

# PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

April 15, 2002

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## Hospitalists Save Groups Time, Money

**M**any physicians are realizing that they can save time and avoid hassles if they hand over their patients to hospitalists. A few years ago, many primary care physicians saw hospitalists as a threat; today, many PCPs are more likely to see them as an asset.

The initiatives that put hospitalists in place seem to be here to stay, although the initial mandates of cost-conscious health plans that hospitals use these inpatient specialists have all but disappeared. In most health systems today, physicians who wish to continue seeing their hospitalized patients may do so. What's more, the National Association of Inpatient Physicians (NAIP), in Philadelphia, reports there are 5,000 hospitalists nationwide and estimates that 20,000 will be needed in the next 10 years.

### Savings in Time, Money

Many doctors are handing over patients to hospitalists because they see a win-win situation. Just as hospitals, managed care organizations, and large medical groups that sponsor hospitalist programs are realizing financial savings, individual practitioners are benefiting as well: They have more time to see patients in their offices and experience fewer hassles.

The 371-bed Danbury Hospital in Danbury, Conn., for example, reports that patients in its four-year-old hospitalist program have an average length of stay that is one day shorter and average charges that are \$1,700 less

than its patients who are not in the program. As for the physicians who hand over their patients to the program's eight hospitalists: They do not have to take overnight calls or do hospital morning rounds, leaving them with more time for outpatient care.

Of all the managed care innovations of the past decade, hospitalist programs are "the only change that is also valuable to PCPs," says Edward J. Volpintesta, MD, a family physician in Bethel, Conn., who takes advantage of Danbury Hospital's program.

True, a PCP can lose an estimated \$10,000 to \$15,000 a year in income to hospitalists, but the PCP also has the potential to recoup that loss by adding office visits. The Advisory Board Co., a research agency in Washington, D.C., that is sponsored by health care systems, estimates that by not treating patients in the hospital PCPs can increase their office charges by \$40,000 a year.

For Volpintesta, that extra time does not translate into extra income because he uses it to deal with paperwork. But he is glad of the change. Office responsibilities are so great and hospital care is so complex, that it's hard to do both well, he says. So far, 85 physicians—more than half of all PCPs on staff at Danbury Hospital—have handed over their patients to the hospitalist program, and other physicians on staff are waiting to do so.

But Theo Blum, MD, is not yet willing to hand over his patients to the

*(Continued on page 10)*

## Should We Find a Way to Promote Primary Care?

The shortage of specialists is a case of supply and demand, writes Richard A. Cooper, MD, and colleagues in the January/February issue of *Health Affairs*. "The reasons are straightforward," they write. "Per capita physician supply is slowly declining while demand is increasing. The supply is sagging because the U.S. population is growing but physician training is not."

Of the demand for specialists, Cooper says, "Our projections are not based on expert opinion—ours or anyone else's—but on an examination of the trends that occurred in the utilization of physician services over the past 70 years. These trends show that society utilizes what it can afford, and what's affordable is a function of aggregate per capita income."

In 1981, the Council on Graduate Medical Education (COGME) predicted a surplus of physician specialists of 15% to 30% by 2000. That surplus has not materialized because the predictors did not consider the U.S. economic expansion of nearly 40% between 1980 and 2000. The predictors also underestimated the growth of the U.S. population by about 25 million.

Furthermore, the COGME's 1981 forecast rested on wishful social planning about what should be considered "good" care. The predictors said such care would require fewer specialists and less costly primary care physicians and that nonphysician clinicians would take up the slack. They also said cost-conscious HMOs would divert care from specialists and the government would constrain the training of high-priced specialists. They did not adequately predict what happened: greater prosperity, a growing population, and an undiminished thirst for medical progress, fostering a demand for specialists.

Some of the predictions have come true, however. HMOs have limited care to specialists, for example, and nonphysician clinicians have provided more primary care. "Yet, even when their contributions are added to the projected effort of clinicians, the combined workforce fails to meet the demand a growing economy will generate—and the shortfall is in specialty medicine," Cooper and colleagues say in the *Health Affairs* article.

Given the growing specialty shortage, it is still highly likely that physicians in training will gravitate to specialties, especially because the public has shown a willingness to pay for specialty care. Also, the medical education system likely will be asked to provide those specialists.

Perhaps we ought to try to steer more patients to primary care whenever possible, if only because doing so may help the health care system extend its limited resources to the greatest number of Americans.



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# Practice Merges Business, Medicine

**P**racticing medicine today requires more than just treating patients effectively; it also requires that physicians develop a certain level of business acumen. Rapidly rising health care rates, coupled with insurers and managed care organizations that are focusing on costs and profit now more than ever before, are making it increasingly difficult for physician practices to survive. In such an environment, seeking out strategic advantages that offer an edge over the competition can be an increasingly important business strategy for physicians who want to ensure the growth and success of their practice.

One physician practice that has been combining the tactical strategies of business with the practice of medicine is Non-Surgical Orthopaedic & Spine Center PC. NSOSC—which specializes in the nonsurgical treatment of musculoskeletal injuries—has six locations in the Atlanta metropolitan area. The founder of the practice, Arnold J. Weil, MD, believes that combining a strong marketing plan with a focus on providing excellent patient care is the key to strengthening a medical group's competitive edge.

"I identified my niche in the medical community, and then I promoted my expertise to the groups I had identified as potential sources for the majority of referrals in my specialty," explains Weil.

Not too long after Weil had joined a chronic pain practice in Marietta, Ga., in 1992, he recognized the growing level of demand for physicians with his specialty. Eight months later, he opened his own practice. Today, NSOSC has three physicians and 12 staff members; it has constructed a new building in Marietta to house the group's main office, it has established five satellite locations in the Atlanta metropolitan area, and it

plans to open more offices in the third quarter of this year. Weil attributes this level of success to a combination of astute marketing strategy and excellent patient care.

## Creating a Marketing Plan

When Weil started the practice, he focused on marketing his services by giving presentations and distributing literature to physicians and patients on the treatment methods he was providing in his practice. In 1995, he designed the practice's Web site, [www.lowbackpain.com](http://www.lowbackpain.com), to promote the practice's nonsurgical philosophy. Currently, the site receives an average of 35,000 visitors per month, as well as e-mail messages from all over the world.

managed care companies operate." For example, the physicians at NSOSC, which has a large workers' compensation patient base, have found it necessary to be familiar with the well-accepted standard-of-care and practice guidelines for injury and illness, Weil says.

"Our physicians have developed and follow specific protocols and diagnostic or treatment algorithms, which allow us to focus on rapid assessment and accurate diagnoses," says Weil. Because of the nature of the practice's specialty, no single remedy results in a patient's immediate recovery, but rather various nonsurgical techniques are used to rehabilitate patients to relatively normal functioning, he explains.

**The founder of the practice believes that combining a strong marketing plan with excellent patient care is the key to strengthening a group's competitive edge.**

In 1997, Weil received his MBA from Kennesaw State University, in Kennesaw, Ga. He says that the knowledge he gained from this degree enabled him to develop, enhance, and scrutinize his business and practice management skills. "I learned to focus on different market segments and fine tune my expertise in the operational areas," Weil says.

"Practicing medicine in a managed care environment requires a very organized and market-oriented approach," he explains. "Staying within a managed care model requires that physicians be aware of the restrictions that managed care companies impose on them (such as cost caps for certain procedures), as well as the limits on treatment and diagnostic parameters under which

"The treatment methods that are used are always patient-specific and individualized depending on the nature and extent of the patient's injury," Weil adds. "By laying out the algorithms in a flow chart fashion, it is easy to follow the diagnosis-to-cure process." This strategy, Weil says, leads to the most cost-effective and clinically proven treatment.

## Setting Priorities

The physicians at NSOSC believe that to succeed in today's diverse and highly competitive health care market, they must identify areas of their practice to enhance so that they can gain a strategic advantage over their competitors. Patient satisfaction is one area they have chosen as a top strategic priority. Feedback from their

*(Continued on page 4)*

**“Staying within a managed care model requires that physicians be aware of the restrictions that managed care companies impose on them (such as cost caps for certain procedures), as well as the limits on treatment and diagnostic parameters under which managed care companies operate.”**

**—Arnold J. Weil, MD, Non-Surgical Orthopaedic & Spine Center PC**

*(Continued from page 3)*

patients on satisfaction surveys revealed that patients rated as important not only the care provided by the physicians in the practice, but also the courtesy of the staff, availability of appointment times, and an aesthetically pleasing office environment. NSOSC used this information to establish the priorities for its marketing strategy and as a benchmark for comparing its performance with that of its competitors.

After establishing the priorities, the physicians and staff at NSOSC took steps to ensure that they would meet or exceed a patient's expectations on every visit. For example, the front office staff is now trained not only to set appointment times so that patients are seen within 24 hours, but also to monitor how long a patient has been waiting in the office to see a physician. If a patient has been waiting longer than 15 minutes, the practice's chief operating officer is notified. On the other hand, patients seeking treatment for orthopedic or spine care from other practices in Atlanta must wait several weeks for an appointment, Weil says.

### **Communicating With Patients**

Providing timely and effective communication with insurance adjusters and employers in the workers' compensation system was chosen as another high-priority area by NSOSC's physicians.

To accomplish this goal, communication has been streamlined among physicians, caseworkers, and staff, while keeping everyone involved in patient care fully aware of all the per-

tinent medical conditions and treatment scenarios for the patients involved. Office forms have been redesigned to streamline phone referral information and other office tasks. In addition, regular in-service training sessions are conducted at staff meetings to ensure that all office procedures are flowing correctly and that any updates to forms or procedures can be implemented efficiently. By keeping office forms and contact information up to date, and office procedures flowing smoothly, the physicians can communicate quickly and effectively with claims adjusters and case managers assigned to each workers' compensation case.

Communicating with patients, which includes educating them, is another priority of the practice. The theory behind patient education, says Weil, is that patients who are knowledgeable about their conditions and treatment options will have a more favorable recovery. To that end, NSOSC distributes to patients and referral sources on a quarterly basis newsletters containing information on diagnostic procedures, symptoms, causes, and treatment methods.

What's more, the practice's main office in Marietta has a center that houses information to educate patients on their condition as well as on anatomy and treatment methods. In the education center, patients can study diagrams and illustrations of the common causes, symptoms, diagnostic tools, and treatment methods for back, neck, and soft tissue injuries. By using the education center, patients are often able to identify

questions they think are important to ask the physicians before they are evaluated, says Weil.

### **Educating Physicians**

Educating other physicians and other health care providers is another strategic tactic NSOSC is using to enhance its visibility and broaden its referral base. Last year, the practice implemented a continuing education program on the nonsurgical treatment of back and neck injuries. NSOSC physicians believe that physical medicine and rehabilitation (physiatry) is an area of medicine that is often unknown to many individuals, and that educating not only primary care providers, but also representatives and staff from insurance companies and other referral groups is important when seeking to gain awareness and visibility in the community.

For its educational programs, the practice targets specific health-related areas after identifying which groups are a potential front-line source for referrals. Since NSOSC has identified the marketing opportunities for its services in workers' compensation, Weil presents educational material to case workers, who, he says, are often overloaded with cases and must be kept up-to-date on new clinical and treatment methods in order to keep their indemnity costs low.

Participants in the program receive continuing education credits toward their license renewal. Weil also conducts seminars for city and county workers and community groups. So far, the effect of the program has been twofold: Outside groups receive first-

hand physician education about nonsurgical techniques, while the practice increases its community awareness in an area—workers' compensation—that it has identified as its niche market.

At the seminars, attendance is taken and referrals are closely tracked. The results of this tracking have shown there is a direct correlation between the seminars and referrals. In addition, evaluation forms are used during the seminars to obtain feedback from the participants. As a result of these evaluations, new topics are being added for the program this year. Although the program is relatively new, it has been so successful in terms of generating referrals that it has become another of NSOSC's top priorities.

### Planning Like a Business

NSOSC's competitors are large and small medical groups that focus on pain management, physical medicine, or orthopedics. To increase its edge over this competition, NSOSC hired a business development and marketing director to coordinate the practice's strategic marketing plan for the next five years. By identifying its growth potential and opportunities, the practice expects to align its strategies more effectively for development in the years to come.

For example, in light of its strong focus on the workers' compensation market, and before opening its satellite offices, NSOSC analyzed the local market to determine which sectors of the Atlanta metropolitan area would be best served by another office. Thorough analyses of the region's demographic and industry data, including statistical information on the projected growth potential of that area, were completed as well. These analyses allowed NSOSC physicians to identify the areas that were both being underserved by their specialty and also housing a concentration of potential referral sources.

In addition, Weil also has applied his business acumen to pricing the practice's services and managing its costs. "I analyzed the different services that we were providing and established the cost basis for each of those services," he explains. "Once I established the cost associated with each level of service, I could negotiate for fees more competitively and manage our fixed costs more effectively."

Negotiating fees and containing costs are crucial to a practice's survival and success in a heavy managed care environment, Weil says. But so is avoiding the pitfalls that don't work in that environment. For example, the old "defensive practice of medicine" standard no longer applies, he argues. "Testing should be limited to only the tests that are necessary for accurate diagnoses and only if the tests would influence the course of treatment," says Weil. "A shotgun approach is not cost-effective or medically appropriate for treating most routine medical problems."

—Edited by Paula D. Grant, in Lincoln, Va. More information on *physician practice strategies* is available on our Web site (see page 16).

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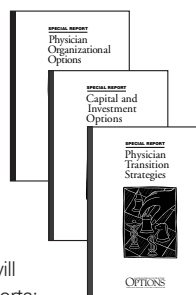
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# Group Turns Losses Into Gains

**D**espite an economy in recession and a shifting health care market, cost control and market concentration have paid off for Brown & Toland Medical Group, a large multispecialty group in San Francisco. Unlike other California groups that have suffered steep financial losses in recent years, Brown & Toland has prospered.

In 1998, the group lost about \$10 million. By 2000, its net income was \$9.6 million. B&T's income in 2001 won't be known until later this year, but it will continue to show a profit, says Richard Angeloni, B&T's communications director.

## Gaining Strength

"Given the current economy and the changes occurring in the Northern California market, we don't expect 2001 to be as good as 2000, but we should still do well," says Angeloni. "The steps that we took to turn around where we were just three years ago are still effective today. We are planning additional cost-saving measures and some moves to increase our enrollment." The group may have lost some enrollment when PacifiCare, a large Northern California health plan, terminated its managed Medicare project. "We won't know those figures for several months," says Angeloni. Current enrollment is about 240,000 lives.

Another factor affecting 2001 revenue negatively was a high unemployment rate in San Francisco, which went from 2.4% in January 2001 to 5.6% in January 2002, says Angeloni.

A somewhat volatile market notwithstanding, Angeloni says the earnings increase in 2000 and the income anticipated for 2001 allow B&T to strengthen its balance sheet and to meet all solvency requirements of the state Department of Managed Health Care (DMHC).

The group's success comes at a time when many of California's approximately 250 medical groups are facing financial hard times. The California Medical Association (CMA) in San Francisco estimates that about 100 California medical groups failed between 1996 and 2001.

According to DMHC, many California groups are having trouble meeting the solvency requirements. Only 44% of the 250 reporting groups met all four standards. "The

looked like we were going to be one of them," he says. "Some people were stunned by our phenomenal recovery."

By making a commitment to cost containment and data collection and by concentrating resources on the San Francisco core market area, the group has avoided the problems other medical groups are facing. B&T actually exceeded its financial goals in 2000 by improving revenue through negotiations for health plan reimbursement increases, and continuing to focus on

**By making a commitment to cost containment and data collection, and by focusing on its core market in San Francisco, the group has avoided the problems other groups are facing in California.**

financial challenges facing medical groups and independent practice associations in California are severe," says Howard D. Atkins, MD, senior medical director of medical management for Empire Blue Cross Blue Shield in San Francisco.

The reasons many of the state's medical groups are failing include weak management and inadequate data collection, says Jeffrey C. Goldsmith, PhD, president of Health Futures Inc., researchers in Charlottesville, Va. Goldsmith has studied the California market and has written on the causes of regional medical group failures for the California HealthCare Foundation in Oakland.

## A Narrower Focus

To succeed, B&T has learned from its mistakes, says Thomas McAfee, medical director. "In 1998, many regional medical groups were going under because they were undercapitalized and weren't being paid enough, and it

the San Francisco market by eliminating other lines of business, says Lin Ho, MD, B&T's chairman of the board. The group left markets in which it was not making money, such as San Mateo, where it had about 200 physicians. "That market was too fragmented and the specialists there have their own IPA," says McAfee. "That situation made it difficult to control costs."

In another cost-cutting measure, the group heavily reduced the scope of its management services organization, a fully owned subsidiary that accounted for about half of the group's deficit. "Our MSO now serves only the needs of our group and is not a separate business entity," says Angeloni. B&T also decreased administrative expenses by 17% in 2000, while reducing physician compensation by about 10%. When the group made a profit in 2000, the cuts were restored and \$2 million was distributed as a bonus in 2001 to the group's 345 primary care physicians

and more than 1,300 specialists.

Although the revenue to be reported in 2001 may not match that of 2000, B&T is addressing that issue by taking steps to expand its market share, which includes expanding its hospital network. "This is in response to physician, patient, and health plan demands for increased access and choice," says Angeloni. In addition to an ongoing relationship with California Pacific Medical Center and the University of California, San Francisco, the group has developed relationships with St. Mary's Hospital and St. Luke's Hospital, both in San Francisco. "The expansion ensures that a growing number of patients have timely access to necessary health care and provides more resources for our physicians," says Ho.

### **An Emphasis on Data**

The group plans to continue cost-reduction initiatives this year, says Angeloni, including a decreasing emphasis on paperwork. "We plan to increase our ability to perform recordkeeping and data collection online," he says. In addition to cost containment and a focused market strategy, the group's recovery is owed in large measure to an emphasis on data collection and related quality initiatives, say group officials.

The group's ability to provide quality health care, and prove it, is critical to patients, physicians, and the group's profitability, says McAfee. Through marketing initiatives, such as news releases and Internet postings, the San Francisco market is aware, for example, that B&T won the Blue Ribbon Award for Quality for three consecutive years from the Pacific Business Group on Health, a coalition based in San Francisco of 33 large employers. PBGH encourages employees and their families to seek care from such groups, and it also recommends that health plans include these groups in their provider panels.

"We have invested money in qual-

ity initiatives for many years, always placing our emphasis on keeping our patients healthy and gathering the information necessary to know what preventive care works," McAfee says. "Our investment has paid off in healthier patients and a financially stronger organization."

By collecting the data necessary to improve the quality of care the group delivers and demonstrating the results, B&T has been able to negotiate better rates with health plans, McAfee says. "We have established ourselves in the perception of consumers and payers in the San Francisco area as among the very best physician groups," he adds.

### **Innovative Initiatives**

B&T has also received high marks for outstanding performance in preventive health care services from the California Cooperative Healthcare Reporting Initiative, a collaborative of purchasers, plans, and providers. B&T has a program aimed at

who have not received the recommended tests or who are not meeting recommended treatment goals for retinal exams, levels of glycosylated hemoglobin (HbA1c), and lipid levels, and cholesterol levels.

"Our physicians are very responsive to these reports," McAfee says. "They realize that the information is coming from other physicians, not from a health plan, and they don't view the reports as admonishing. Instead, they understand that our efforts are part of an ongoing commitment to quality."

B&T's primary care physicians receive quarterly score cards showing what percentage of their patients have received certain types of care, such as cervical cancer screening and mammograms for women ages 52 to 69. They also get a list of patients who have not been screened and letters to send to patients who need such screens. "Providing high-quality data is a primary motivator for many physicians," McAfee says.

**"The steps that we took to turn around where we were just three years ago are still effective today."**

**—Richard Angeloni, Brown & Toland**

improving outcomes for patients with asthma and for patients with diabetes.

Here's an example. B&T developed a program designed to manage blood sugar levels among patients with diabetes. As a participant in the Diabetes Continuous Quality Improvement Project, the group has developed and distributed clinical practice guidelines for the treatment of patients with Type II (insulin-dependent) diabetes.

Member physicians are sent semi-annual reports on the status of their patients, including what tests are needed and the results of recent tests. Physicians get information on patients

The data included in the asthma and diabetes initiatives are gathered from medical and pharmacy claims, encounter records, and laboratory tests. "It is a labor-intensive effort, especially gathering the information on diabetes," says David Boyd, B&T's supervisor of health care analysis.

The recognition of Brown & Toland's commitment to quality has been an important element of the group's success, says Angeloni. "We intend to continue to exceed the expectations of the marketplace."

—Reported and written by Martin Sipkoff, in Gettysburg, Pa. More practice strategies are available on our Web site (see page 16).

# Adequate Capitation Rates Needed

**R**eimbursement schemes that delegate financial risk to physician groups can be viable as long as the rate structures are appropriate, says Bill Gill, MBA. “The risk bearer in an improperly priced model is a vanishing breed,” Gill says. “The medical groups that can negotiate reasonable rates—and are willing to walk away from contracts with unreasonably low rates—will be more likely to survive.”

Gill is president and CEO of the Facey Medical Group in Mission Hills, Calif. Prior to joining Facey, Gill was the COO of UniMed Medical Management Group in San Jose, Calif. He has more than 20 years of experience in health care senior management. Facey is a large, multispecialty group practice of 110 physicians that provides care to 100,000 prepaid members in Southern California.

## Failures and Change

“Currently, the health care industry is in a bad position,” Gill comments. “We are seeing failed businesses in both the payer and physician organization arenas. As a result, patients and physicians have experienced a loss of faith in the stability of the industry.” Gill offered his comments at the 2001 Medical Group Management Association (MGMA) Joint Conference of the Los Angeles and Orange County chapters, held last fall in Norwalk, Calif.

The viability of the capitation model is ambivalent, largely because of the failures of a number of medical groups, Gill believes. “Health plans that are heavily invested in delegated

risk models—such as PacifiCare (in Santa Ana, Calif.), HealthNet (in Woodland Hills, Calif.), and Aetna U.S. Healthcare (in Hartford, Conn.)—are experiencing very poor stock performance,” he notes. “As a result, both investors and the public are looking at the delegated model as a questionable entity.”

But the main problem does not begin with reimbursement models that delegate financial risk to physician groups, he says. Rather, physician groups that have failed under managed care did not adapt to the specific efficiency and productivity requirements of a capitated environment. “Physicians have not mismanaged their practices,” says Gill. “They managed their businesses in the same way they always have, ignoring the changes in the health care industry. Although the laws of economics have worked against physician organizations, that does not mean we should sit by and whine. We have to do something about it.”

## Inadequate Contracts

Several factors have caused a decline in the number of physician organizations. “The first problem has been inadequate contract rates,” Gill says. Since HMO price wars drove premium rates down, contracted rates paid to physicians fell as well. “But physicians allowed that rate decrease to happen,” he says. “Physicians tend to be volume-driven, interested in negotiating any and all contracts, regardless of the rate. That is simply a poor business strategy.”

Therefore, physician groups need

to contract selectively, Gill argues. “We cannot continue to contract with every plan at any price,” he says. “Furthermore, selective contracting goes beyond just contracting with health plans. Medical groups accepting capitated contracts must also consider which hospitals to contract with, because some hospitals may have priced themselves at a higher rate than the contract can bear.”

Internal contracting should be reviewed as well. “Sometimes, a sense of entitlement prevails in a large multispecialty medical group,” Gill notes. “But hard staffing decisions have to be made. For example, a group should not pay \$120,000 a year to a pediatrician who sees only 18 patients a day.” Similarly, support staffing should be analyzed to ensure optimal business efficiency.

## Benefits of Delegated Risk

Selective contracting with health plans is especially important under a capitated model of reimbursement. This model has several advantages over other models even though it has been sharply criticized in the media, Gill notes. Careful analysis of appropriate rates can help physicians survive under this model, he says.

“One clear advantage is the arbitrage benefit,” Gill explains. “For example, with 100,000 prepaid lives, Facey can command favorable rates from cardiologists, neurologists, anesthesiologists, and other specialists.”

In addition, because there is a controlled population of both physicians and patients, quality can be monitored and supported. “We can con-

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**The failures of a number of medical groups have caused physicians to question the viability of the capitation model. Capitation can work, but physicians must contract selectively to succeed with this model.**

**“The fact that physicians have achieved efficiencies over the past 10 years has served only to lower the price of health care services. The efficiencies we achieved were simply passed along as a savings to the health plans and employers, which now get the same product at a lower price.”**

**—Bill Gill, MBA, Facey Medical Group**

*(Continued from page 8)*

control quality by selectively screening physicians, as well as have continuity of care at the patient level,” Gill says. “In an open health care system where patients switch plans and providers, continuity of care is a big challenge.”

Finally, the delegated model offers an incentive for efficiency. “In all businesses, efficiency is driven by an incentive to be efficient,” Gill observes. “In a fee-for-service environment, physicians were given the incentive to use the health care system to the maximum reasonable level. Under capitation, physicians seek efficiency.”

Still, the delegated model has disadvantages. “The biggest disadvantage is that providers bear risk without having the ability to affect price,” Gill says. “When physicians are taking capitation for all the health care of a patient and they do not have the ability to affect the price at which it is being sold or the benefits that are being covered, they are at a competitive disadvantage. At the least, physicians who are negotiating percentage-of-premium contracts must require a guaranteed payment floor, or else they will be out of business.”

Second, physicians do not benefit financially from their efficiency gains because the cost saving advantages of capitation accrue to payers rather than to physicians. “Efficiencies are not ‘banked,’” Gill says. “The fact that physicians have achieved efficiencies over the past 10 years has served only to lower the price of health care services. We did not

accrue any financial benefits. The efficiencies we achieved were simply passed along as a savings to health plans and employers, which now get the same product at a lower price.”

Another disadvantage is that health plans that set prices in the capitated model bear no risk for improper pricing, until the point at which the medical groups fail, Gill adds.

For these and other reasons, the delegated model is vilified by many in the industry, especially physicians. “Certainly, nondelegated models require a lower administrative overhead at the medical group level,” Gill acknowledges. MGMA studies show that the staffing ratio per physician in a capitated medical group is about one full-time employee per doctor higher than the ratio in a noncapitated group, he adds. “In a nondelegated model, a medical group does not need to bear the costs of such functions as utilization management and referral coordinators,” he says.

“But medical associations and specialty societies need to be careful what they wish for, because they just might get it,” Gill cautions. “I have been in an environment where the delegated model did not exist, and where the health plans were in control. The neurologists and orthopedists either did not participate or were reimbursed only 70% of Medicare-allowable rates. Certainly, there may be a model that is better than the delegated model, but I do not see a better option; rather, the alternatives are just as painful and

offer even less control to physicians.”

In addition, nondelegated models cannot ensure either preventive care or continuity of care. “Preventive care and continuity of care did not exist before capitation,” Gill says. “Both will surely decline in a nondelegated model.”

### **Cost Sharing Needed**

Even while physicians may stand firm when negotiating contract rates, other factors that can cause practices to fail may be beyond their control. These factors would need to be addressed for physician groups to be financially viable under the delegated model, Gill says.

For example, the Balanced Budget Act of 1997 has held down physician reimbursement. “The act incorporated an artificial price suppression of no more than 2% annual increases, regardless of real-world medical economics,” Gill explains. “Many of us who believed that Medicare would be the health plan to provide us with enough profit so we could withstand the price wars in the commercial sector are finding out that the Medicare business is the poorest.”

To prevent more failures of physician groups and to prevent physicians from turning away Medicare patients, the government must support reasonable annual increases in provider payments, Gill believes. “By implementing the artificial price suppression of rates, the government has led or contributed significantly to the bankruptcies of physician organizations,” he

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program. While the solo physician in Danbury praises the quality of the program, he prefers to see his own hospitalized patients. Also, he enjoys the professional stimulation of the hospital. "The newest therapies start out there," he says, and he can chat with specialists and visit residents, who "force me to address the 'why' of what I do."

But Blum is beginning to understand the financial sacrifice he is making. Typically, he sees one hospitalized patient a day, which requires two hours, including driving time. Medicare pays him \$70 to \$162 for the first visit to the patient, and less for subsequent visits. During that time, he could see 10 patients in his office, and Medicare would pay him \$55.39 per patient, assuming the rate for an established office visit of mid-level severity.

### Wave of the Future

Rob Mascia, MD, a family physician in Brookfield, Conn., participates in the Danbury program in part because he believes it's "the wave of the future." Hospitalist programs make sense because they are an adjustment to the fundamental shifts that are occurring in medical care delivery, he says.

Two decades ago, it was well worth a physician's time to do hospital rounds, because one doctor might see a dozen patients. Since then, managed care has cut the number of hospital beds in use each day by sending the healthiest patients home sooner and by having more procedures done on an outpatient basis. Combined, the five physicians in his office have just three to five patients in the hospital at any one time, Mascia says. What's

more, because hospital patients are sicker today, they may respond better if a physician is there 24 hours a day, seven days a week, he adds.

The hospitalist phenomenon is part of a trend toward compartmentalization, in which each doctor has specific duties in the hospital, says Burton Dibble, MD, a member of the board of directors of the American Academy of Family Physicians, in Leawood, Kan. AAFP takes a neutral position on hospitalists.

In the 1980s, physicians on staff were expected to work in the hospital's emergency department, but now emergency physicians do that work, Biddle says.

Proponents say compartmentalization makes doctors more efficient. Hospitalists become experts in using hospital services, are accustomed to treating illnesses common to hospitalized patients, and are always available to read test results so that they can consider an early discharge. With these advantages, the NAIP says, hospitalists lower length of stay by 15% and reduce readmissions.

### Getting Started

But hospitalist programs are not necessarily easy to start or guaranteed to be successful.

William Delaney, MD, director of the hospitalist program at Danbury Hospital, says hospital administrators were initially skeptical when he and other physicians proposed the idea. "We had to prove it would be affordable," he says. Delaney was asking his hospital for a subsidy because physician fees are not enough to cover the cost of the program. The NAIP

reports that hospitalists receive only 50% to 70% of their compensation from professional fees, and the rest is based on expected savings.

A growing body of literature shows that hospitalists reduce length of stay and cut costs without adversely affecting quality of care. The Danbury program produced immediate savings, Delaney says, and scored well in the areas of patient satisfaction, medical records completion, coding documentation, PCP satisfaction, and timeliness of medical record completion.

But not all hospitalist programs succeed. Baptist Health System, which runs five hospitals in San Antonio, Texas, ended a two-year-old contract last fall with a hospitalist company that had failed to deliver as administrators expected, says Charles Duncan, MD, Baptist's executive vice president of medical affairs. Baptist is trying again under a new contract that started in October with Cogent Healthcare, in Laguna Hills, Calif. Cogent acts as a middleman for two subcontracted local hospitalist companies, handles outcomes data, and runs a postdischarge care management program, Duncan says.

The NAIP reports that only 2% of hospitalist programs are mandatory. When hospitalists emerged in the mid-1990s, some insurers pushed for mandatory participation because they had only a limited number of patients in each hospital and needed as much participation as possible. But the programs caused strife in some markets, explains NAIP President Mark Williams, MD, a hospitalist in Atlanta. Since 1999, when the NAIP said it opposed mandatory pro-

**One physician estimates that it takes him two hours to see one hospitalized Medicare patient. The government will pay up to \$162 for the first visit and less for subsequent visits. In the same time, he could see 10 patients in his office, and Medicare could pay him \$55.39 for each one.**

grams, “the whole mandatory issue has pretty much died down,” he says.

Based on his experience of setting up hospitalist programs at facilities run by HCA Inc., a health care services company in Nashville, Williams says that most physicians need about a year to become accustomed to the change. “At first, they try to be everywhere and do everything,” he says. “Then slowly they turn over their patients to the hospitalist programs.”

Because residents tend to do hospitalists’ work, hospitalist programs in academic medical centers are rare, Williams says. He supervises 28 hospitalists at Emory University’s six affiliated community hospitals in Atlanta, although Emory University Hospital does not have a hospitalist program.

### **Hospitalists in Groups**

Medical groups also are using inpatient physicians, but to be successful, it may be best for these programs if hospital charges are included in the capitation rate, thereby giving physicians a strong financial incentive to control costs and length of stay.

CareMore Medical Group, in Downey, Calif., has seven hospitalists treating hundreds of patients each week. The group has 50 full-time physicians and 120 PCPs in an affiliated IPA. As part of this nine-year-old hospitalist program, inpatient physicians see discharged patients in a clinic and work closely with four case managers and six case management assistants.

“We manage insurance risk very well,” says Donald Furman, MD, CareMore’s chief medical officer. CareMore has cut average length of stay almost in half, from 5.5 days to 2.3 days since the program started, he says.

When the program began in 1993, some physicians resigned in protest; they opposed the program because they viewed it as a loss of control, a perceived lack of continuity of care, and a lack of communication, Fur-

man explains. “We have addressed a lot of those issues,” he says.

To sustain coverage around the clock, hospitalist programs need at least four or five inpatient specialists. “It’s hard to have only one or two hospitalists,” Dibble explains. Nonetheless, smaller groups can set up call-sharing arrangements that function like hospitalist programs. One physician who has an interest in hospital service does such work for an eight-member primary care group near Dibble in New Hampshire. To supplement his income, the physician still needs to do some work in

fees cannot sustain them is that Medicare and many insurers make only one payment for professional services to any one doctor on any given day, Williams explains. So if a hospitalist treats a patient in the morning and then again if a serious complication develops in the afternoon, the hospitalist would be paid nothing for the second treatment. “This situation makes it hard to be financially viable,” he says.

To prove that they deserve subsidies, hospitalists must rely heavily on outcomes data. They also use these data to determine essential care guide-

**The National Association of Inpatient Physicians reports that there are 5,000 hospitalists working in facilities nationwide, and it estimates that 20,000 will be needed in the next 10 years.**

the office and his colleagues must make rounds when he’s off-duty.

In any program involving patient care, communication is critical to success. Therefore, hospitalist programs have rules for making sure PCPs are informed. CareMore has given many of its physicians beepers to communicate with hospitalists, Furman says. What’s more, hospitalists speak with the doctor about every patient every day, he adds.

At Baptist, the hospitalist must inform the doctor of any significant change in condition, such as admission to the ICU, cardiac arrest, or discharge. “It is these regulations that make the biggest difference,” Duncan explains. Hospitalists at Danbury Hospital are required to fax doctors the patient’s admission and discharge records within 24 hours.

### **Unsettled Issues**

Compensation is a difficult issue for hospitalists. One reason that their

lines for each condition, such as congestive heart failure and pneumonia.

The NAIP is considering whether to create a new medical specialty for hospitalists. If it decides to do so, the specialty would have its own training programs and separate boards, just as emergency physicians did two decades ago.

Today, most hospitalists are trained in internal medicine. Williams, who teaches internists at Emory University, says that a training program for hospitalists would add additional topics, such as quality improvement, patient safety, and end-of-life care.

Creating a hospitalist specialty would show that hospitalists have become essential, Williams says. “The delivery of care in hospitals has become far more complex and much more intense than it was in the past,” he adds.

—Reported and written by Leigh Page, in Oak Park, Ill. More information on practice strategies is available on our Web site (see page 16).

**“Many organizations that have failed have been mismanaged. Just because we are practicing medicine and saving lives does not mean that we are above the laws of economics. When the good, strong medical groups start to falter and go out of business, then we should worry.”**

**—Bill Gill, MBA, Facey Medical Group**

*(Continued from page 9)*

says. “Physicians simply cannot survive with price increases of less than 5% per year over the next five years. Reasonable reimbursement is required if physician groups are to survive.”

In addition, employers and patients need to share more of the cost burden if medical groups are to be financially viable in the future, Gill adds.

“People have a childlike, irresponsible view of health care,” Gill comments. “They have been getting health care services at a very low cost to themselves for so long that they have begun to resent the need to pay for these services.” Unquestionably, patients will have to accept a greater share of the cost of their health care than they have in the past. This cost sharing will improve the financial viability of health care systems and will result in cost-effective decision-making regarding which services they want. “Patients have been users, not consumers, of health care,” Gill says. “They received the services, but someone else was paying for them. Clearly, low copayments make HMO members act as users rather than consumers. Higher copayments will force consumerism and will lead to responsible decisionmaking about care at the level of the patient.”

Similarly, employers will also have to accept higher health care costs. “Employers have had to offer greater benefits to employees as an employee retention strategy, due to a thriving economy and low unemployment,” Gill says. “Greater benefits lead to higher costs. With the recent downshift in the economy, employers, which have not had to bear these

health care costs, will now have to bear a greater percentage of them.”

### **What’s Next?**

The delegated model can be a viable method of reimbursement, as long as rates adequately reflect the actual costs of care. “The delegated model will disappear unless global capitation is adequate,” Gill explains. Global capitation adequacy refers to the balance between the cost of the premium and what providers are paid. “Furthermore, global capitation must include a cost structure for the patients such that they bear a relative cost of care,” he says. “Requiring patients to contribute to care will affect utilization behavior in the right direction, and it will help support sufficient funding of the system.”

Still, not all physician organizations will—or should—survive, Gill believes. “The marginal IPAs that might be of poor quality, have poor market value, are poorly managed, and are commanding poor pricing should go out of business,” he says. “Many organizations that have failed have been mismanaged. Just because we are practicing medicine and saving lives does not mean that we are above the laws of economics. When the good, strong medical groups start to falter and go out of business, then we should worry.”

In fact, physician organizations that command a strong regional presence will thrive and should be able to dictate contract fees and terms. “Organizations such as Facey, the Bristol Park Medical Group (in Bristol Park, Calif.), and Partners

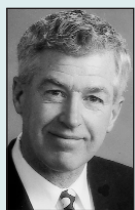
Healthcare (in Boston) will demand the necessary capitation rates, command respect from their physicians, require their physicians to practice appropriately, and be able to adapt to many environments,” says Gill. “This is true not just for capitated groups, but for all medical groups that are the premier groups in their communities.”

Despite some well-publicized failures of medical groups, the group practice model is here to stay, Gill asserts. “Our business model will not go away,” he explains. “Physicians prefer practicing in medical groups over other practice options. Going back to the cottage industry of solo practice is not practical, because of lifestyle factors and because of the complexity of practicing on our own. The physician organization is a desirable commodity, and it will have a long life. How it manifests itself for its future survival is the question to be asked.”

The market is pressuring all physicians, Gill continues. “We are now in an environment in which the future is somewhat Darwinian—and it threatens all of us,” Gill concludes. “Not all medical groups will survive. Yet, we will have the same number of patients next year, but they will be older and sicker and need more medical care. So the medical profession will survive. The groups that can restructure their individual businesses and adapt to the current environment will survive as well.”

—Edited by Deborah J. Neveleff, in *North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).*

# Rising Malpractice Rates, Other Costs Threaten Viability of Many Practices



*Tim Norbeck has served as executive director of the Connecticut State Medical Society in New Haven since 1977. He has worked with physicians since 1967, spending*

*six years at the American Medical Association in Chicago until 1973, and serving as executive director of the Rhode Island Medical Society from 1973 to 1977. In this interview, Norbeck discusses with Richard L. Reece, MD, editor in chief, the problems physicians are currently having with medical malpractice insurance.*

**Q:** The media has reported on the high cost of medical malpractice insurance. In Connecticut, some rates are rising more than 30% per year. What is causing this problem?

**A:** There is no question that physicians in Connecticut and around the country are facing a bona fide malpractice insurance premium crisis. A number of factors are causing this problem.

First, consider the trends in jury awards. During the 1980s, the number of claims being paid declined, making malpractice insurance a somewhat profitable business. More companies entered the market, thereby increasing competition and driving down or stabilizing rates. But during the 1990s, jury awards

increased from an average of \$1.95 million in 1993 to \$3.49 million in 1999 and continued to increase through 2001.

A second factor involves the stock market. Insurers that might typically use investment income to offset their increasing costs now must raise their premiums. What's more, premiums in malpractice insurance are likely to continue rising as long as the stock market is weak.

Third, the tragic events of Sept. 11 have driven the costs of reinsurance higher, which adds even more costs to all insurers.

We must add in other factors as well: frivolous lawsuits, which have always been a problem; new technologies, which may cause unrealistic patient expectations for outcomes, which then drive the number of lawsuits; and the perception that managed care has adversely affected quality.

Another important component is the need to practice defensive medicine. For example, even if a physician does not believe that a serious head injury resulted from a patient falling off a bike, the physician's failure to have all applicable tests performed would be used in court against him. Attempting to save the system money, while an admirable intention, would be a poor defense.

Still another cause for the problem involves the many physicians who take on nearly impossible cases, only

to get sued if recovery was not complete—the “no good deed goes unpunished” principle. But it should be noted that physicians strongly support fair compensation for patients who have been injured by negligence. It is the system, however, that is clearly out of sync.

**Q:** Does the fact that patients can sue their doctors but not HMOs factor into the crisis?

**A:** There is a connection. Physicians and hospitals are the only parties that patients can sue when they believe that negligence has occurred or that their expectations were not met. Like foreign diplomats, HMOs enjoy immunity from lawsuits.

The AMA has led the fight for patients' rights legislation in Congress. The Senate passed a bill in June and the House passed a different bill in August, but the two Houses never came to an agreement on a bill. Any hope for imminent legislation was erased after Sept. 11. Patients' right to sue HMOs is a complex issue and continues to be debated, although it has been in the background and probably will be for at least another four to six months.

**Q:** Why has increased medical technology driven more lawsuits?

**A:** People have always had high expectations for their physicians, and doctors have deserved that confidence. But sometimes it works against them. People think that doc-

*(Continued on page 14)*

**“Physicians and hospitals are the only parties patients can sue when they believe that negligence has occurred or that expectations were not met. Like foreign diplomats, HMOs enjoy immunity from lawsuits.”**

**“Four issues of magnitude are affecting physicians all at once: the flawed Medicare payment formula, the malpractice insurance premium crisis, the HIPAA regulations that generate the need for costly measures, and the managed care squeeze.”**

*(Continued from page 13)*

tors are miracle workers and aggressive lawyers feed this misperception. Some lawyers say that with increased medical technology, patients should be getting better outcomes. Some seize on any delay in care and suggest to juries that new technology, if applied immediately, might have made a difference in an unfortunate outcome.

Some people think that new technologies will make outcomes equal for all patients. But this logic is not always reasonable. If you and I each have knee surgery, you may recover faster than I do because your body heals better than mine. You may be playing tennis in six months and I may not be able to play for two years, but that does not mean that your surgeon was necessarily better than mine or that your surgery was better. Many such factors come into play, and unfortunately they work against physicians instead of for them.

**Q:** *The factors affecting malpractice insurance trends vary by state. Do some physicians react by either retiring or relocating?*

**A:** Yes. West Virginia and Pennsylvania have had the most media coverage on the malpractice insurance premium crisis, and indications are that physicians are leaving these states. But the malpractice insurance crisis is very real in all states nationwide.

**Q:** *What is the effect of the malpractice crisis in the context of other problems in health care?*

**A:** The effects of the malpractice insurance crisis are unquestionably exacerbated by other issues physicians confront. In my 35 years

of working with and for physicians, I cannot recall four issues of such magnitude affecting physicians all at once: the flawed Medicare payment formula, the malpractice insurance premium crisis, the regulations of the Health Insurance Portability and Accountability Act (HIPAA) that generate the need for a compliance officer in each medical office (plus other costly measures), and the managed care squeeze. As a result of these issues, reimbursements to physicians are dropping at the same time their overhead is soaring.

For example, as of Jan. 1, there has been a 5.4% cut in Medicare reimbursement for outpatient care. Since managed care companies often tie their payment formulas to Medicare, reduced Medicare payments will affect those reimbursements.

This problem is exacerbated by increases in practice expenses, which some experts predict will increase by more than 6% this year. As a result, physicians will be incurring losses of 11.4% in 2002. Those losses cannot continue without causing great financial strain for physicians and inevitably resulting in reduced access to care for patients. Throw in reduced Medicaid reimbursements, which are already ridiculously low to begin with, plus the hassles of complying with regulations and managed care strictures, and some physicians will have no choice but to either cease practicing or relocate.

Not enough members of Congress fully recognize the disastrous impact these falling reimbursements and increasing expenses have on physicians' practices.

**Q:** *What is the status of the societies' lawsuits against HMOs?*

**A:** Six states have joined Connecticut in filing suit against HMOs in their state courts and others are contemplating filing suit. Our suit claims that HMOs have systematically harmed physicians and patients by their illegal policies and practices, which include arbitrarily denying medically necessary care, denying care without proper explanation, arbitrarily downcoding claims, failing to staff utilization and clinical departments properly, and engaging in improper claims review by employing computerized programs to reduce or deny claims automatically.

We also claim that the health plans have systematically breached the terms of their contracts with physicians. These lawsuits are directed at health plan policies that leave initial medical care decisions to insurance company bureaucrats instead of relying on the judgment and expertise of physicians.

However, we all would like to solve this problem in a way other than litigation. Nobody wants to litigate, particularly physicians and physician organizations. But when we have attempted to communicate our concerns to managed care plans, the plans have basically ignored us. Legislators have passed some managed care reforms, such as prompt-payment laws, and those measures have been ignored as well. Everyone knows that there is no level playing field for physicians. So what other alternative is there?

If we are successful in these lawsuits, we are confident that once

again physicians will be able to make medical decisions for their patients that stick. Both physicians and patients will rediscover that special bond and relationship that has been eroded under managed care.

**Q:** *How are these problems affecting the medical profession?*

**A:** For one thing, enrollment in medical schools is declining. Medicine is no longer as attractive a profession as it once was. Second, physicians are angry, distraught, disillusioned, and their spirit is broken. They have spent years being educated, receiving professional training, and then being in practice so they can do the best for their patients, just to have their decisions overruled by HMOs. The system must change. Physicians and patients must once again be respected and recognized as the most important and vital components in the delivery of health care.

Many physicians are wondering if they can take this much longer. They are working longer and harder than ever before. Physicians love to take care of their patients and they love to work beyond age 60 or 65. But medical practice is just not emotionally rewarding for them anymore. They can't always do what they want to do for their patients, and they are getting steamrolled financially by rising expenses and falling reimbursements.

**Q:** *Why has the public not appreciated the plight of physicians?*

**A:** The public has always bought into the false perception that all physicians do very well financially. In reality, many medical practices, especially primary care practices, are a low-margin business. Hospitals and physician practice management companies found this out when they acquired practices. But most people don't recognize this fact or how important physicians' offices are to the economies of the cities, towns, and hamlets where they are located. Physician practices employ people just like everybody else. They acquire

space, technology, and equipment. They are small businesses, with bills to pay and payrolls to meet just like all small businesses.

It is surprising to some, but health care is often the single largest business in a community. And people will keep getting sick, so we need the physician practices to exist and to be viable. But the economic status of many physicians' practices is particularly fragile right now, and any one of these issues—the Medicare reimbursement cutbacks, the malpractice premium crisis, the demands of HIPAA, or the continued managed care squeeze—can be the straw that breaks the back of many practices.

**Q:** *Do people realize how devastating emotionally a malpractice lawsuit can be for a physician—whether he or she wins or loses?*

**A:** Absolutely not. The juries are saying, 'I like this physician,

*you think will be the future of managed care?*

**A:** The managed care system we know it is done for, and many people applaud that. The system showed great promise for reducing costs and there were certain areas where some costs were cut—but usually on the backs of physicians, hospitals, and other caregivers. But what really has been achieved? Quality is threatened, physician autonomy has been decimated, and physician morale is plummeting. And, patients are unhappy as well.

**Q:** *Will Congress help resolve the malpractice crisis?*

**A:** Many people think that any long-term solutions to this crisis lie with the passing of tort reform measures by Congress. However, state legislatures that passed tort reform legislation to address the problem have seen some of their

**The economic status of many physicians' practices is particularly fragile right now, and any one of these issues can be the straw that breaks the back of many practices.**

but the patient did not get what he or she had hoped for, so the award will not really cost the physician anything. Let the insurance company pick up the tab.' But a lawsuit costs a physician a tremendous amount in emotional trauma, lost time, legal costs, and an increase in his or her malpractice insurance premium rates. One of the major contributing problems in this crisis is that well-meaning juries often do not look at who is at fault or whether negligence was involved, but rather who is best able to pay. This is a reality that cuts across the entire tort system, not just medical malpractice insurance. It is a dangerous, slippery slope.

**Q:** *Given the problems facing the health care industry, what do*

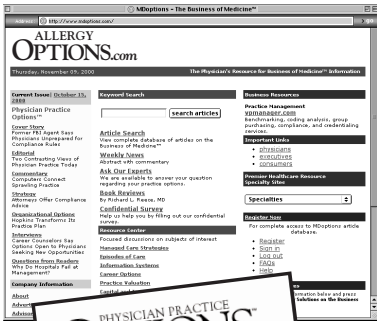
*measures ruled unconstitutional.*

**Q:** *What will it take to achieve national tort reform?*

**A:** To achieve tort reform nationally, Congress must understand and address the malpractice insurance crisis. Helping lawmakers and the public understand the enormity of this crisis is the job of organized medicine, meaning the AMA and the state, county, and specialty medical societies. We will also need help from the media, which did a superb job in exposing the false promises of managed care. It can help a great deal in publicizing this crisis as well.

—*Edited by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).*

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