

# PHYSICIAN PRACTICE OPTIONS™

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A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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## Physicians, Hospitals Need New Forms of Partnership

In many ways, the movement by hospitals to buy and use physician practices to build integrated care networks has been unsuccessful. Hospitals have seen lucrative practice revenue shrink after buying physician groups, and physicians have become greatly dissatisfied with hospitals as employers.

Even so, almost 50% of U.S. physicians are employed by an organization outside of their own practice, a large increase from 1989 levels when only 29% of U.S. doctors were so employed, according to a recent report from a survey by the American Medical Association, based on 1995 data (the most recent data available). In most cases, the organizations employing physicians are hospitals. Yet, physicians interviewed for this article were so dissatisfied about working for a hospital that they did not want their names used here.

Fortunately, this situation may change, as physicians and hospitals examine what they have learned by participating in these unsuccessful acquisitions. In addition, two recent reports discuss possible solutions to the problems. One report, *Physician Partnering: Gaining Value from Physician Practice Management Arrangements*, was written by the Croes Oliva Group, physician practice management consultants, in Burlington, Mass. Croes Oliva wrote the report for the Governance Institute, a health care research organization in LaJolla, Calif. The other report, *The Physician Practice Acquisition Resource Book*, was written by William O. Cleverly, Patrick J. Knott, and Carson F. Dye of the Center for Healthcare Industry Performance Studies, health care researchers, in Columbus, Ohio.

Jayne Oliva, a principal of the Croes

Oliva Group and co-author of *Physician Partnering*, predicts improvements in the next generation of deals between physicians and hospitals. "The second phase will provide an opportunity for physicians and hospitals to get it right this time," says Oliva. "An element of experimentation was certainly evident during the first round of acquisitions, but as those first sets of contracts come up for renewal, there is plenty of opportunity for change."

#### Physicians' Experience

Physicians are dissatisfied being hospital employees because many have lost control over clinical decision-making. Also, they may have experienced excessive patient turnover and reduced compensation. One specialist in New Orleans says he felt stuck with a deal. "I had built a good situation for myself, but when the offer came, I thought it might be even better," the New Orleans physician says, asking that his name be withheld. "Here was a chance to be relieved of the day-to-day decision-making and to spend more time with my patients. After the first-year settling-in period, the situation was a mess. I wanted to get out of the arrangement but realized that if I did, I'd have nothing: no patients, no practice, no receivables."

Seeking a way out, the physician reviewed the contract he'd signed with the hospital. "I found a clause stating that if I decided to terminate my relationship with the hospital, I could not practice within a 15-mile radius," he said. "I'd have to basically relocate and start from scratch."

John McDaniel, president of Physician Management Group Inc., a practice management company in New Orleans, says

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## Looking Ahead to Managed Care's Future

Predicting the future of today's health care trends is difficult. Even so, we have faced this daunting challenge since our first issue in February 1996 in an effort to keep physicians aware of what is happening—and could happen—in the rapidly changing health care market. Most recently, we offered predictions about future market trends in our January cover article, "Five Trends to Watch in 1998."

Now, we offer the prognostications of Peter Kongstvedt, MD, a member of the editorial Advisory Board of *Physician Practice Options* and a partner with Ernst & Young, CPAs and health care consultants, in Washington, D.C. In his article, "The Future of Managed Care" (the full text of which is available on the Internet at [www.ey.com](http://www.ey.com)), Kongstvedt says we can reasonably predict the following about managed care:

- Health care payers and purchasers will demand that health care providers be held to higher standards for fiscal results, clinical outcomes, health status, and patient satisfaction. These increased levels of accountability "will not be rewarded by extra income, but rather will be the price of admission," Kongstvedt says.
- We can expect more government regulations on issues that generate controversy among consumers and thus are attractive to legislators, such as health plan requirements that patients who have had mastectomies or normal vaginal deliveries be sent home promptly.
- Insurers and managed care organizations will shift the financial risk of delivering care to hospitals and physicians. This shift will mean that providers will need to administer risk by handling all of the administrative and financial aspects of delivering care.
- As providers assume more of the financial risk of delivering care, all organizations involved in health care will need to consolidate into larger groups. Physicians will need to form or join large organizations by becoming members of large physician groups, HMO employees, or employees in other venues, such as hospitals or physician-hospital organizations. Or, physicians will need to affiliate with physician practice management companies. Insurers, HMOs, hospitals, and pharmaceutical companies will merge with or acquire competitors.
- All organizations involved in delivering health care will need more sophisticated electronic data and communication capabilities to analyze patterns of care, to improve health status and patient satisfaction, and to become more efficient while decreasing costs.
- Since the end result may never be clear, the organizations purchasing and delivering care will need to be aware that the rules will constantly shift.

In some markets, these trends are obvious now, but in other markets, they may still be years away. Nonetheless, there is little doubt that change is coming quickly. While visiting a small New England state recently to encourage physicians to organize an integrated group, I spoke with a senior executive from a large managed care organization. He said, "We're responsible for all our members, but we'd be glad to hand over that responsibility to physicians. We're just waiting for physician groups to form that are large enough and tightly organized to accept risk and to be accountable. Physician power will be directly proportional to their organizational competency." Obviously, the executive was speaking about only his market, but his comments apply broadly.



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# Endocrinologists Use Disease Management to Prove Their Value to MCOs

By Stanley Feld, MD, FACP, FACE

It's a classic controversy in managed care: Health plans limit access to specialists, arguing that such care is often not cost effective. Specialists contend that they can provide better care to patients with chronic or serious illness and do so more cost effectively than the typical primary care physician (PCP). But most specialties lack persuasive data to support their argument.

Now, the American Association of Clinical Endocrinologists (AACE), in Jacksonville, Fla., is conducting an outcomes study, called AACECare, to prove its contention as it relates to patients with diabetes mellitus. The society has formed an IPA of clinical endocrinologists to contract with insurers and to deliver care according to AACE guidelines for the treatment of type 1 and type 2 diabetes. In the one- to two-year pilot program in northern New Jersey and Atlanta, AACE will gather outcomes data for each enrolled patient with diabetes so that it can compare the patient's current health status with that of the prior two years. Additionally, the cost of care for the approximately 10,000 patients in the pilot program will be compared with that of diabetes patients in the general population.

If results support AACECare's clinical efficacy and cost effectiveness, the IPA plans to offer its services to managed care organizations (MCOs) nationwide. The model also will be extended to other endocrine diseases. In that case, AACECare could serve as a model for other physician specialties wishing to justify their worth to MCOs.

Diabetes is a good disease for specialists to prove their mettle because it is a frequent target for disease management among

MCOs. It accounts for about 15% of health care costs but affects only 5% of the population, according to AACE.

Diabetes disease management programs are marked by serious flaws, however. They usually are run not by physicians knowledgeable about diabetes care but rather by physician extenders, such as physician assistants or nurse practitioners. Although physicians often direct the programs from afar, the treatment of type 1 and type 2 diabetes must be done along a continuum of care with the physician and patient working together.

Many disease management programs also limit access to endocrinologists and other specialists by requiring a PCP referral and using payment structures to discourage PCPs from making such referrals. These programs also offer standardized, isolated, one-time patient education programs rather than customized, integrated, and repeated individualized training that recognizes the continuum of care. Individualized diabetes education is important because patients must be trained to test their blood sugar daily and alter their diet and medication to normalize blood sugar levels. Normalizing blood sugar levels has been shown to reduce the risk of serious, expensive complications. To do so, patients need to become responsible for managing their disease.

AACE's IPA, also called AACECare, will deliver care in accordance with AACE's self-management guidelines. Care is directed by endocrinologists or other physicians committed to diabetes management, and intensive diabetes education is tailored to the patient's knowledge and symptoms. Most endocrinologists in the two pilot areas have joined the IPA, and AACECare representatives are contracting with insurers and MCOs in those regions.

## The Problem

The need for better management of diabetes is obvious to endocrinologists and MCOs. The direct cost of diabetes care is

estimated at more than \$108 billion annually. Treatment of complications such as eye, kidney, neurologic, and macrovascular damage accounts for 80% of that total, according to AACE's calculations from data in the Diabetes Control and Complications Trial (DCCT), reported in *The New England Journal of Medicine*, Sept. 30, 1993. Controlling blood sugar to near-normal levels can lower the risk of complications, as well as the risk of emergencies, infections, and hospital admissions.

Actuarial calculations from DCCT data indicate that delivering the proactive, preventive care needed to control blood sugar can halve the cost of diabetes management, saving about \$54 billion. Therefore, a system like AACECare that successfully delivers preventive care and reduces the risk of acute and chronic complications would provide MCOs with significant savings and a competitive advantage, as well as better health care for diabetes patients. The key to such care is getting patients to interact positively with the system of care and to take responsibility for their care.

## Self-management

AACECare uses AACE's diabetes care guidelines, which focus on teaching patients to manage their own care. Patients can normalize their blood sugar through an often demanding regimen of monitoring blood glucose levels and appropriately adjusting diet and medication. Insulin, pharmacologic therapy, and diabetes education, however, cannot be successful if the patient does not use them properly. The patient therefore is taught to become the expert in diabetes care, assisted by the physician and the diabetes self-management team.

The centerpiece of the program is a patient-physician contract (see sidebar). The patient agrees to follow the system of intensive self-management; the physician commits himself or herself, along with

(Continued on page 4)

*Stanley Feld, MD, FACP, FACE, is past president of the American Association of Clinical Endocrinologists and a member of the organization's steering committee for AACECare.*

other health care professionals, to teach the patient the self-care regimen.

MCOs offering diabetes education generally provide the same information to every patient, regardless of the patient's prior knowledge, disease status, or ability to absorb the material. Diabetes education often is delivered by a nurse or diabetes educator rather than in a coordinated effort involving the physician and the diabetes self-management team.

In AACECare, patient knowledge and

motivation to learn are measured through written tests at an initial evaluation. Knowledge and motivation then are reassessed periodically to determine potential subjects for further education and guidance. Members of the health care team, led by the endocrinologist, continuously provide training and support to empower the patient as part of routine visits every three months to monitor the disease. This customized approach, in which education is integrated into other aspects of care and

delivered at least in part by the physician, is much more likely to be successful than routine diabetes education not tailored specifically to the patient's needs.

Another hallmark of the intensive self-management program is the leadership of a clinical endocrinologist interested in and knowledgeable about patient self-management. Many diabetes disease management programs promulgated by MCOs or other organizations have failed because they were not designed by a physician informed about or committed to diabetes care or patient self-management. Patient education and care must be driven by physicians because patients listen primarily to physicians rather than to other health care providers. Nurses, diabetes educators, and other health care professionals can make important contributions to the care of diabetes patients, but the patient should perceive that the team is led by the physician and that the physician regards the disease as serious.

## AACECare's Patient-Physician Contract

AACECare manages diabetes patients according to the guidelines of the American Association of Clinical Endocrinologists (AACE). The guidelines stress the importance of the patient's role in managing the disease in partnership with the physician as leader of the health care team. Unless the patient closely monitors blood sugar levels and otherwise complies with therapy, treatment cannot be successful. Therefore, AACE recommends that patients and physicians sign the following contract, in which the parties agree to carry out their roles in diabetes care.

I understand that if I agree to participate in the Intensive Diabetes Self-Management System, I will be expected to do the following:

- Dedicate myself to getting my blood glucose level as close to normal as possible by following the instructions of the Diabetes Self-Management team.
- Visit the clinic regularly for a physical examination, laboratory tests, and nutrition counseling (follow-up visits will be scheduled every three months or more frequently if necessary).
- Bring a detailed, one-day food record to each follow-up visit, to provide necessary nutrition information for myself and my dietitian, and to adjust my eating habits to meet the nutrition goals established by my dietitian.
- Use medication(s) as prescribed by my health care team.
- Monitor my blood glucose levels at home as instructed, and bring the results to each follow-up visit.
- Follow my prescribed exercise plan.
- Obtain identification as a patient with diabetes in case of an emergency.
- Ask my physician and other members of my health care team to explain any aspect of my case that I do not entirely understand.

I understand that if I do not monitor myself carefully there is a risk of hypoglycemia. I also understand that if I do not strive to normalize my blood sugar, I am at increased risk of developing the complications of diabetes mellitus. My signature indicates that I have read and understand the agreement.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

I agree to provide the leadership for the Intensive Diabetes Self-Management System. Team members will be available to answer your questions and help you self-manage your diabetes. I will continue to encourage you to maintain the best possible control of your diabetes.

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Date

## Measuring Outcomes

Intensive self-management requires a greater investment of resources in preventive care than MCOs typically invest. AACECare's outcomes study is expected to demonstrate that this investment saves money on balance by reducing the risk of emergencies, infections, and hospital admissions. In the longer term of roughly eight years or less, AACECare's protocols also should lower the likelihood of serious, costly complications affecting the eyes, kidneys, nervous system, macrovasculature, and heart.

To demonstrate the cost effectiveness of intensive diabetes self-management, AACECare will collect outcomes and cost-of-care data for all participating patients. Measures reflecting diabetes control (such as glycohemoglobin and lipid levels, and body weight; quality of life; eye exams; foot care; immunizations; hypertension control; exercise; missed work days; morbidity; and mortality) will become part of an electronic medical record transmitted to AACECare offices. The data will be collected at each visit, uploaded to a central file server, and used for continuing quality improvement of the delivery of care.

Patients also will be asked to send data electronically from their own blood glucose monitors to their physician's offices every

two weeks. Collecting such blood glucose data will enable physicians to monitor patients' health status and patients' compliance with the home-monitoring regimen. Also, collecting these data will help patients learn how to make self-management decisions and changes in their own treatment.

The patients who do not comply with the patient-physician contract will be viewed as having opted out of the program, and their care will be managed by a primary care physician. This step avoids wasting valued resources if patients cannot or will not participate, ensuring that the resources needed for the intensive self-management system are devoted to the patients most interested in and able to participate in it.

In return for managing a portion of an insurer's diabetic population, AACECare asks to be paid the national average cost for diabetes care in the prior year, adjusted for risk depending on the already existing complications (such as hypertension, heart disease, hyperlipidemia, or kidney disease) in the patients to be covered. If the actual cost of care under AACECare is less than the national average cost, AACECare would share the savings so that AACE would get approximately 40% of the savings, the insurance company 20%, the employer 20%, and the patient 20%. It is believed that this program is the first of its kind to share any savings with patients.

Reimbursement for certain kinds of care, such as myocardial infarction, would not come out of AACECare's fixed payment but would be covered under what's called a bill-above provision, meaning such costs would be billed separately. This system would align the incentives of the patient, the insurer, employers, and physicians. Hospital costs would fall, as would the need for procedures to treat diabetes complications. Ideally, diabetics would stay healthier longer.

#### A Changing Climate

Programs like AACECare have not been tried before because MCO executives historically have believed that high rates of member turnover discourage investment in preventing long-term diabetes complications. High turnover means the plan that funded the care required to achieve tight blood sugar control was unlikely to reap the benefits of reduced complications years later. MCOs are realizing that some plan will be covering the patient when diabetes complications develop, so it is in all plans' interest to attempt to prevent complications.

The growing number of "health news junkies," or patients who wish to learn to manage their own illnesses, also bodes well for the success of a care plan that is driven by patient responsibility, such as AACECare's.

MCOs and other insurers have an opportunity to fulfill managed care's promise of delivering cost-effective, quality care by developing products and services in partnership with experts focused on fostering a healthier population of diabetes patients. This shift can save the health care system significant amounts of money.

*Editor's note:* More information about AACECare, the self-management program, the guidelines, and the patient contract is available on AACE's Internet site at [www.aace.com](http://www.aace.com).

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# Group Works Hard to Remain Independent

**A**s more small, private practices join multispecialty groups and large provider organizations, Concord Health Associates, in Concord, Mass., remains staunchly—and successfully— independent. Constant vigilance, strong management skills, and the right mix of clinicians are keys to the success of this four-physician group located in Concord's Emerson Hospital. Says cardiologist Richard Daum, MD, the founder and leader of the practice, "You have to continuously adapt to meet patients' changing needs and to remain competitive in a capitated managed care environment. We constantly analyze how we do what we do. We always have our eye on the marketplace."

The group's vigilance has paid off impressively. The 10-year-old group has reduced its cost-per-patient by 50% over the past seven years, while patient satisfaction surveys conducted by three of the group's affiliated HMOs place the group's patient satisfaction levels in the 95th percentile statewide, Daum says. The group is one of the few remaining successful independent private practices in an area dominated by physician networks owned by hospitals and managed health plans.

Daum is a charter member of the Ad Hoc Committee to Defend Health Care, the group that threw HMO annual reports into Boston Harbor in December to protest the growth of for-profit medicine. "Corporations making profits have no place in health care economics," he says. "Our mission must be purely Samaritan." His firm convictions, along with his training in management as well as medicine, inform his decision-making.

## An Unconventional Approach

The group's approach to managed care is unconventional, but offers lessons for physicians seeking to thrive under managed care while remaining independent.

The group's success can be attributed at least in part to the fact that each physician provides both primary care and specialty care services. As a result, fewer referrals are necessary, thereby saving money. Perhaps just as important, the tensions that can arise in multispecialty groups around the dispar-

ity in primary versus specialty care compensation are eliminated. The group comprises two board-certified cardiologists who are also certified in internal medicine; one internist/gastroenterologist; and one board-certified specialist in internal medicine and pulmonary medicine. To support the physician staff, the group includes two nurse practitioners, who together specialize in women's health, sports medicine, and orthopedics; a clinical social worker; a certified cardiac technician; and about 10 office staff.

"We have the ideal configuration for the current marketplace," says Daum. "Patients like having specialists who can also provide their primary care, and managed care organizations want one person to act as the gatekeeper. They recognize that especially for sicker patients, a specialist is the ideal person to provide primary care." But Daum points out that the group didn't start this way: Its

referring huge numbers of ortho patients who didn't need surgery, but just physical therapy. So we hired a nurse practitioner who could do physical therapy." With so many specialties covered in-house, the group's referral rate is low. "Our cost performance is about the same as a general internist group because we don't refer out too much," says Daum.

## High Productivity

The group also is highly productive, seeing about 120 patients a day, Daum adds. "We see the same number of patients that a group three times our size does." He attributes this productivity level to a driving work ethic and an exacting hiring process: "We interview 20 or 30 people for each position, and choose people who are highly motivated, qualified enough to be in a large teaching-hospital setting, but who prefer private practice. We look for people who can make it in these times of

**"You have to continuously change according to the patients' needs and to remain competitive in a capitated managed care environment."**

**—Richard Daum, MD, Concord Health Associates**

success can be attributed to reading the changing environment continuously and making appropriate adjustments as needed.

"I began in 1988 as a solo practitioner in cardiology, and when my practice really got going, I took on other cardiologists," says Daum. "But when I studied the group's productivity and revenues in 1992, I saw that we were top-heavy with cardiologists. So as they left, I replaced them with a gastroenterologist and a pulmonary specialist." It was the right combination, but there was a downside, says Daum.

Because of the range of specialties in combination with primary care, "we attracted sicker, more expensive patients," he says. The solution? "We hired nurse practitioners to help manage the healthier patients and create more balance in our financial structure." The nurse practitioners they hired had important specialty skills as well. "One of our biggest problems was orthopedics; we were

shifting sand." The sheer number of patients makes productivity important in the group: "I personally have 14,000 patients," says Daum, "and I see about 50 patients a day." Some days start at 7 a.m., some days end at 9 p.m.; he also sees patients on Saturdays.

The 46-year-old Daum was a late entry into the medical profession, entering Cornell University Medical College at age 31. Prior to starting medical school, he had earned a Master's degree from Harvard University in health policy and management, and worked in hospital administrative positions, where he gained an appreciation for running the business of health care. "I'm a rarity, with training on both sides of the fence," he says. "I went into clinical practice to take care of patients, but I wind up using my management training and executive skills just as much as my medical skills."

Pharmacy expense is another area in which Daum says the group has cut costs

**“If you don’t have the management skills, you have to acquire the skills by aligning yourself with someone who does, or by hiring a professional administrator. That will be your road to survival.”**

**—Jayne Oliva, the Croes Oliva Group**

successfully. “I prescribe more cholesterol-lowering drugs than any other doctor in the region,” he says, “but I’ve also reduced my pharmacy costs more than any other doctor.” How? “I study the literature and prescribe drugs that give me more bang for the buck. I won’t be bullied by an HMO into prescribing a cheaper drug based on cost alone, but if I find something that works just as well or better and is cheaper, I’ll use it.”

Patient education is an important factor in gaining compliance when prescribing new medications, Daum says. “I lay out the facts for my patients, and tell them if the new drug doesn’t work as well or better for them, then we’ll absolutely change back to the old one.”

The same thing goes for emergency room use and referrals out-of-network. “We educate patients in a kind and gentle way about what to do in an emergency, and we encourage them to call us before they go to the ER. I tell patients they certainly can go to the ER, but they’ll probably wait for hours, see someone who’s trained in a lot of different things but won’t know them as well as I do. If they come to my office, I can see them faster and take better care of them.” Because Daum’s practice is located in the hospital, the ER staff often notifies the practice when its patients come to the ER with a non-emergency problem. Likewise, Daum says, his patients know they will be transferred to the ER from the doctor’s office if necessary, which makes them more comfortable going to the office in the first place.

#### Careful Referrals

When referring patients out of the group, Daum explains to them why he has chosen the referral specialists he has, how qualified they are, and how he works in partnership with them to care for patients. “I ask for their feedback on how the referral doctor treated them, and if they say the doctor did not perform, then I’ll call him or her and discuss it. I’m not always popular for this, but my job is to be my patients’ advocate

and get them the best care I can.”

That trust is the foundation on which Daum and his colleagues have built such a successful practice. “There is only one way to do things for the patient, and that’s the right way. My patients know I will never cut corners at their expense.” It is that strong ethic that guides his relationships with managed care organizations and insurers. “I won’t work under capitation,” he says. “It’s against my religion.” He also believes at-risk contracts create the wrong incentives, penalizing doctors whose patients have complex illnesses. “If more doctors refused to accept these conditions, this [compensation] initiative would fail.” Of the practice’s patients 55% are enrolled in managed care plans, and 45% are in Medicare.

Under terms Daum negotiated, the group has contracts with every managed care organization and insurer in the region except for two: “They tried to influence my medical decision-making, canceled tests I had ordered, restricted tests I could perform. I won’t work that way. I dropped them.” He’s also beginning to drop out of PPOs and IPAs. “I don’t want them telling us what to do,” he says. Instead, he contracts directly with managed care organizations and insurers. Besides, he adds, “It’s old conventional wisdom that large networks are where it’s at: Smaller size groups can do a great job managing care.”

He advises other medical groups to read HMO contracts carefully to sniff out incentives to cut corners, such as a precertification process in which the time interval for precertification precludes the doctor from taking responsible care of patients in urgent situations. “If it’s in the contract, don’t sign it. Don’t sign a contract with a hold-harmless clause; if the HMO wants me to be cost-effective and is providing strong incentives, it should share my risk. If it won’t share my risk, I know it has something to hide.”

Jayne Oliva, a principal in the Croes Oliva Group, physician practice management consultants in Burlington, Mass., says Daum is

doing all the right things. “If every physician could run a practice like this, we wouldn’t be looking at a health care landscape where more than 50% of physicians are employed by a corporation.” The fact that Daum has his finger on the pulse of his practice is the first step toward controlling its future, she adds. “So many physicians move through their days without knowing how the business is doing,” she says. “Daum could probably tell you the status of everything in his practice every day. That’s what it takes to run a business.”

While Oliva acknowledges that not everyone has Daum’s background or interest in management, she believes the group offers lessons for other physicians nonetheless. “If you don’t have the management skills, you have to acquire the skills by aligning yourself with someone who does, or by hiring a professional administrator. That will be your road to survival,” she says.

Oliva says Daum’s example suggests the importance of the following strategies:

- Respond to the marketplace. Offer the services patients and payers desire by either building an organization or networking with peers to do so.
- Support strategic goals with sound operational execution. Daum hired nurse practitioners as a cost-effective way to provide routine primary care.
- Keep costs down by maintaining high productivity. Daum can do so by providing broad access for patients.
- Educate patients. Educating patients can help make them partners in a group’s success.
- Track results. Knowing how the practice is doing allows the group to make mid-course corrections when necessary.

With the right mix of business skills and medical staff, independent groups can remain so, Oliva says. “If you can run the business well, you don’t have to leap into the arms of a suitor,” she says.

—Reported and written by Ann B. Gordon, a health care writer in Wayland, Mass.

## Experts Outline Strategies to Resolve Problems

Seeking solutions to the problems inherent in sales of physician groups to hospitals, the Croes Oliva Group, physician practice management consultants, in Burlington, Mass., has outlined strategies both sides can use. "Communication is key," says Jayne Oliva, a principal of the Croes Oliva Group and co-author of *Physician Partnering: Gaining Value from Physician Practice Management Arrangements*. "When physicians understand what the purchaser is looking for, when they've asked the right questions before signing on the dotted line, they are more likely to maintain their own level of satisfaction, patient care, and, therefore, revenue," Oliva says.

An accurate estimation of the financial value of the practice by the hospital is also critical because overvaluation is a common mistake.

Says Larry McGovern, vice president of Medical Practice Management at St. Vincent's Hospital and Health Center, in Billings, Mont., "Appropriate and careful valuation is very, very important." Anyone considering acquiring a practice should consult with experts in the field, McGovern recommends. "It may seem expensive and time consuming during the process, but it is worth it in the long run." Working with an informed consultant helped St. Vincent's when it was buying several physician practices in recent years, McGovern says, mostly because the consultants helped the hospital to value the practices accurately.

A Minneapolis primary care physician, who asked that his name be withheld, regrets not having brought in a third-party consultant. "If I had used a third-party consultant or other expert, I could have saved myself a lot of grief," particularly

over the value of the practice, he says.

Croes Oliva cautions administrators and physicians alike to undertake careful and thorough discussions about who pays for what. The issue of relocation is a good example of where cost issues may be overlooked. "Let's say, the hospital decides to move a practice to a higher rent district," says Oliva. "Who pays for the overhead at this new, more expensive locale? The physician? The hospital?"

Physicians also should address concerns about overcapacity before selling to an acquisitive hospital. To avoid the common problem of having too many doctors, Oliva recommends that physicians evaluate how many practice acquisitions the hospital has made recently. An AMA survey and a 1996 study by the federal Agency for Health Care Policy and Research, in Rockville, Md., found that hospitals use more resources than private practices yet generate less revenue per physician. By determining whether a hospital is still acquiring practices in an area in which stiff competition already exists, physicians can help to determine whether another acquisition would be necessary and beneficial.

Physicians also should determine if hospitals and other acquiring organizations have the ability to fulfill promises of operational support. Information systems management is a typical area in which both the practice and the hospital can assess support capabilities, McGovern explains. "If I have established the goal of acquiring 20 practices, can I be successful having 20 separate management software programs? Probably not," says McGovern. "I need to be careful about what I promise operationally."

### Creative Compensation

McGovern believes that if a hospital and a physician group being acquired each have qualified and experienced personnel, the resulting new organization will have a greater chance of success. "Bring in people who have experience in practice management," he advises.

McGovern recommends that hospitals motivate physicians by keeping the entrepreneurial spirit alive. Physicians who bristle at the idea of giving up some of the freedoms of private practice may find that financial incentives reestablish for the once independent physician the link between effort and reward.

The PCP in Minneapolis agrees. "When you are your own boss, you are directly connected to the bottom line," he says. "It's yours and you have complete control over it."

One effective way to ensure continued profitability is to tie compensation to revenue. Although there is no one magic formula, a successful incentive compensation arrangement will include two elements, says Oliva: a stable base with predictable increases established via merit, and bonuses for meeting short-term goals, such as productivity targets.

Compensation should be tied to profitability, says McGovern. "But it also has to be kept in line with the idea of mutual success and mutual goals," he adds.

In a recent publication, The Health Care Advisory Board, a 1,400-member consulting and service organization in Washington D.C., offered advice on physician compensation arrangements. The title alone, *61,760 Possible Combinations for Compensating Physicians*, shows that a wide variety of compensation plans are in use today.

(Continued from page 1)

this specialist's concerns are common. "Physicians attempting to terminate an agreement sometimes find that they would be left with nothing," McDaniel says. "And there is almost a sense of shame associated with the process. It's a kind of 'I should

have known better' attitude."

A primary care physician (PCP) in Minneapolis bristles at the common lament of hospital administrators that physicians typically become less productive after being put on a hospital's payroll. "I have a problem with that," he says. "I sold

my practice thinking it would be a win-win situation. I would have the chance to hand off some administrative duties, make some money, and concentrate on practicing medicine. No such luck. To put it mildly, my patients freaked. Many of them felt that the quality of the care would go down,

many switched to competitors' practices. The change in administrative procedures alone was enough to make patients think about looking elsewhere for care."

The Minneapolis PCP found that the changes the hospital made in his office procedures had a significant effect on patients. "In the practice, office visit procedures were simple. A patient had to confirm only that the basics—name, address, insurance—hadn't changed," the PCP says. "It took, maybe five minutes. But the new procedures were ridiculous. Patients were asked to come to the clinic a half hour earlier just to check in. So, we did become 'less productive' as the number of contact hours took a nose dive—because of paperwork not because my colleagues and I didn't feel like working."

### The Learning Curve

Hospitals buy physician practices partly because they believe hiring physicians will help them fill unused beds, according to a 1995 survey by The Robert Wood Johnson Foundation, a philanthropy in Princeton, N.J. Another reason hospitals buy practices, the foundation said, is that managed care organizations and large for-profit health care providers have been buying up practices, and hospitals believe they also need to do so to remain competitive.

Hospitals, however, have failed to generate profits from these purchases at expected rates. The foundation survey found that the average practice purchased for about \$500,000 had an actual value of about \$250,000. Only 17% of the hospitals surveyed had posted profits on practices purchased within the preceding two years. In part, these problems result from inexperience.

"By purchasing a physician practice, a hospital is attempting to conduct a business it has never been in," says Oliva. Many hospitals don't realize or won't admit that "they aren't in the business of practice management. They're in the hospital business." According to management guru Peter Drucker, the hospital business consists of "the most complex organizations ever created by humankind."

Since the trend of hospitals buying physician practices is relatively new, there is little information about how to do it well, Oliva says. "It creates a learning curve for doctors and hospital administrators," she

explains. "Many hospitals must first create a completely new entity in order to own a practice, and then must develop the infrastructure to manage that new entity. This is a very expensive endeavor, and it's sometimes assumed that the practice will bear the burden of that capital investment."

In fact, many hospital administrators fail to understand the basic economics of physician practices. "In a physician group, 85% of revenue comes from the front lines, the examination room," says Oliva. "Managing the practice is an extension of that core business. Unfortunately, that's something hospitals cannot focus on because of the nature of their mission." Hospitals are bound to such diverse missions as training new physicians and delivering community services, thereby diluting management resources and taking the focus away from the physician's mission of

physicians practicing for more than 25 years. "When a hospital looks to recruit younger physicians, it may find that business inexperience is a crucial factor in perceived productivity drops," Oliva says. Although older, more tenured physicians may make up a lower percentage of those on a payroll, they are less likely to have losses occurring in their practices. "In effect, they can almost teach the hospital how to manage, and what does and does not work," asserts Oliva.

Lacking experience in managing practices, hospital administrators are uncomfortable enforcing rules in acquired practices. "They have a tendency not to do what they say they will, or what's outlined," Oliva says. "If a practice has an average of 36 patient contact hours per week, and that number drops to 28 after the acquisition, a hospital may find, via an audit, that

**"I sold my practice thinking it would be a win-win situation. I would have the chance to hand off some administrative duties, make some money, and concentrate on practicing medicine. No such luck. To put it mildly, my patients freaked."**

**—Minneapolis primary care physician**

delivering direct patient care.

"If a doctor understands that hiring a nurse practitioner will increase the number of patient contact hours, the hire is made," Oliva says. "No meeting with the board, no committee or review is required. A practice can quickly adapt to the changes necessary to increase patient contact and, thereby, revenue. A hospital may have all the philosophical buy-in in the world; it may understand completely that a practice needs a nurse practitioner. But from agreement to action can take months, possibly a year."

### The Age Factor

Another reason hospitals have lost money on practice acquisitions is the age and experience of the physicians involved. The AMA survey found that 64% of physicians practicing for less than five years are employed by a hospital, network, or other organization, as compared with 32% of

the real visit number is even lower, say between 20 and 24 hours per week. Clearly, something isn't working in this case, and the group manager should ask, 'What's going on? Why are we seeing this drop? You [the group] are obligated to remain at 36 hours.' Many practice managers in hospitals are uncomfortable with this level of intervention, but they have to do the follow through. They're the boss now." In other words, hospital administrators will need to manage these groups more closely.

Inexperience among hospital administrators may lead to other problems as well. Administrators bemoan losses in revenue due to decreased productivity, for example, but Oliva and others have found decreased productivity is more perception than reality. It may be that administrators are now responsible for managing the practice's financial results but do so less efficiently

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than the physicians did. If, in fact, the number of contact hours among physicians has declined, then managing inefficiently will only exacerbate the problem or further contribute to the perception of reduced productivity.

"The first thing a hospital seeks to do after a purchase is to take control of the billing and accounting procedures," Oliva says. As a result, a physician's ability to detect profit and loss discrepancies may disappear. "When a practice is in charge of its own financials, it can keep an eye on basic things, such as receivables," she explains. "I've seen situations where a first quarter report languished in committee for two months, and finally made it back to the practice late in the third quarter. I've seen receivables sit in the hospital bureaucracy for more than 90 days, so of course it's going to look like the group the hospital paid an arm and a leg for is losing money. But the doctors have not suddenly stopped working or become less productive."

The specialist in New Orleans experienced this problem: "I had no idea how the financial situation was doing, but I suddenly got called on the carpet by the administration for losing massive amounts of revenue. I had no clue; no one ever discussed what was going on," he says.

Shifts in clinical procedures can be equally disruptive, hindering physicians' ability to maintain patient contact at the prepurchase level. For example, when the new owners of a group heard that patients wanted later hours, Oliva relates, the group decided to remain open one night a week until 9 p.m. The clinic lab, however, closed at 5 p.m., so patients needing any kind of phlebotomy had to reschedule. "The hospital manager was completely unaware of this situation," Oliva says. "She kept wondering why the caseload was going down with the very strategy designed to keep it at a higher level."

Patient admitting procedures also may change after an acquisition, further reducing patient case load. Physician practices often have efficient, standardized admitting procedures, but "a hospital may come in and reinvent the wheel," says Oliva. "I've seen practices describe admitting procedures in four paragraphs, using one form, and a hospital will insist on describing it in four pages, using four forms."

## First-year Practice Profitability per Physician

	Hospital	PPMC	Medical Group
Family practice	-\$5,261	\$11,261	\$6,176
Internal medicine	-\$18,079	\$23,875	\$3,899
Pediatrics	-\$8,573	N/A	\$22,464
Ob/Gyn	-\$14,682	\$71,347	\$32,299
Multispecialty	-\$117,758	-\$37,008	N/A

Source: *The Physician Practice Acquisition Resource Book*, Center for Healthcare Industry Performance Studies, Columbus, Ohio, 1997.

### Tending to Overpay

Hospitals also tend to overpay. They pay higher physician salaries than other organizations, which can contribute to a perceived decrease in profitability, according to both reports, and they set practice purchase prices too high because hospital administrators do not accurately evaluate physician practices costs. Typically, hospitals anticipate the cost of corporate infrastructure adequately, but they do not sufficiently anticipate investments needed for retraining, staff turnover, and the capital expenditures necessary for communication and information systems.

Careful valuation is important to any purchase, says Cleverly, a CPA with the Center for Healthcare Industry Performance Studies (CHIPS), and co-author of *The Physician Practice Acquisition Resource Book*. Based on information gathered from a survey of 1,200 physicians involved in approximately 460 practice acquisitions from 1994 to 1996, the report is primarily a valuation tool for physicians considering selling their practices. It also offers insight into why acquisitions have not met with the expected success.

"Overestimation of value and poor projection of revenue for existing practices are major factors in postpurchase disappointment," Cleverly says. "Physicians need to ask tough questions and hospitals need to see clearly when it comes to practice value." Surprisingly, the survey found practices engaging in traditional fee-for-service care, not capitation, were more likely to be losing revenue. "This is quite contrary to what we assumed going into

the study," he says. "We expected to see large pools of capitation revenue falling off after the purchase, when it was almost 80% fee-for-service groups showing losses." As a result, Cleverly believes hospital administrators should resist the temptation to blame capitation alone for decreases in revenue.

For some physicians, productivity does decline after their practice is sold, in part because physician income levels decrease as physicians no longer control the practice's finances. Although hospital-salaried physicians generally make more than salaried physicians working for HMOs, salaried physicians do not earn as much as they may have earned in private practice, the AMA says. In 1995, employed physicians were earning approximately \$136,000 per year, while those in private practice were earning an average of \$199,000 per year. There may be resentment, then, because those physicians are not being paid what they were before.

After being burned for failing to value practices appropriately, hospitals are likely to learn from their mistakes, Oliva predicts. In fact, the trial-and-error-prone problems of today are likely to be resolved as both sides gain experience, she says. Meanwhile, physicians should "go in with their eyes and ears open, and work with, not against, each other," Oliva says. "Hire the best people you can find to guide you through the process. After all, you wouldn't take a trip to a strange location without first consulting a map, right?"

—Reported and written by Maria Hecht, a health care writer in Boston.

# MSO Executive Says Physician Groups Can Have Independence and Market Clout



**Elizabeth Gallup, MD, JD, MBA,** is president and CEO of Choice HealthSource, in Kansas City, Mo., and co-author of *How Physicians Can Avoid Surrender and Lead*

*Change* (American College of Physician Executives, Tampa, Fla.: 1996). Previously, she was executive director of Community Health Partners, a physician network in Kansas City, Mo.; president of Stratics Healthcare Consulting, a Kansas City company that works with physicians and hospitals; a health care consultant with William M. Mercer Inc., in Kansas City, Mo.; medical director for Trans World Airlines; assistant general counsel for the American Academy of Family Physicians; vice president of physician and business development for Shawnee Mission Hospital in Overland Park, Kan.; and associate clinical professor at the School of Medicine of the University of Missouri-Kansas City. Gallup is a board-certified family physician, having earned her medical degree from The Ohio State University. She also has a law degree from the University of Toledo, and an MBA from the University of South Florida. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

**Q.** Dr. Gallup, please tell us about Choice HealthSource and what it does.

**A.** Choice HealthSource is owned by Community Health Partners (CHP), a multispecialty independent practice association. CHP, which is about two years old, started out with only 20 independent primary care physicians and now has 85 primary care physicians and about 85 subspecialists in its network. Community Health Partners formed Choice HealthSource as a management services organization (MSO), and we're in the process of acquiring managed care global risk contracts, which will be managed through Choice HealthSource.

**Q.** Dr. Gallup, you have a fascinating background—MD, JD, and MBA degrees, and you're a board-certified family practitioner. In your career, you've been a medical director for Trans World Airlines, vice president of business development for a hospital, and a lawyer for the American Academy of Family Physicians. Have these varied career roles helped you in your current organization?

**A.** Yes, but the most important job I've had that helped me form my views on this organization was being a full-time private practitioner in Defiance, Ohio. I'm a physician at heart, through and through. In fact, I wanted to be a physician since I was in the second grade. In helping this organization, I always try to do what I thought I needed when I was in private practice—in other words, whatever would help me to enhance my ability to deliver good patient care. That is the hallmark of what our larger organization can now do; namely, as a group of physicians preserve high-quality patient care. The other positions I've had were helpful in that I experienced the corporate world, as well as the world of the societies and government and lobbying, but not one of them was as singularly helpful as being a private practitioner in full-time practice.

**Q.** What do physicians in full-time private practice need today?

**A.** They need clarity. They need simplification. What our organization tries to do is to apply our own guidelines, protocols, policies, procedures, and formularies to all patients, regardless of the payer source, whether the patients are indemnity insured, with one preferred provider organization or another, or with one HMO or another. That strategy helps to simplify our process of taking care of our patients. Having to access only one set of guidelines or policies or procedures, instead of a hundred because we're in a hundred different managed care entities, helps patients by bringing clarity to the decision-making process. Sometimes, depending on who pays for the patient's care, you may have to go over one hurdle or many hurdles. What

we need is simplification and clarification. We also need the practicing physicians—not the nonclinical people in distant offices—to be making the rules.

**Q.** You said that one purpose of your organization is to empower physicians. Does doing that give physicians more power in the marketplace? If so, does it make your organization a more competitive player?

**A.** I believe the power that physicians have comes when they work together to the limits that the laws will allow. But when you start negotiating on behalf of a larger group of physicians, your clout increases in the marketplace such that you can work on more of a partnership basis with the insurers in that market. Our organization is not trying to supplant the role of the insurer, the HMO, or the preferred provider organization, but rather to work with them on a more level playing field instead of simply being subjected to their whims.

**Q.** Let's discuss the Kansas City market. The New York Times has portrayed Kansas City as a tumultuous environment with two large hospital systems and Blue Cross Blue Shield dominating the situation and the doctors in disarray. But aren't you saying that the doctors there are getting organized?

**A.** Now, the independent physicians are getting organized, precisely because of the problems identified earlier. It's been fairly easy for Blue Cross Blue Shield and the hospitals to employ the first tier of physicians who have had problems running their practices, who don't have much business sense, and who aren't necessarily entrepreneurial or independent-minded. But for the past two years, the local hospitals haven't been able to make a dent in hiring any of the groups that have joined our organization. And the physicians who are independent now are organizing. In Kansas City, there's our group and another group of physicians called Metropolitan Physicians Alliance. Community Health Partners was started to preserve the independent practice of medicine, which is not to say that some of our groups won't link up with each other

**“It’s a matter of doing what the patient needs at the right time, at the right place, for the right price. I think accountability means doing that.”**

at some point, but if they do, they’ll work for a locally run, physician-owned entity, not a physician practice management company that’s run from somewhere else, or a hospital, or an insurance company. So, while it is true that two hospital systems dominate in Kansas City, a third hospital system—Columbia/HCA—provides an alternative. It has a good reputation in the Kansas City community even though it’s not the dominant player. Also, independent physicians have huge practices.

On the other hand, I don’t know many employed physicians who are at full capacity in terms of the number of patients being seen on a daily basis. That’s because a lot of them are young, new, or not well established, and the hospitals hired indiscriminately so that they now have more physicians than they need for their patients. So, even though about half the primary care physicians in Kansas City are employed, the half who are not employed by the hospitals control a huge number of patients.

Some employers in Kansas City are starting to file lawsuits against insurers. One employer lawsuit against an insurer, for example, charges that the insurer offered to supply a provider network, and the employer signed up. When it later realized that 70% of its employees would have to change primary care physicians, it filed suit against the insurer. We, as an independent group of physicians, may be able to capitalize on the desire of patients to stay with their own primary care physicians and specialists if we can work with insurers in partnership.

**Q.** *So, you’re organizing strong independent physicians into a physician-owned IPA but you’re not really trying to form an integrated group of 170 doctors?*

**A.** No. I fully anticipate that, in time, some of these groups will coalesce, and that especially some of the one- or two-practitioner groups will join the larger groups. But that would be a natural occurrence, something that we certainly would foster, and we would promote, but it’s not a necessity. There are many examples of IPAs on both the East Coast and the West Coast

that have become quite successful without the groups being fully integrated under one taxpayer identification number.

**Q.** *But even when those groups form out of this IPA, they will have the strength of your agreed-upon guidelines, right?*

**A.** Right. What we do as a unit is to have a unified set of guidelines on how we approach precertification, concurrent review, retrospective review, in other words, how we approach the patient. So, in managing the patient, we will act as a unified group.

**Q.** *How are you gluing these people together in terms of information systems?*

**A.** One way will be the claims system because a lot of information comes from claims. We are working with a research group that can do case mix and severity adjusting of data from claims information. Later, it may become practical, feasible, and cost effective to have an on-line electronic medical record. Once we can measure physician performance on a case-mix severity-adjusted basis, many of the current problems in the system will be taken care of.

**Q.** *Will you have a way to monitor quality compliance?*

**A.** We’re modeling ourselves so that the HMOs can delegate to us the National Committee for Quality Assurance’s requirements, which include all the requirements of the Health Plan Employer Data and Information Set (HEDIS) requirements. HEDIS is a tool used to measure health plan performance. Like most IPAs that are successful, we’re trying to have most of the services in the contracts delegated to us, including credentialing, HEDIS measurements, and other quality measures.

**Q.** *You became well known last year after the book you co-authored with Cyd Slayton was published. Does its subtitle, Gaining Real Influence in Your Own Health Care Organization Before It’s Too Late, reflect your experience with Choice HealthSource?*

**A.** Yes. Our organization was created to be an advocate for physicians and patients. We believe that the best decisions

made about a patient’s care are made jointly by the physician and the patient—and those two alone. The way this can be accomplished is to empower physicians to take back the decision-making process from the insurers and other third parties. To do that, you have to have organizations that know how to acquire and manage the revenue stream. Doing so allows physicians to get back to working with patients.

**Q.** *There’s a certain martial tone to your book—battlefield language almost: how to avoid surrender, to lead change. You seem to be encouraging physicians to mount the ramparts and to assert themselves. Are you?*

**A.** I am. That’s because I’ve seen what has happened to some physicians who have followed the employment model. After they’ve sold their practices, for whatever reason, and become employed, they see the bureaucracy they have to deal with and they basically give up, leaving the patients with no one to be their standard bearer. This situation is not in the patient’s best interest. My book tries to martial physicians to, if possible, stay independent, but even if not independent, to at least have the courage to speak up on behalf of what’s in the patient’s best interest.

**Q.** *What does “accountability” mean to you in terms of a practicing physician? How does a physician become “accountable” to payers and to patients?*

**A.** It’s like the adage: You don’t practice a different sort of medicine depending on the patient’s payer status; you practice the same medicine regardless of the payer’s status. It’s just that you might have to jump through different hoops to do so. First and foremost, the physician must always figure out what is in the best interest of the patient. Unnecessary tests, duplicated tests, unnecessarily long hospitalizations, and so on are no more in the best interest of the patient than are the current identified problems with “drive-through mastectomies” and “drive-through deliveries.” It’s a matter of doing what the patient needs at the right time, at the right place, for the right price. And I think that accountability means doing that. ■

# To Avoid Penalties, Group Practices Need to Know the Self-referral Law

By Katherine A. Nino, JD

The increasing prevalence of managed care has contributed to a rise in physician aggregation. While physicians participating in ventures with other physicians can improve patient care, increase efficiencies, and enable physicians to be more successful in a highly competitive market, such participation requires physicians to pay careful attention to complex laws that are implicated when they so collaborate.

The federal Self-referral Law, also known as the “Stark” laws after congressional sponsor Fortney “Pete” Stark (D-Calif.), for example, makes it illegal for a physician to refer Medicare or Medicaid patients to an entity for designated health services if the physician or an immediate family member of the physician has a financial relationship with that entity. The initial Stark laws, called Stark I, were enacted in 1989 and relate to referrals for clinical laboratory services only. In 1993, Stark II provisions added 10 more health services, in addition to clinical laboratory services. (See sidebar “Designated Health Services Under the Stark Laws.”) In 1995, the federal Health Care Financing Administration (HCFA) issued final regulations interpreting Stark I; on Jan. 9 of this year, it released proposed regulations interpreting Stark II.

Under the Stark laws, the term “financial relationship” is broadly defined to include both compensation arrangements and investment or ownership interests. As a result, referrals from physicians participating in a wide variety of collaborations may be illegal. The Stark laws except from illegality, however, certain referrals between a physician and an entity, including some referrals for services provided through the referring physician’s group practice.

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Therefore, being organized as a group practice can offer physicians the advantage of being able to refer patients to their partners without running the risk of federal prosecution or of significant civil monetary penalties, or of being excluded from Medicare and Medicaid.

## Key Exceptions

Two key Stark law exceptions accommodate group practices. One is the Physicians’ Services exception, which permits referrals for physician services provided personally by (or under the personal supervision of) another physician in the same group practice. The second exception, the In-office Ancillary Services exception, is more complicated. First, it does not apply to durable medical equipment (excluding infusion pumps), or to parenteral and enteral nutrients, and related equipment and supplies. Second, to qualify for the exception, the services must be furnished by the referring physician, by a physician in the same group practice, or by individuals directly supervised by the physician or by another physician in the group practice.

Third, Section 1877(b)(2) clarifies that the services fall under the In-office Ancillary Services exception if they are performed:

- In a building in which the referring physician (or another physician in the same group practice) provides physicians’ services unrelated to the furnishing of designated health services, or
- In the case of a referring physician who is a member of a group practice, in another building used by the group practice to provide some or all of the group’s clinical laboratory services, or in a building used by the group practice for the centralized provision of the group’s designated health services (other than clinical laboratory services).

Fourth, the services must be billed by the physician performing or supervising the ser-

vices, by the group practice under a billing number assigned to the group practice, or by an entity that is wholly owned by the physician or group practice.

## Group Practices and Hospitals

Another exception carved out for group practices applies only to certain arrangements between group practices and hospitals. Essentially, this exception permits arrangements through which a group provides designated services and a hospital bills for the provision of such services. To qualify for this exception, the arrangement

## Designated Health Services Under the Stark Laws

The Stark laws define “designated health services” as any of the following:

- Clinical laboratory services;
- Physical therapy services;
- Occupational therapy services;
- Radiology, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services;
- Radiation therapy services and supplies;
- Durable medical equipment and supplies;
- Parenteral and enteral nutrients, equipment, and supplies;
- Prosthetics, orthotics, and prosthetic devices;
- Home health services and supplies;
- Outpatient prescription drugs; and
- Inpatient and outpatient hospital services.

must meet six requirements, which were clarified by regulations proposed by HCFA on Jan. 9, as follows:

1. Regarding services provided to an inpatient of the hospital, the arrangement is pursuant to inpatient hospital services.
2. The arrangement began before, and has continued without interruption since, Dec. 19, 1989. This criterion may still be met even if the agreement between the parties has changed over time so that it covers different services or so that the services are provided by different individuals in the same group practice.
3. At least 75% of the designated health services covered under the arrangement are in fact furnished by the group under the arrangement.
4. The arrangement is in accordance with a written agreement that specifies the services to be furnished by the parties and the compensation for services furnished under the agreement.
5. The compensation paid over the term of the agreement is consistent with fair market value, and the compensation per unit of service is fixed in advance and is not determined so as to take into account the volume or value of any referrals or other business generated between the parties.

6. The compensation is provided in accordance with an agreement that would be commercially reasonable even if no referrals were made to the entity.

The above exceptions permit certain referrals within a group practice, but they apply only when the group in question meets the government's definition and narrow interpretation of the term "group practice." Therefore, physicians seeking to use the exceptions must ensure that their groups are structured to meet the meaning of group practice as defined by the Stark laws and interpreted by the regulations. (See sidebar "Proposal Clarifies the Requirements for Qualifying as a Group Practice.")

### Defining "Group Practice"

The Stark laws and regulations define group practice as "a group of two or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association" which meets the following requirements, as interpreted by HCFA:

- Each physician member of the group provides substantially the full range of patient care services that he or she routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities,

equipment, and personnel.

- At least 75% of the patient care services of group members are provided through the group and are billed under a billing number assigned to the group, and amounts received are treated as receipts of the group.
- Overhead expenses and income from the practice are distributed according to methods that were both previously determined and that indicate that the practice is a unified business.
- No member directly or indirectly receives compensation based on the volume or value of referrals by the physician, but a physician may be paid a share of the overall profits or a productivity bonus based on services personally performed or supervised.
- Members of the group personally conduct no less than 75% of the physician-patient encounters of the group practice.

### Attestation

Even a group that is structured to meet the government's narrow definition of group practice cannot take advantage of these exceptions unless it also has submitted annually a written statement to its insurer to attest that, during the most recent 12-month period, 75% of the total patient care services of group practice members was furnished through the group, was billed under a number assigned to the group, and the amounts so received were treated as receipts of the group. Start-up groups, or groups that have been unable to meet the group practice requirements in the past, must attest that they will meet the 75% standard in the next 12 months. Following this 12-month period, such groups must attest that they have met this standard, billed for those services under a billing number assigned to the group, and treated amounts received for those services as receipts of the group.

By organizing as a group practice, physicians may be able to avoid liability for referring Medicare and Medicaid patients to an entity in which they have a financial interest. But because the Stark laws narrowly define what constitutes a group practice, physicians should consult a qualified attorney to ensure that they comply with the group practice requirements and appropriately attest to doing so. ■

## Proposal Clarifies Requirements for Qualifying as a Group Practice

On Jan. 9, the federal Health Care Financing Administration (HCFA) released proposed regulations that provide guidance on how groups must be structured to take advantage of the group practice exceptions. According to the proposed regulations:

- A group practice must consist of one legal entity. HCFA has suggested, however, that a group practice is still one legal entity even if it is composed of owners who are actually individual professional corporations, or is owned by physicians who are individually incorporated.
- "Members" of a group practice include physician partners and other physician owners (including physicians whose interest is held by an individual professional corporation), and full-time and part-time physician employees. Further, these physicians are considered members during the time they furnish patient care services to the group. Independent contractors are excluded from this definition.
- "Patient care services" include not only physicians' tasks that benefit the medical needs of specific patients, but also those that benefit the group practice or patients in general.
- "Encounter" is defined as any appointment during which a group practice patient is actually examined or treated by a physician.

# Closely Held PPMCs May Be Worth a Look

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

Much of the press coverage about physician practice management companies (PPMCs) has focused on the more than 40 such organizations that are publicly traded. Among the reasons the publicly traded companies get more attention is public offerings are widely reported and PPMC stock prices have risen dramatically. At least as many privately held PPMCs are operating, however, and they have strong capital partners and plans for significant growth. Rather than affiliating with a publicly traded PPMC or

expanding independently, physicians may favor affiliating with a private PPMC for several reasons, including the following:

- The size of private PPMCs relative to public PPMCs. Since the private companies are smaller than their publicly traded counterparts, physicians may have a greater role in the development and governance of these companies.
- Aligned incentives. Private PPMCs would be highly motivated to commit substantial resources to their founding clinics, or the clinics that initially

become part of the organization. The long-term success of the company would depend on its ability to add value in terms of management, capital, and information systems to these founding groups.

- Access to capital. Private PPMCs often receive venture capital funding to support growth and development.
- Potential equity appreciation. If a private PPMC completes a public offering, the value of any stock the physicians hold would increase substantially. ■

## Selected Privately Held PPMCs

These PPMCs received venture capital funding last year.

Company	Specialty	Recent funding (in \$ millions)	Source and date of funding
Aesthetics Medical Management Inc., Windsor, Conn.	Plastic surgery	\$15	Frontenac Co., Chicago; Piper Jaffray, Minneapolis; June
Community Rehab Centers, Burlington, Mass.	Physical, occupational, and speech therapy	\$7.8	Dillon Read, New York; Seacoast Capital Partners, Danvers, Mass.; Sears Pension Plan, Chicago; Westbury Capital Partners, Westbury, N.Y.; February
Kelson Physician Partners, Bloomfield, Conn.	Pediatrics	\$16	Delphi Ventures, Menlo Park, Calif.; Interwest Partners, Menlo Park; Marquette Venture Partners, Deerfield, Ill.; Pacific Ventures Group, Encino, Calif.; Bessemer Ventures, Wellesley Hills, Mass.; PNC Equity Management, Pittsburgh; December
MaterniCare, Laguna Hills, Calif.	Women's health	\$13	Mayfield Fund, Menlo Park; Weiss, Peck & Greer, San Francisco; Vector Fund Management, Deerfield, Ill.; Oxford Bioscience Partners, Westport, Conn.; ZC Healthcare Risk Solutions, New York; March.
Neurosource Inc., Chicago	Neurosurgery	\$12.5	Sprout Group, New York; Health Care Equity Partners, Lisle, Ill.; Piper Jaffray; August
Paidos Health Management Services Inc., Deerfield, Ill.	Neonatology	\$7	United HealthCare, Minneapolis; Zurich Center Reinsurance, New York; December
Physician Partners Inc., Portland, Ore.	Multispecialty	\$15	First Union Capital Partners, Charlotte, N.C.; August
Physician Solutions Inc., Brentwood, Tenn.	Pathology	\$18	Sprout Group; 21st Century Ventures, Birmingham, Ala.; December

Source: Corporate Research Group, New Rochelle, N.Y., 1998.

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### Disease Management Network to Serve HIV Patients

Bernard Salick, MD, chairman and CEO of Bentley Health Care, Beverly Hills, Calif., is building a network of clinics to treat patients with cancer and HIV/AIDS. The network will begin operating in the Bronx, N.Y., in an affiliation with the Montefiore Medical Center that will encompass three cancer centers, an AIDS center, and several AIDS clinics in the New York City area. Later, Bentley plans to open cancer and AIDS centers in Connecticut and New Jersey before opening facilities nationwide. The affiliation helps Montefiore, a large academic medical center, compete more aggressively against managed care organizations.

Regarded as a visionary in disease management, Salick founded Salick Health Care Inc., in Los Angeles, which developed the first capitated program to offer a full range of treatment services to cancer patients. Salick Health Care was later sold to Zeneca Group, of London, for \$480 million.

**Comment:** *Since the success of Salick Health Care, more than a dozen disease management companies have begun offering treatment for chronic and costly conditions under full-risk capitated contracts.*

### Number of Medical School Applications Drops

For the first time in seven years, the number of students applying to medical school dropped in 1996. Last year, the number dropped again. Last year, some 43,020 students applied to medical schools, a decrease of 8.4% from the year earlier.

**Comment:** *At least two factors may explain why applications have declined: the surplus of doctors in many markets, and working as an employee rather than as an independent professional may be an unattractive option for students.*

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- How can I make my practice more profitable?

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Richard L. Reece, MD  
Editor-in-Chief  
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