience, is because the medical profession gave them the idea. In the past, the profession said, “All doctors are roughly equal except for a few bad apples, and all the rest of us provide good quality care.” If that is so, then why not just pick the lowest cost provider? Therefore, the successful protectionism of the past has come back to haunt the profession in the present.

Second, one must note that the physicians who complain are the dissatisfied ones. No physician is going to write to you and say, “Let me tell you how I improved care because of my HMO.” Finally, when HMOs try to go beyond cost and help improve clinical practice by, for instance, sending out clinical guidelines, some physicians complain that “five different HMOs have five different guidelines.” But if they don’t get guidelines, they complain that the HMO cares only about cost. While HMOs still have a great deal of improving to do, many

of those complaining are not constructive critics. What they are really saying is they want to be left alone and have the same autonomy as in the old days. That’s not going to happen, and it should not happen.

Q. In your book, you come down fairly hard on doctors who ignore or disregard scientific evidence, and you cite examples of doctors who fail to advise or treat their patients based on this evidence. In my view, this happens partly because we have 700,000 doctors practicing in small groups that might not promulgate this advice. Also, they are overwhelmed by the miscellaneous information that crosses their desk, as well as by conflicting treatment theories. How should one promulgate and enforce the use of such information? It takes an organization with economic teeth, right?

“We’re going through a transition period in which many physicians fear they will lose their autonomy and be held accountable only for cost measures. That result would not be good for either doctors or their patients.”

A. Yes. I agree with you completely. The disconnect between research medicine and the everyday practice of medicine is one of the central themes of my book. Groups of doctors organized together can accomplish improvements in care that individual doctors, no matter how well intentioned, simply cannot.

Q. That comment fits with the general thesis of your book, in which you say, “Information and accountability are fast becoming the new realities of a once insular profession.” What do you mean by that?

A. In a fee-for-service system made up primarily of solo practitioners, you do not want to alienate peers who send referrals to you because your livelihood could dry up. That led to what I call the “fee-for-service gag rule”: Don’t rock the boat, don’t jeopardize

referrals. By contrast, in a managed care world in which groups of physicians contract on the basis of quality as well as cost, there is a huge incentive for all doctors in a group to measure and to improve their practice constantly. In business, continuous quality improvement (CQI) didn’t catch on until it became a matter of economic survival—quality or else. The same thing will happen in medicine. The best CQI is not cookbook medicine, but a balancing act between autonomy and accountability. And I give real-life examples in the book. Give doctors better information and let them use it.

Right now, we’re going through a transition period in which many physicians fear they will lose their autonomy and be held accountable only for cost measures. That

result would not be good for either doctors or their patients.

Q. So, this period we’re in now is one of a transition that is difficult?

A. It is very difficult. I would love to say that there is a villain in this story, but there isn’t. In every aspect of American life today, the public wants more without paying more. More services from the government without more taxes. Better products from companies, but not higher prices. In health care, it’s the same. The public wants unlimited care, but without paying more for insurance or out of pocket. Similarly, the public thinks the uninsured should be covered but is unwilling to pay taxes for it. The public, of course, is us. Our health care system was not imposed on us; we created it together. All of us share responsibility. ■

PSO Regulations Will Be Demanding

By Edward B. Hirshfeld, JD

The Balanced Budget Act of 1997, which became law on Aug. 5, created a new opportunity for physicians. The act allows physicians and entities to form provider-sponsored organizations. PSOs are health plans owned by providers that may be offered to Medicare recipients as an alternative to the traditional fee-for-service Medicare program.

The act created the Medicare+Choice program, which greatly expands the types of health plans available to persons over age 65, and PSOs are among the options available to them. While PSOs are an exciting new opportunity, regulatory requirements for them and the Medicare+Choice program will be demanding. So, before embarking on a plan to develop a PSO, physicians should understand the requirements and be certain that their organization can meet them. Physicians should also assess market conditions carefully before proceeding because PSOs will face tough competition for Medicare patients from other kinds of Medicare+Choice plans.

Regulations that define the permissible configurations and ownership of PSOs were scheduled to be published by early this month, regulations for PSO solvency standards are due on April 1, and regulations setting forth the requirements for the Medicare+Choice program are due on June 1. This fall, Medicare beneficiaries will be able to enroll in Medicare+Choice plans for 1999.

Definitions

Under the act, a PSO must be established or organized, and be operated by, a health care provider or a group of affiliated health care providers. It can be a public, private, for-profit, or nonprofit entity. It also must provide a substantial proportion of the health care items and services in the Medicare benefits package directly through the providers or affiliated providers.

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

Moreover, the affiliated providers must share, directly or indirectly, in substantial financial risk with respect to providing such services and have at least a majority financial interest in the entity. The federal Department of Health and Human Services (HHS) is developing regulations that will amplify these requirements. On Jan. 8, HHS publicly disclosed the planned contents for these regulations, but was not

vice corporation (the principal business of which is performing services) and one or more "other service corporations" or "other organizations." For independent physicians, choosing the latter alternative means they would need to aggregate their pension plans for tax purposes, which could cause unfavorable changes to individual pension plans.

Before embarking on a plan to develop a PSO, physicians should understand the requirements and be certain that their organization can meet them.

expected to issue them until late last month or early this month. The regulations will have a significant effect on what configurations of providers may constitute a PSO.

The act defines "provider" as an individual required by state law to have a license to render health care services or as an entity engaged in the delivery of health care services. An entity must be licensed by a state only if state law requires it to have a license. HHS said that a provider also must be involved in the direct delivery of health care.

To be affiliated, providers must be organized within one of four sets of relationships. Three sets require interrelated corporations and are best suited to integrated delivery systems:

- An entity in which a provider controls, is controlled by, or is under common control with another provider, in which control is defined as having 51% of the voting or governance rights in the entity;
- An organization in which the providers are in a controlled group of corporations under Section 1563 of the Internal Revenue Code, which includes parent-subsidiary and "brother-sister" corporate relationships; or
- An entity in which the providers are in an affiliated service group under Section 414 of the Internal Revenue Code, consisting of at least one ser-

The fourth method of affiliation requires that each provider be a participant in a lawful combination in which each provider shares substantial financial risk in connection with the organization's operations. Relationships in which providers participate together in risk-sharing arrangements (such as capitation, fee withholds, or a percentage-of-premium or bonus or penalty system) will satisfy this requirement, HHS has said. Thus, this method of affiliation does not require that one kind of provider owns or controls another, and does not require all affiliated providers to have an interest in the ownership or control of the PSO.

This option is important because in defining the "substantial proportion requirement," the act requires HHS to assume that a PSO has responsibility for providing "significantly more than the majority" of the items and services "through its own affiliated providers." The affiliated providers in a PSO must deliver at least 70% of the items and services in the Medicare benefits package, HHS has said. Since physician services account for about 40% of Medicare expenditures, and hospital services about 60%, the substantial-proportion rule means physicians must affiliate with a hospital to form a PSO. This option for affiliation allows physi-

Regulations that define the permissible configurations and ownership of PSOs were scheduled to be published by early this month, regulations for PSO solvency standards are due on April 1, and regulations setting forth the requirements for the Medicare+Choice program are due on June 1.

icians to form a PSO without offering a hospital or other kinds of providers an interest in the ownership or control of the PSO. Conversely, a hospital can form a PSO without offering an interest in ownership or control to physicians.

A provision in the act addresses the issues involved in sharing substantial financial risk and majority interest. It ensures that the providers delivering services share the financial risk and control the organization. Since HHS has said that not every affiliated provider must have an interest in the ownership or control of a PSO, a subset of the affiliated providers may have the required majority interest. However, HHS also has said that all affiliated providers must share in the PSO's overall risk of loss and opportunity for profit. Therefore, those providers that do not have an interest in the ownership or control of a PSO must be part of a risk-sharing relationship (such as capitation, fee withholds, or a percentage-of-premium or bonus or penalty system), giving them a stake in controlling the PSO's overall costs and maintaining or enhancing its overall quality of care. Also, HHS has said a PSO may have a nonprovider minority partner, such as a venture capital firm or a licensed health plan, that has capital or management expertise in Medicare-risk plans.

Requirements

Solvency. HHS is developing a certification process in which it will evaluate whether a PSO meets federal solvency standards within 60 days of receiving an application. HHS is scheduled to develop solvency standards for PSOs by April 1, and must take into account three specific factors affecting solvency:

- The PSO's delivery system assets and its ability to provide services directly to enrollees through affiliated providers;
- Alternative means of protecting against

insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of a PSO to meet its service obligations through direct delivery of care; and

- Standards developed by the National Association of Insurance Commissioners for risk-based health care delivery organizations.

Licensure. Under the act, each PSO must be "organized and licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state in which it offers" a plan to Medicare patients. A PSO may obtain from HHS a waiver of state licensure requirements if the state fails to act on a substantially complete application within 90 days, the state denies the licensing application based on discriminatory treatment, or the state denies the application based on solvency standards different from federal PSO solvency standards. To obtain a waiver, providers must apply by Nov. 1, 2002, although Congress might extend that deadline. A waiver would last for 36 months and may not be renewed. Waivers would be given only for issues related to state solvency standards and licensure procedures and requirements. Any PSO that receives a waiver must comply with all state consumer protection and quality standards that are not inconsistent with federal standards developed for the Medicare+Choice program. HHS is obligated to act on an application for a waiver within 60 days. Therefore, the entire cycle of application for a state license, state denial, application for certification and a waiver to HHS, and granting of certification and waiver would take 150 days.

Benefits and minimum enrollment. A PSO must underwrite and deliver the entire

Medicare benefits package, but the so-called 50-50 rule, which requires Medicare HMOs to have at least one commercial enrollee for every Medicare enrollee, is being eliminated for Medicare+Choice plans. PSOs must have a minimum enrollment of 1,500 individuals, or 500 if the PSO operates primarily outside of urban areas. HHS has discretion to waive the minimum enrollment requirement for Medicare+Choice plans for the first three years of the program.

Payment. Medicare will pay all Medicare+Choice plans a fixed amount per patient per month. Payment rates will be announced no later than March 1 for the following calendar year, and the factors for calculating rates will be announced at least 45 days before that date. The health-risk-adjusted rates will be calculated based in part on the methods currently used to calculate payments for Medicare HMOs, but with adjustments to reduce geographic variation and other factors. The act sets a minimum payment rate for this year of \$367 per member per month.

First Steps

Given that the act laid the groundwork, PSOs can start to form now. Terms and definitions for PSOs were scheduled to be issued late last month or by early this month, and physicians can use that information to form a PSO and apply for a state license. Since solvency standards are due on April 1, a PSO could apply to HHS for certification of solvency and a waiver from state licensure requirements immediately after that date. Thus, the 150-day cycle necessary to obtain certification and waiver of licensure could be completed in time for the Medicare+Choice open enrollment program in the fall. But this timing sequence depends on HHS completing regulations, which is not assured. Physicians should watch for developments. ■

PPMCs Are Raising Capital at a Blistering Pace

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

Physician practice management companies (PPMCs) raised \$2 billion last year, a 6% increase over 1996 levels. PPMC's entering the public markets for the first time account for a substantial portion of this amount. As of Dec. 31, 1997, publicly traded PPMC's numbered 44, comprising 29 single-specialty organizations and 15 multispecialty entities. Investors are attracted to PPMC's because they can provide significant growth opportunities by affiliating with physician practices and because they add value to the affiliated practices by providing capital and management expertise.

Recent Offerings

In November, PPMC's serving physicians in a variety of specialties filed for or completed initial public offerings (IPOs). On Nov. 12, U.S. Physicians Inc., in Fort Washington,

Pa., filed for a \$50 million IPO. The company provides management services to orthopedic surgeons, neurologists, oncologists, and other specialists. It has existing or pending affiliation agreements with 90 physicians providing care in 64 practices in Delaware, New Jersey, New York, and Pennsylvania.

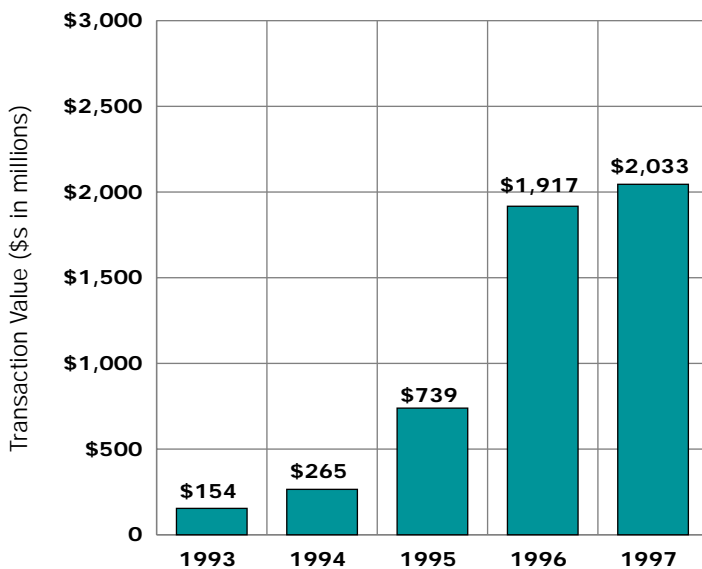
On Nov. 13, Physician Health Corp., in Atlanta, filed for an IPO worth an estimated \$69 million. The company provides administrative and ancillary services for 23 independent provider networks and two company-sponsored networks. Combined, the 25 networks have 3,000 physicians. The company also manages 19 practices, representing 62 physicians, and plans to acquire 15 additional practices totaling 104 physicians.

On Nov. 21, American Physician Partners, in Dallas, a PPMC specializing in

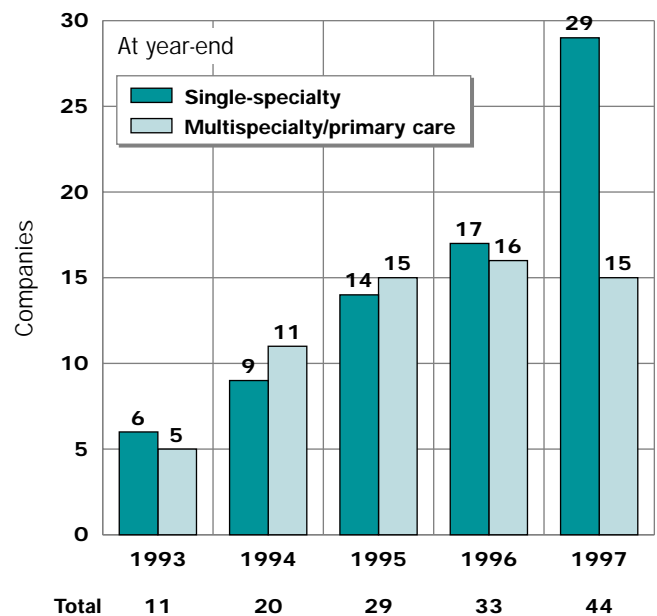
radiology practices, raised \$36 million from an IPO. The company plans to use this money to help fund the cash portion of the \$226.5 million it has agreed to pay for its first seven radiology practices. The seven practices represent 223 physicians in California, Maryland, New York, and Texas. Of the \$226.5 million purchase price, \$50.7 million will be paid in cash, \$23.9 million will be used to repay debt at the seven practices; and the physician shareholders will receive \$151.9 million in American Physician common stock.

Securing capital in the public markets allows PPMC's to consolidate and organize physician practices. As more and more PPMC's follow this trend, physicians across all specialties are more likely to face the decision of whether to affiliate with such organizations. ■

Capital Raised by Public PPMC's



Publicly Traded PPMC's



Source: Townsend & Frew Co. and Securities Data Co., New York.

W.L. Douglas Townsend Jr. is managing director and CEO of Townsend Frew & Co., an investment banking firm in Durham, N.C., specializing in health care transactions. He is also a member of the Advisory Board of Physician Practice Options. Jill S. Frew is managing director of Townsend Frew & Co.

AMA Hopes Its Accreditation Criteria Become a National Standard

The AMA believes the current system of assessing physicians' performance and accrediting them is duplicative and fragmented. Seeking a better system, it has developed the AMA Program for Physician Accreditation (AMAP), and hopes AMAP will become a uniform national quality standard for organizations assessing physician performance.

For physicians, AMAP is designed to reduce the hassle and redundancy of current assessment programs, the AMA says. Even though participation by physicians in AMAP is voluntary, Randolph D. Smoak Jr., MD, chairman of the AMAP Governing Body and vice chairman of the AMA's board of trustees, expects most physicians to participate. "Participation in this national, single system could save money and significantly reduce hassle," Smoak says. "On average, physicians have to be accredited by 10 or 11 different plans, which takes time and money—anywhere from \$250 to \$500 per accreditation." The initiative aims to establish a standard of physician excellence that will be universally accepted by insurers, hospitals, and other organizations.

Currently, managed care organizations (MCOs) assess the qualifications of the physicians they include in their networks. MCOs frequently hire regional credentialing verification organizations to examine physicians' qualifications, and each MCO has its own standards for accreditation and performance measurement.

"This is something physicians should have done years ago so everyone else wouldn't be measuring us, including people who don't understand health care," comments Richard Liliedahl, MD, a health care consultant with Milliman & Robertson Inc., actuaries and health care consultants in Seattle. "The concern is whether third parties will accept the AMA as being objective. But even if not all physician profiling organizations do accept the AMA standards, having some national accreditation and performance measurement could allow for a greater degree of uniformity in the quality of training received by the people who perform physician evaluations."

Lee Newcomer, MD, chief medical officer for United HealthCare Corp., in Minneapolis, believes AMAP is a positive step for physicians. UHC recently implemented a program of measuring performance at the physician level, the first HMO to do so. Most MCOs gather performance data at the health plan level. "Because of our performance measures initiative, we have had several talks with the

"As it is, many people will see the effort as the fox guarding the hen house." —James Nuckolls, MD

AMA about AMAP, suggesting ways doctors can measure and improve their performance," Newcomer says. "The AMA's work dovetails nicely with our efforts."

AMAP was approved by the AMA's Board of Trustees in June. It will be phased in over the next several years by state medical societies, says Smoak. The New Jersey State Medical Society became the first to institute AMAP when it began the program last month. The medical societies in Alabama, Idaho, Massachusetts, and Washington, D.C., also have expressed an interest in the program, Smoak says.

Other medical societies are raising concerns, however. Some have said they do not wish to participate until standards have been tested in practice. And some individual physicians are worried as well. "I hope they don't try to do too much too fast," comments James Nuckolls, MD, CEO of Carilion Healthcare Corp., a medical group in Roanoke, Va. "This is a complicated and detailed process that will take a lot of man-hours to set up. It will be valuable only if it's done carefully. As it is, many people will see the effort as the fox guarding the hen house."

AMAP is designed to evaluate individual physicians in five areas:

1. Physician credentials, including the academic, training, and work histories of physicians;
2. Personal qualifications, such as abiding by the AMA's Principles of Medical Ethics;
3. The environment of care, which includes the clinical, operational, and manage-

- ment systems in a physician's office;
4. Clinical performance, as measured against a national benchmark; and
5. Patient care results, which include the results of patient satisfaction surveys.

Accreditation under AMAP would be good for two years, during which time the accredited physician must participate in a medical organization in which his or her performance would undergo peer review.

Beginning in July, accredited physicians also must complete one or more AMAP-approved self-assessment programs.

Among the required AMAP accreditation standards are:

- Satisfactory completion of medical, postgraduate, and continuing medical education;
- No record of felony or fraud convictions;
- No state or federal disciplinary action of any kind within the past five years; and
- A satisfactory score on a site review of the medical office.

Site reviews will address five areas of medical practice quality:

1. Safety of the physical environment, including adequate procedures for infection control and the storage and removal of hazardous materials;
2. Physical appearance and access;
3. Office administrative systems, including appointment scheduling, triage procedures, and patient follow-up;
4. Staffing and staff performance; and
5. Medical records.

Comment: It is telling that Newcomer says AMAP will never replace UHC's own credentialing program. "We're still hoping it will be a useful and significant part of our evaluation process," Newcomer says. "If it's done carefully and proves itself over time, we hope we can someday use AMAP without feeling a need to recheck AMA's data." Further, Newcomer hopes the AMA treats its initial efforts as a pilot program, carefully evaluating which criteria are meaningful and which data collection practices are effective.

Elderly Face Cuts in Medicare HMO Benefits

Managed care organizations have been offering generous health care coverage designed to lure millions of elderly Americans on Medicare into HMOs. The generous benefits have worked so well that these Medicare-risk HMOs enrolled 500,000 new patients per month last year.

Now, however, Medicare-risk HMOs are facing sharply higher drug costs, and under the federal Balanced Budget Act of 1997, Congress capped the amount the government will pay for Medicare coverage in HMOs. As a result, Medicare-risk HMOs are now charging monthly premiums and are eliminating free prescriptions, eyeglasses, and dental care.

Comment: *A Medicare-risk patient who has a health condition and wants to change to traditional fee-for-service Medicare coverage may be denied Medigap coverage, said John Rother, legislative director of the American Association of Retired Persons. Other seniors who want to change back may have to pay much more for a new Medigap policy than they had paid previously, simply because they are older and rates are age-based.*

Physicians' Specialty Corp. Buys ENT Practice

Physicians' Specialty Corp., in Atlanta, has purchased the assets of Cobb Ear, Nose & Throat Associates, PC, a group practice of six physicians in Atlanta. Physicians' Specialty Corp. is a physician practice management company (PPMC) that provides management services to specialists treating diseases and disorders of the ear, nose, throat, head, and neck.

Comment: *The development of a PPMC to serve ENTs is an example of a trend to develop specialty PPMCs. By the end of the year, publicly traded PPMCs are likely to represent every major specialty.*

TOLL-FREE LINE FOR PHYSICIANS

888 / 457 - 8800

PHYSICIAN PRACTICE OPTIONS is a practical information resource for physicians making the transition to managed care.

In the search for new practice options, physicians are asking a variety of questions, including:

- What's the value of my practice?
- Should I sell my practice and to whom?
- How do I educate myself to deal with managed care?
- What are my career options?
- How do I evaluate my organizational options?
- Where should I go to get capital?
- How can I make my practice more profitable?

We are available to answer all such queries from readers. If we don't know the answer, we have vast resources at our disposal and will help to locate the appropriate expert.

To reach us, readers are invited to call toll-free: **888/457-8800**. The service is free to readers.

Richard L. Reece, MD
Editor-in-Chief
PHYSICIAN PRACTICE OPTIONS

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

February 1998



Premier Healthcare Resource
Suite 300, 99 Cherry Hill Road
Parsippany, NJ 07054

BULK RATE
U.S. POSTAGE
PAID
SMITHTOWN, N.Y.
Permit No. 15