

PHYSICIAN PRACTICE OPTIONS™

April 15, 1999

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Some Physicians Find Value in Saying No to HMOs

One bad incident was enough to turn New York City ophthalmologist Barry G. Chaiken against managed care. When a patient covered under an experimental Blue Cross capitation plan back in the 1980s required an emergency procedure to relieve pressure in her eye from glaucoma, Chaiken could not use his hospital's laser without approval from the insurer.

"It took 48 hours and conversations with two doctors and an administrator before I could get approval," recalls Chaiken, 47. "The next day I quit the plan. I said I would never deal with this kind of insanity again."

On the opposite coast, family physician Thomas LaGrelus, 55, of Torrance, Calif., also had an early brush with capitation and care was delayed. "I told my partners we were involved with a criminal organization," LaGrelus says. "What insurers are encouraging is unethical and immoral," I said. My partners said, 'Look at this big check! I resigned from the group and opened a solo practice.'

Both Chaiken and LaGrelus now actively solicit others to join what might today be considered radical organizations; that is, groups of members who agree to sign few or no HMO or PPO contracts.

Chaiken's group is the Association of Independent Physicians of New York; LaGrelus' group is called INDOC, which stands for Independent Doctors. Physicians who belong to these groups say they differentiate themselves by giving patients a lot of personalized attention. Free from managed care constraints, these physicians do not follow prescribed formularies, use mandated laboratories or hospitals, or send patients to certain doctors just because the physicians are listed on panels.

About 8,000 physicians nationally are associated with these types of groups, and their ranks may be swelling. Membership in one, the Association of American Physicians and Surgeons (AAPS), in Tucson, Ariz., quadrupled in nine years to its current 4,000 members. Not surprisingly, the group's HMO-avoidance messages have garnered a tremendous amount of media coverage on TV news magazines and nightly news programs, on the radio, and in newspapers.

Cash-Flow Considerations

The question many physicians would ask those who have joined these organizations is this: How does any physician who professes to be against HMOs meet expenses without the patient flow such plans provide? Surprisingly, many of the physicians who have joined these organizations don't have practices catering to wealthy patients.

"Eighty-five percent of my practice consists of patients who are fed up with managed care," LaGrelus says. "They are on plans that have POS (point-of-service) or out-of-network options. They pay me out of pocket and collect the reimbursement themselves."

Nearly 92% of American workers who have employer-provided health coverage are offered at least one plan that covers care provided by out-of-network physicians and hospitals, such as a PPO, POS, or fee-for-service plan, according to the American Association of Health Plans (AAHP), a lobbying group in Washington, D.C., that represents HMOs. In January, a report from William M. Mercer Inc., benefits consultants in New York, showed that enrollment in HMOs and POS plans declined to 47%

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Is Managed Care at the Crossroads?

Recently, I interviewed Peter R. Kongstvedt, MD, a board-certified internist who is a partner with Ernst & Young, CPAs and health care consultants, in Washington, D.C. Kongstvedt and another E&Y partner, David W. Plocher, MD, have just had published *Best Practices in Medical Management* (Aspen Publishers, Gaithersburg, Md., 1998), a comprehensive treatise on the clinical aspects of managed care. The book is timely given recent predictions about the coming fall of managed care.

Many observers believe managed care in general and HMOs in particular are floundering and may be moving toward extinction. In a recent survey of 4,200 employers, William M. Mercer Inc. reported that HMO enrollment declined last year for the first time.

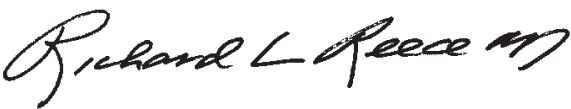
Eli Ginzberg, PhD, a respected health care economist at Columbia University, says, "The fortunes of managed care have taken a sudden downturn and there are growing difficulties and an uncertain future facing for-profit managed care companies." These factors may mean the government will step in to provide basic coverage for the entire population, Ginzberg said in the Jan. 14 issue of the *New England Journal of Medicine*.

J.D. Kleinke, the chairman of Health Strategies Network, researchers and consultants in Denver, writes in *Bleeding Edge: The Business of Health Care in the New Century* (Aspen Publishers, 1998) that HMOs are transitional organizational vehicles and that price wars will drive their profit to zero. As a result, HMOs will be replaced by physicians and hospitals in competing organizations using HMO management techniques, he says. Of HMOs, PPOs, and other types of managed care organizations, Kleinke asks, "After prices are adjusted to reflect competitive bidding and after the most obvious excessive utilization is pruned from a population's medical experience, what is left for the MCO to do?"

Douglas Emery, president of Zoadigm Health Systems, health researchers in Salt Lake City, says in his new book, *Global Fees for Episodes of Care* (McGraw-Hill, 1999): "One thing's for sure: managed care is in trouble. HMO growth is down (having been surpassed by, of all things, PPO growth); capitation has not caught on, and growth in global capitation has been stagnant for almost four years; vertical integration is disintegrating almost everywhere; and integrated delivery systems are performing poorly along just about every measurable line...."

Of the possible demise of HMOs and managed care, Kongstvedt, who is also a member of our editorial Advisory Board, sagely comments, "All pundits are always wrong." What is clear is that medical management that focuses on best practices will survive. Kongstvedt's 674-page book has 59 contributors, including 18 physicians and 13 registered nurses. The 44 chapters draw heavily on the experiences of physicians and other providers from HealthPartners, a 750,000-member HMO in Minneapolis, and on the work of 14 E&Y consultants in various parts of the country.

My advice to physicians in the face of current looming uncertainties is this: Read Kongstvedt's book so that you can learn the best-practice strategies of managed health plans. You may very well need to master these practices when you're in charge of your own managed care organization and responsible for its costs and outcomes.



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Physicians Seek to Maintain Autonomy

By Thomas M. Gorey, JD

What should physicians do when the local medical services market is about to change in a significant way? A group of pediatricians in Tampa, Fla., decided to take decisive action—while they still had an opportunity to influence the evolution of the pediatric services market.

In 1996, most pediatricians in the Tampa area were generally satisfied with their practice arrangements, but some pediatricians were becoming concerned with the changes taking place. For one, managed care had become a major influence, and four or five large payers had come to dominate the market. With a rapidly declining number of fee-for-service patients, pediatricians were beginning to recognize that unless they took action soon, the viability of their practices could be threatened.

Another significant change was the entry into the market of First Physicians, a physician practice management company in Atlanta that had been buying physician practices. First Physicians bought a practice of nine pediatricians, and the head of this pediatric group urged other local pediatricians to consider selling their practices to First Physicians. Independent-minded pediatricians in Tampa were concerned about this development for several reasons. First, they feared that First Physicians would be overly focused on the bottom line and, as a result, would initiate measures that would threaten the pediatricians' clinical autonomy. Second, they were skeptical about the financial aspects of First Physicians' buy-out proposal and were concerned that the company might be purchased by another entity (which, in fact, did occur when First Physicians was later acquired by PhyCor, the physician practice management company in Nashville, Tenn.). Others were concerned with the organization's lack of a substantial track record in practice management.

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A third development, which caused perhaps the greatest concern among pediatricians, was that a Tampa hospital, which was responsible for the majority of the inpatient pediatric care in the market, began actively purchasing pediatric practices. Pediatricians in the community recognized that if they remained fragmented, while the hospital and First Physicians continued to acquire practices, they would be at a considerable disadvantage in the market.

Evaluating Options

In February 1996, a group of physicians representing six pediatric groups and a solo pediatric practitioner met to discuss their options. At this first meeting, the physi-

group, with one tax identification number, but with separate care centers for each previously independent pediatric group. The pediatricians believed this approach would allow them to continue to practice in their existing offices, while taking advantage of economies of scale, professional management services, integrated information systems, and common quality assurance protocols. In January 1997, the Pediatric Health Care Alliance (PHCA), a professional corporation, was formed.

Executing the Merger

One of the more interesting aspects of the merger process, and one that PHCA representatives point to as a key element in their

By merging, the pediatricians planned to continue to practice in existing offices, while taking advantage of economies of scale.

cians discussed the idea of forming an IPA, but soon concluded that they needed a tighter, more structured organization if they were to provide a viable alternative to the pediatric networks being organized by the hospital and by First Physicians.

Ultimately, the physicians decided that if they were going to achieve the desired effect, they would have to become a fully integrated group. Underlying this decision was the fact that some of the physicians involved in these discussions had been part of a multispecialty IPA in the early 1990s that was unsuccessful, partly because it was unable to bind its members to the terms of negotiated contracts.

The physicians retained a consultant affiliated with the Medical Group Management Association, in Englewood, Colo. In addition to conducting a feasibility study, the consultant performed a "cultural assessment," which involved interviewing each pediatrician regarding practice style and practice issues.

The concept that emerged through the consulting process was that of an integrated

success, is the fact that the physicians used only one attorney and one consultant. As one physician commented, "We did not have to go through 25 sets of negotiations on every document. We already knew that no lawyer is ever satisfied with another lawyer's work." The physicians had a high level of confidence in the professionals they hired, which allowed them to move expeditiously in consummating the merger.

The physicians formed a six-member administrative council comprised of one administrative staff representative from each of the sites. The council's mission was to meet with the consultant weekly and work with him to complete the incremental steps necessary to complete the merger. Each task was assigned to a specific task force of two or three members. Topics the task forces addressed included work hours, purchasing, vendors, disability insurance, health insurance, malpractice insurance, and banking arrangements.

The administrative council served as more than just a mechanism for gathering information and resolving operational issues. The

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office staff members from each of the practices depended on the council to ensure that their opinions were included in the development of the group's policies and procedures. The council also served as a link between the physicians and the office staff and as a vehicle for building relationships among the staffs of the component practices.

An ongoing effort was developed to keep office staff informed and comfortable with the planned merger. In addition to frequent meetings, PHCA sponsored employee parties in the months immediately prior to the merger to help promote a feeling of collegiality. A promise by the physicians that there would be no layoffs as a result of the merger helped minimize office staff members' anxiety and motivated the staff to devote considerable time and effort to ensuring a smooth and successful merger.

During PHCA's first year, the medical group experienced difficulties with collections and realized that it needed to acquire additional business expertise regarding collections and a more sophisticated information system. When PHCA's information system advisers saw the difficulties the group was having with collections and with its information system, they offered to show PHCA how to maximize utilization of their current information system. PHCA agreed and also asked these individuals to help the group with its collections systems.

As a result of these discussions, in January 1998—just one year after PHCA was incorporated—PHCA partnered with the group's information system vendor—PHA Investment Inc. in Tampa—to form the Pediatric Health Alliance MSO. The MSO's goal in the short term was to eliminate the group's backlog of claims, while its long-term vision was to allow pediatricians to thrive in a changing market and to manage their offices efficiently and cost-effectively.

The Pediatric Health Alliance MSO, which has an administrative staff of about 30 persons, employs PHCA's nursing and office staff and handles all administrative functions related to the group's operations, including providing services related to billing and collections, finance, quality assurance, utilization management, contracting, clinic operations, and physician network development.

Most of the day-to-day operations associ-

ated with the physicians' practices still are carried out at the individual practice sites, although PHCA gradually has been establishing its new corporate identity. The group has developed a personnel manual for the practice sites, for example, and is moving toward uniform office procedures, as well as

the group's executive director. The physicians said they had been reluctant to bring in an executive director before the merger was final because they were afraid the merger might fail. In retrospect, they believe that the transition to the new group would have gone more smoothly if the executive direc-

Group leaders believe the best approach would be to use existing computers until the new group is prepared to implement a new system.

centralized appointments, centralized nurse triaging, and uniform medical charts.

When PHCA was formed, it did not reorganize the office staff at the care sites. The group, however, now is beginning to examine the issue of care site staffing and making difficult economic decisions.

Lessons Learned

PHCA has reaped some important benefits from the merger, including the ability to purchase supplies, professional liability insurance, and health insurance at more favorable rates than it could get previously. The merger also has enabled the physicians to implement an effective information system, which will allow them to track costs, utilization, and other data necessary to succeed in managed care contracting.

Looking back on their experiences of merging to form a single group, PHCA's physicians point to a number of important lessons learned. Limiting the number of physicians participating in the merger was an important strategic decision, for example. When the plans to form PHCA became public, other physicians and groups sought to participate in the process. Despite the potential for hurt feelings, members of PHCA's steering committee declined such offers, believing they already had a nucleus of committed, compatible physicians who could work well together.

PHCA representatives commented that if they were going through the merger again, they would make a more determined effort to establish a strong administrative infrastructure early in the process. Specifically, they mentioned that it was a mistake to wait until the first day of operations to bring in

tor had been working on the group's administrative issues for at least several months prior to commencement of operations.

PHCA leaders also said that even though they needed a new information system in order to assist in collections, they regretted rushing the process of converting to a new information system. Contrary to conventional wisdom among physicians, PHCA leaders believe the best approach regarding information systems until the new group is fully prepared to implement a new system in a planned, incremental fashion.

Although PHCA physicians have had to reconcile themselves to the loss of some business autonomy under the new structure, the group framework has enabled them to retain a maximum level of clinical autonomy.

Rather than pursuing additional, large-scale practice mergers to accomplish its strategic goals, PHCA plans to expand gradually by bringing in additional physicians as needed. PHCA also intends to rely on its MSO, to form alliances with other primary care physicians in the region.

Editor's note: PHCA is one of six medical groups profiled in *Case Study Analysis of Physician Practice Mergers*, a study released last year by Policy Planning Associates. The study was sponsored by the AMA, the American Academy of Pediatrics, and five other associations. For a copy of the study, physicians may call the Michigan State Medical Society at 517/336-5769. The price is \$25 for physician members of one of the sponsoring medical societies and \$95 for others.

The Corporate Medical Director Position Requires a Multidisciplinary Approach

By Donald Snyder, MD, FACP

Frustrated with the day-to-day complications of managed care, many physicians are wondering what it would be like to work in another capacity, such as a corporate medical director. A corporate medical director must have extraordinary clinical skills, which can be acquired only through years of experience and in a career that is multidisciplinary. To be a CMD, a physician must have superb diagnostic acumen, good medical judgment, and a solid grasp on interpersonal dynamics, as well as be able to recognize subtle signs of mental illness and have a working knowledge of psychosomatic medicine. A broad business background and a willingness to be a “team player” are also necessary.

Modern corporations are more than legal entities organized to produce goods and services. They function largely as a result of complex interrelationships involving people, and that is where a CMD comes in. As a senior corporate officer, a CMD's charge is to enhance the wellness of a company's employees and to nurture their interrelationships. Programs directed by a CMD play a large part in keeping a corporation's employees healthy, and hence have a direct effect on the vitality of the organization itself.

Attending to the well-being of a company's employees is a serious matter, one that enlightened organizations—though they are few in number—realize is in their own self-interest. Ideally, every corporation should have a CMD responsible for administering a variety of programs essential to employee health. These include employee education programs on substance abuse, stress management, and retirement plan-

ning; oversight of care for employees traveling abroad; and consultative services on applicants for employment, the potential effect of major corporate changes such as downsizing, and the effective implementation of managed care.

Examples

Following is information on a CMD's key responsibilities for practicing physicians who are considering taking on this unusual role. The case studies included, which highlight the need for CMD-initiated programs, are derived from 30 years of experience in clinical medicine, medical research, and corporate medical consultation.

Substance abuse. The CMD should be involved with setting corporate workplace policy, implementing a drug-free workplace, and evaluating candidates for employment. Establishing and maintaining a drug-free environment, in particular, is critical to the safe, effective, and efficient operation of any business. Beyond ensuring compliance with the law, it has a positive effect on employee

fired, as dictated by corporate policy. Had a medical professional not stepped in, the story would have ended there.

Because the company did not have a CMD, I was brought in to consult on the case. After spending several hours with the employee and his family, I determined that the man was not a substance abuser. Rather, his test result was false-positive because he had eaten poppy seed rolls and muffins for breakfast. On retesting, the man was negative for opiates and he was reinstated. Thanks to my intervention, the company did not incur the cost of replacing this employee and avoided possible litigation, while the employee's career and family relationships—and possibly his marriage—were saved from destruction.

Corporate downsizing. Another company with which I had experience was a large high-tech manufacturer that did not have its own CMD. Long known for paternalism, this company often was said to care for employees “from womb to tomb.” More recently, however, changes in industry and

The manufacturer failed to consider the long-term cost of its actions, resulting in liability issues and disruption of business.

efficiency, judgment, and performance; reduces time lost on the job; lowers the cost of workers' compensation insurance; and may result in discounts on premiums for both health and liability insurance.

In my experience, a CMD plays a key role in implementing the policies and practices necessary to ensure a drug-free environment. That point is illustrated by the case of a young father of two, whom I treated some years ago for a positive drug-test result. This man was a valued long-term employee in a management position at the time drug testing was introduced in his workplace. When he tested positive for opiates, the man was

management had resulted in downsizing and a rapid series of relocations.

At one point, this manufacturer gave 9,000 employees a choice between early retirement and relocation to a distant city. Because the retirement package was particularly inviting, many people were more than willing to accept it. They were not, however, given any preparation or counseling for this major life change. Soon the company's medical office was filled with employees complaining of anxiety attacks, insomnia, anorexia, depression, frigidity, promiscuity, psychosomatic problems, and significant family and marital disorders.

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Some workers faced even more serious situations, such as marital separation and divorce, and a few attempted suicide. I was consulted because the company's medical team, primarily responsible for "walk-in" medicine and clerical tasks, was not trained to handle the situation. Victims of the events in their own right, these professionals had been kept in the dark about the downsizing until it occurred.

In its rush to achieve short-term benefits, the manufacturer had failed to consider the long-term cost of its actions. The result for the company: significant liability issues, increased medical costs, long-term disability claims, negative workers' compensation insurance ratings, and disruption of business because of employees' medical problems. Had the executives sought advice from a CMD in advance, many of these negative consequences might have been avoided.

Stress Management. Stress is a daily fact of life. A CMD, with his or her professional knowledge and expertise, is in a position to educate corporate employees about the physiologic consequences of unremitting stress and can introduce methods of ameliorating stress. If employees are taught management techniques and also understand the need for "recovery periods," stress can be channeled into improved efficiency and productivity. In the absence of such a combined approach, however, stress can and inevitably does have a deleterious effect on both corporate and private life.

An example of this result was the case of a chief executive consumed by a need to be firmly in control. He insisted on having intimate knowledge about all business decisions at all levels of his corporation. This style was effective when the man was a division manager, although he found it difficult to maintain working relationships with associates for long. When he became CEO, the combination of a controlling style and much greater responsibilities left him no time for family life, real vacations, or even lunch away from the desk. Determined to stay in touch with the office and unable to delegate work effectively, he took phone calls and responded to faxes and e-mail messages at home, while traveling, and even on social occasions. Any attempt at a "recovery period" left the man anxious and frustrated, signs of burnout in progress. The predictable result was that key

personnel on his staff quit, he became estranged from his wife, and, finally, he suffered a serious heart attack.

I counseled this executive on stress management only after catastrophe had struck. My services probably wouldn't have been needed, however, had a CMD

The corporate medical director may be called upon to attend to employees throughout the world.

been on the company's staff. The CMD could have recognized the man's psychic overload early and instituted crisis intervention promptly, potentially preventing the negative consequences for the man, his family, and his employer.

Managed care. With the advent of managed care, the scope of the CMD's responsibilities has increased dramatically. A CMD should be prepared to serve as a medical consultant to employees who do not have long-term relationships with private physicians because their health care is provided by a managed care plan.

Many corporations contract with HMOs or other managed care plans for their employees' health insurance. Under these types of programs, private physicians have been replaced by what insurers euphemistically call providers or gatekeeper physicians. As the term implies, "gatekeepers" are primarily charged with restricting employee access to medical services, rather than with practicing modern medicine. Many managed care companies provide incentives to primary care physicians to encourage them to restrict referrals to subspecialists. In effect, the industry has destroyed the bond between employees and physicians in a drive to increase profits and decrease the level of service provided to patients.

Because of these practices, many physicians are resigning from HMOs in disgust. Their patients then must choose other participating providers, who know nothing about the individuals' health history or family and professional relationships. As this cycle continues, continuity of knowledge about patients is lost, making it difficult for them to get timely medical advice, appropriate care, and the benefits of preventive medicine. In some companies, it then falls

to the CMD—as the medical professional most accessible to an employee—to fill the gap in continuity of care that is left in the absence of the personal physician.

Travel medicine. Multinational corporations doing business in a global economy and their CMDs face unique medical con-

cerns. A CMD may be called upon to attend to employees throughout the world and to make key decisions about whether health care should be delivered in a foreign country or after a patient is transported back to the United States. If the CMD is not available to an employee in person, contact by telephone, over an intranet (a private, corporate-owned system that uses Internet technology), or through a video link can help allay a workers' fears and increase his or her sense of security. It also may allow the CMD to gauge the employee's prognosis, enabling the company to base its business plans on an expert medical opinion.

The company also should consult the CMD for recommendations on control of infectious disease among employees who travel abroad. A CMD should establish policies on the need for immunization, implement educational programs, and counsel employees who work or travel to areas where disease is endemic about indications for preventive therapy and techniques for avoiding transmission.

Diagnostic acumen. Evaluation of the health status of potential clients, customers, competitors, new hires, and succession candidates based on casual contact is another unique task often performed by a CMD. After observing an individual at a meeting or during a social event, the CMD may be asked to arrive at a tentative medical diagnosis. The CMD's professional insight might prove useful, for example, in corroborating the company's suspicions that a client is an alcoholic or a substance abuser or in determining when during the business day a customer with a chronic health problem is most functional. The company also should call upon the CMD to develop programs to increase staff understanding about

substance abuse and disabilities and awareness of the implications for the workplace.

Psychology of retirement. Issues related to retirement are another important area in which a CMD should become involved. The phenomenal growth in the stock market during the past decade has created new wealth for many employees. Coupled with the recent wave of corporate downsizing, more employees now have a strong impetus to take early retirement. Employees often are concerned about the economic effect of retirement but few give much thought to the psychological and emotional effects of this major life change. CMDs are in a unique position to provide individuals who are considering retirement with education and counseling about their options.

Whatever their level of income, all employees have personal and family concerns that need to be addressed, and these workers likely have developed defense mechanisms and support systems for dealing with day-to-day life. Under the stress of retirement and relocation, however, these layers of protection can unravel. Age is not a determining factor because we are all vulnerable to periods when our energy, emotional flexibility, physical health, and emotional resources are at a low ebb.

A CMD is in an ideal position to help employees avoid the emotional pitfalls inherent in retirement by orchestrating a program that incorporates both advanced preparation and postretirement counseling. Ideally, a CMD should begin educating employees about emotional issues and methods of avoiding and dealing with stress one to two years before a worker retires. An effective preretirement education program not only demonstrates corporate concern and directly benefits employees and their families, but also can engender loyalty among those who have retired. After employees have retired, the company may find it beneficial to maintain contact with them because they represent a wealth of information about the company and its industry and are a potential source of part-time help.

The case of a man I treated for depression demonstrates what can go wrong when employees do not have the benefit of preretirement counseling. This manager spent many hours making pension decisions before he simultaneously took early retirement and

relocated with his wife. What he failed to consider, however, was how he was going to adjust to a new home and fill his time. He quickly became bored and disconsolate and developed insomnia. Used to keeping busy by herself, his wife began to feel restricted by his constant presence. Far from family and friends, the couple had no support system to which they could turn and soon began arguing. Their confrontations eventually escalated into accusations of promiscuity and their 35-year marriage ended in divorce. This disastrous outcome might have been avoided if the employee had received counseling from a CMD about the emotional consequences of retirement and relocation.

The corporate structure. The previous cases illustrate only a few facets of a CMD's diverse responsibilities. The nature of these activities dictates that the CMD will work in concert with the human resources department (HR), the chief financial offi-

confidentiality. The OGC can provide guidelines to the CMD about sensitive issues that are potential sources of litigation and can help identify information in employee medical records that cannot be distributed without the employees' permission. In turn, the CMD can help the OGC avoid litigation and minimize corporate liability by developing policies aimed at preventing litigation. In areas such as crisis intervention, sexual harassment, and long-term disability, a CMD's medical knowledge can be used to foster prevention, ensure prompt identification of problems among the employee population, and institute appropriate therapy and referrals.

Conclusion

To function most effectively within a corporation, a CMD should be a member of the senior management team and thus hold a title of respect among his or her peers. An

Few companies appreciate the cost savings that can result from a medical director's involvement in every aspect of corporate life.

cer (CFO), and the office of the general counsel (OGC). As an adjunct to the HR department, rather than adding to the staff's workload, the CMD should assist them in dealing with personnel and benefits issues. They should come to view the CMD as a consultant who can help the corporation manage multifaceted benefits and recruitment programs.

Interactions with the CFO's office will offer the opportunity to demonstrate the positive effect the CMD's programs have on the corporation's bottom line. The CMD should work with the CFO to design guidelines for analyzing the cost-effectiveness of programs such as a drug-free workplace and a day care program. Vigilant attention to the cost-versus-benefit ratios of the company's health benefits programs is one of a CMD's chief responsibilities. In a for-profit company, the medical office must fit seamlessly into the overall corporate structure.

The OGC can help a CMD balance the corporation's desire for information and accountability with the need for employee

open-door policy also is important to inspire confidence in employees and encourage them to bring issues to the medical office's attention promptly so that crises and litigation can be avoided. Such practices, along with professionalism in the workplace, also will facilitate a CMD's interaction with other executives.

Few companies appreciate the value and breadth of a CMD's activities or the potential cost savings that can result because of his or her involvement in every aspect of corporate life. Companies that employ CMDs clearly have visionary and enlightened management. Their executives realize that business is a complex set of human interrelationships and not just a mechanistic production line.

The net result for the company with a CMD should be improved morale, reduced absenteeism, and enhanced employee health and productivity. The savings realized through programs administered by a CMD should more than cover the salary of this unusual corporate officer. ■

(Continued from page 1)

from 50% of all workers last year, the first such decline in five years. Enrollment in traditional indemnity plans declined to 13% from 15% and enrollment in PPOs rose to 40% from 35%, Mercer said.

Despite these enrollment trends, many physicians who withdraw from all HMO contracts are amazed at how well they are surviving. Las Vegas gynecologist Lisa Underwood, MD, lost 50% of her patient volume but lost no income when she switched from a practice that had 70% managed care patients in 1996 to less than 10%. She kept direct contracts she had with large self-insured employers and she set the fees for those contracts.

"The first three months, my salary declined, but by the end of the first year, I came out even," she says. "With managed care plans, I was seeing 25 patients a day at 20% of my fee. Now I see 15 patients a day at full fee." What's more, she now works eight-hour days rather than 12, she adds.

While Underwood had an increase in fees, she also had a decrease in administrative work, meaning she could reduce the size of her staff. She no longer needs three staff persons to handle managed care paperwork, such as authorizations, precertifications, filing, posting, and tracking late insurance payments.

Underwood's anger at managed care reached its zenith over formulary restrictions and surgical protocols. "People don't fit into protocols," she says. "I was writing letters every night to get exceptions to the rules. I was doing more paperwork to get around the red tape. The added insult was that I was getting paid 20% of my fee and having to pay three people to chase down payments," she says.

She cautions other doctors who consider disenrolling from plans to consider their practice style. Her typical new patient office visit is an hour long and includes a free ultrasound. "Fee-for-service doctors must offer more than eight-minute appointments or they won't be in business," she explains.

Underwood, 44, is a member of AAPS, which, like similar groups, offers marketing and advertising support to raise the profile of non-HMO member physicians. Some of these organizations even push legislative reform. Top agenda items are support of

medical savings accounts, the demise of employer-provided health insurance, out-of-network options for patients in managed care, and removal of gag rules that discourage doctors from telling patients about all treatment options, regardless of whether the insurer approves them.

Is this a maverick minority destined never to gain a critical mass or the beginning of an organized resistance movement, a revolution in the making? Managed care experts do not believe they see a trend. Only 8% of nonfederal, patient care physicians are free of HMO contracts, says Donald White, a spokesperson for the AAHP. A recent report from the AMA, *Socioeconomic Characteristics of Medical Practice 1997-98*, shows that 92% of physicians participate in managed care contracting. Martin Gonzalez, an author of the report, says that in 1996, it was 88%.

"The choice not to affiliate with managed care plans is not representative of the overwhelming majority of physicians who practice through HMOs and other forms of managed health care," White says. John Hurley, MD, the director of medical education for Kaiser Permanente in Washington, D.C., says, "There are plenty of doctors waiting to take on the HMO patients that

disenrollments are making headlines too.

"I think the anti-HMO movement will grow because the press and politicians have done an excellent job of vilifying HMOs," says David Lack, president of the Council for Affordable Health Insurance, a non-profit consortium in Alexandria, Va., of independent insurers and employers.

In January, *The New York Times* reported that half of all physicians at one New York hospital have whittled down the plans they accept. And 10% of doctors at that hospital completely dropped out of managed care plans last year.

Medical management consultants see these actions as a blip. "We've always had doctors who have said, 'HMO, hell no,'" says Robert Bohlmann, a consultant with the Medical Group Management Association, in Englewood, Colo. "They are cavalier. If it's not an HMO, it's going to be something else like it that they don't like."

What is irrefutable is that managed care has long suffered a barrage of criticism and some of the criticism is justified. Physicians complain about their lack of freedom and reduced compensation. Patients, of course, are angry if care is denied, delayed, or inappropriate. Yet, despite its failings, managed care has won the support of employers that

"With managed care plans, I was seeing 25 patients a day at 20% of my fee. Now I see 15 patients a day at full fee."

—Lisa Underwood, MD

these anti-HMO doctors refuse."

Antagonism between physicians and health plans is undoubtedly strong. "There is a movement now to get off some plans. It's been building gradually," says Tucson, Ariz., internist Jane M. Orient, MD, executive director of AAPS and author of *Your Doctor Is Not In, Healthy Skepticism About National Health Care* (Crown Publishers, 1994).

In one of the biggest rebellions against a health insurer, 400 doctors in the Genesis Physicians' Practice Association in Dallas broke their contracts with Aetna Inc.'s HMO last fall. Physicians complained Aetna was slow in paying claims. Other

buy health care for their workers.

In an effort to counter this backlash against managed care, health plans are countering with advertising, spending \$6 million in one 1998 campaign alone, "The Truth About Managed Care." That campaign, with the tag line, "The Health Care You Want at a Price You Can Afford," was supported by the Coalition for Affordable Quality Healthcare, a political action group, funded by managed care insurers and employers.

Even physicians who support managed care believe HMOs must change. "Doctors are mad and frustrated; but HMOs are not

“Employers are driving the HMOs. Doctors should sit down at the table with the CEOs of health care purchasers and resolve the problems.”

—Bill Williams, MD, National Association of Managed Care Physicians

to blame,” says Bill Williams, MD, a family practitioner and senior vice president for the National Association of Managed Care Physicians, an organization in Richmond, Va., that has 3,500 members. “Employers are driving the HMOs. Doctors should stop complaining and sit down at the table with CEO purchasers of health care and resolve the problems.”

HMOs were designed to help employers solve the problem of rising health care costs brought on by fee-for-service insurance. Physicians who practice HMO avoidance contend costs are not held down by HMOs but driven up by what they believe are large amounts of administrative waste.

When Allan Weissnar, MD, a pediatrician in Torrance, Calif., reviewed his per-patient revenue, he was surprised at the findings. He learned that 35% of 2,200 patients were enrolled in an HMO, but they represented 65% of his office work and only 19% of his income. At that point, he began disenrolling from all his HMOs last year.

Quality vs. Quality

“It was a big gamble but I was having to compromise my practice principles,” Weissnar says. His breaking point came when his IPA suggested that when dealing with patients in capitated plans he should take his own x-rays and remove any foreign bodies from his patients’ eyes. Otherwise, he would lose income by referring these patients to specialists.

Weissnar has worked with 30 health plans, 15 HMOs, and 15 PPOs. He dropped all the HMOs. The result? “Most of my HMO patients changed their insurance plans to a PPO plan I would accept,” he says. “I transferred out only 100 patient records.” Over the course of a year, his income declined only \$3,000. “The patients love it because I’m not beaten up and I’m not cranky when I talk to them on the phone,” says Weissnar, 50.

A frequent accusation leveled against managed care plans is that the fees are dis-

counted so much that physicians need to make patients wait for months for appointments and they see large numbers of patients daily. “Because of the sheer volume of patients you are forced to see, patients may not get the quality of care they deserve,” says Arnold Ison, MD, 60, a dermatologist in St. Petersburg, Fla., who is president of DocTra, a group of physicians who oppose HMOs.

Payers deny this charge. In a fact sheet issued last year, “Dispelling Managed Care Myths,” the AAHP said its statistical analysis showed that physicians spent more time on direct patient care activities in 1996 (26.9 minutes) than they did in 1985 (24.3 minutes).

Pepe Granat, MD, a family practitioner in Miami, says that even if physicians spend more time with patients, “HMO doctors are subtly pressured to do things in a certain way.” Granat refuses to accept HMO patients, in part because he believes managed care creates irreconcilable conflicts of interest.

“Even good doctors can’t give the best possible and timely advice under this system,” says Mark Hepler, an attorney in Oxnard, Calif., who has become famous for winning large judgments against managed care insurers for denials and delays in treatment. Hepler and his family see only physicians who do not take HMO patients.

Of course, managed care critics say denials, delays, and limits to care are common. The AAHP refutes these complaints, however, citing a study of more than 2,000 physicians that appeared in the fall 1997 issue of *Inquiry* which showed that physicians using managed care techniques denied care only 3% of the time.

That has not been the experience of anti-HMO doctors who sometimes provide on-call coverage for HMO physicians. Granat has gone so far as to personally guarantee payment of hospital bills for HMO patients she sees who are told to wait for hospital authorization.

Concern About Cost

Those who prefer managed care fear that if enough physicians oppose HMOs, the movement will spur a return to high-cost fee-for-service medicine. “My suspicion is that fee-for-service physicians who tend not to behave in a cost-conscious way will revert to premanaged care days with uncontrolled utilization,” says Rosalie Phillips, executive director of the Tufts Managed Care Institute, a collaborative formed in 1995 between the Tufts University School of Medicine and the Tufts Health Plan. Its goal is to help health care professionals learn to practice high-quality medicine in a managed care environment.

Physicians who oppose HMOs believe health care costs can be controlled under fee-for-service medicine if all patients have medical savings accounts and control their own medical costs.

“Insurance should be decoupled from the place of employment,” says Miguel Faria, MD, 45, a neurologist who is a member of AAPS. “As long as you have this, patients will spend medical care dollars as if it’s someone else’s money.”

Beyond the health policy implications, physicians who oppose HMOs believe the most significant benefit from disenrolling from managed care plans is an increase in job and career satisfaction. “It’s possible to do the job right and have happy patients and a happy doctor,” says Marilyn Marcus, 50, a DO in Miami who signs no HMO or PPO contracts.

For new doctors fresh out of residency and trying to build practices, or for doctors working in towns where a single employer or health plan dominates, however, dealing with HMOs may be inescapable. What’s more, for doctors who rely on referrals, such as anesthesiologists and surgeons, relinquishing managed care plans must start with primary care doctors and trickle down. —Reported and written by Maureen Glabman, in Miami.

Leasing Offers Management Alternatives

By John McDaniel and Richard C. Holdren

The number of physician practice acquisitions exploded in the 1990s, as hospitals and for-profit corporations sought to strengthen their market positions by solidifying their physician base. Many of these acquisitions seemed to represent highly profitable opportunities for physicians, who could sell their practices for cash, stock in publicly owned physician practice management companies, or both. In particular, PPMC stock was attractive to physicians because it did not create an immediate income tax liability and, for a while, most PPMC stock appreciated dramatically.

Between January and October of last year, however, market capitalization of publicly owned PPMCs fell from \$13 billion to approximately \$4 billion.

Like PPMCs, hospitals also acquired many physician practices over the past few years, and like PPMCs, hospitals also struggled to make money from these acquisitions. In situations in which hospitals, usually nonprofit institutions, acquired practices for cash, earnings of those practices decreased in almost all cases.

What can be learned from these experiences? Neither hospitals nor Wall Street has found the key to dealing with the two distinct aspects of medicine: administration and clinical practice.

Practice leasing offers a different solution to the problems hospitals and PPMCs face. In a leasing arrangement, physicians continue to own their practices and its assets, while contracting with an outside agency for all administrative services.

On the surface, practice leasing resembles a practice management contract, or a contract with a management services organization (MSO). But there is a key differ-

ence. When contracting with an MSO, physicians pay a set monthly fee for administrative services. In a practice leasing arrangement, physicians—who are the lessors and owners—receive a guaranteed income based on a percentage of total collections, such as a predetermined percentage of net revenue. The management company (the lessee) receives the balance of the revenue and pays all practice expenses out of this balance. If overhead costs are higher than the allocated percentage of net income, the management company covers the shortfall. If overhead costs are lower than the allocated percentage of net income, the management company retains the difference; this arrangement represents its compensation for providing the practice management services. Another difference between leasing and MSO arrangements is that the leasing agreement can be canceled with a 90-day notice by either party; MSO contracts often last for years.

The Underlying Concept

Leasing is a partnership approach: Both the physicians and the management company have an incentive to improve the profitability of the practice, in terms of increasing practice efficiency and developing new sources of revenue.

Administrative functions today span numerous areas, including billing, coding, collections, operations, information systems, managed care contracting, and marketing. Physicians have the option of using outside vendors to provide various services. For example, specialized computer consultants for medical practices can set up and maintain clinical tracking and other data-collection systems. There are marketing specialists, and those who collect accounts receivable. And it is likely that some combination of these services, if implemented appropriately, could improve the profitability of a practice.

The process of selecting, and then coordinating, different outside services is similar to building a house. In construction, specialized trades are analogous to individual medical administrative services. For

each task, such as plumbing and electrical wiring, the best tradesman for the project must be found, at the best price. There must be an overall plan and a schedule, and the various tradesmen must arrive on time and finish their jobs on schedule.

In effect, physicians in a medical practice who contract with individual outside vendors for specific administrative services are acting as their own general contractors. In a leasing arrangement, the management company is doing the job of the general contractor with an added benefit: The physicians' income is a guaranteed percentage of total net revenue, no matter what. Moreover, since the physicians retain ownership of their practices, all major decisions are made jointly by the physicians and the management company because the management company cannot make operational decisions unilaterally.

Experience shows that many practices can reduce their overhead as a percentage of total collections by as much as 10% within a short time, primarily through initiatives that increase revenue (see table). In a leasing arrangement, this means that the percentage of income allocated to physicians would increase.

Physician compensation in a leasing arrangement is based on income over the past 12 months. It is determined by calculating the total income during that time and deciding what percentage of the total the physicians received. Then, an estimate is made of how much the remaining percentage, or overhead expense, can be decreased, and a percentage is agreed upon for the lease. For example, if the overhead was 38% but can be decreased to 33%, the contractual amount would be 33%, allocating the extra 5% of the total to the physicians.

Practice Assessment

The management company assesses the practice to determine the feasibility of such an arrangement. This process is not nearly as involved as the due diligence process when the sale of a practice is being considered. It begins with a questionnaire completed by physicians, which often includes

John McDaniel is president and chief executive officer of Physician Management Group Inc., a physician practice management company in New Orleans that offers leasing arrangements.

Richard Holdren is president and CEO of RH+ Medical Group Inc., a national medical practice appraisal and brokerage firm in Houston.

the following items: the physician's practice goals, new patient sources, information about competitors, top referral sources, facilities where the physician practices, current management resources and services being used, information about the market in question, whether the practice has a business plan, and financial information, including future capital needs. After reviewing the questionnaire, the management company assesses the practice; based on knowledge of the market and cost benchmarking data, the company determines how the profits of the practice can be increased.

Enhancing Profitability

As a result of what is learned from the questionnaire, a leasing company will review and may make changes in any or all of the following: reimbursement systems, billing and collections, accounts receivable management, operating expenses, and practice growth

Reimbursement systems. Correcting undercoding and adjusting practice fee schedules to a higher percentile of usual and customary charges often increase revenue. Chart audits and reimbursement education for both physicians and office staff will solve undercoding problems. In a leasing situation, the partnership relationship between physicians and the management company creates a strong incentive for a cooperative effort to improve coding procedures, although it is the physicians who control coding. The management company can review a practice's coding procedures, and then educate the physician and the office staff to help the practice maximize profitability.

Billing and collections. Comparing the percentage of collectible charges that were actually received with industry standards often shows that a practice can increase collections significantly. The speed of billing, as well as effective follow-up, are critical issues. The management company assesses billing and collections procedures and can implement new systems to maximize cash flow.

Accounts receivable management. Reviewing the ratio of longer to shorter outstanding balances, identifying major payers to target, and pursuing aged balances

Leasing's Effect on the Bottom Line

| | Before Lease | After Lease | Change |
|------------------------|--------------|-------------|----------|
| Total revenue | \$367,400 | \$404,140 | \$36,740 |
| Patient refunds | (\$7,775) | (\$8,553) | (\$778) |
| Net income | \$359,625 | \$395,588 | \$35,963 |
| Operating expenses | \$119,800 | \$119,800 | 0 |
| Overhead % | 33.31% | 30.28% | — |
| Predistribution income | \$239,825 | \$275,788 | \$35,963 |
| Management fee | \$0 | \$11,971 | \$11,971 |
| Physician compensation | \$239,825 | \$263,817 | \$23,992 |

Definitions

Patient refunds. After patients pay their bills, an insurer may reimburse the practice either in whole or in part. Any resulting overpayment is refunded to the patient.

Overhead %. The percentage of collections spent on operating expenses (all nonphysician expenses, such as nurses' salaries, supplies, and utilities).

Predistribution income. Income that is available for distribution to the physicians after overhead (operating expenses) is paid.

Source: Physician Management Group Inc., New Orleans, and RH+ Medical Group Inc., Houston.

often indicate an opportunity to improve cash flow significantly. Accounts receivable balances may well be larger than a physician's home equity; these sums could be earning interest, adding to cash flow. The management company reviews a practice's accounts receivable rate and then compares this rate with industry norms to determine if accounts receivable can be reduced.

Operating expenses. A comparison of the percentage of total income spent on operating expenses—such as payroll, benefits, rent, utilities, and medical supply costs—with industry standards often reveals another avenue for improvement, particularly if it is possible to cut costs of medical supplies through group purchasing pools. The management company can determine how to access such group purchasing mechanisms.

Practice growth. Both physician productivity and growth opportunities in a given market may offer new potential. The types of activities to generate new business vary from one specialty to another. Primary care physicians, for example, rarely do regular recalls of patients for annual checkups. Yet, dentists do so routinely. Specialists may be able to generate a significant amount of additional referrals by spending time social-

ly, or in community activities, with their referral sources. Overall, the market has to be assessed accurately and realistic ways to tap into opportunities should be pursued.

Leasing Varieties

Practice leasing is based on the premise that a management company leases a physician-owned practice, and this strategy can be applied in a variety of settings. For example, one physician practice could lease other practices and provide administrative services to them. This strategy might be a good one for a specialist who leases practices owned by several solo primary care physicians because it builds a strong relationship for referrals without a large capital investment. Naturally, the specialists' practice would need to provide effective management, and may outsource that function.

In an environment in which both patient volume and practice costs are continually increasing, it becomes more difficult to balance and integrate the administrative and medical delivery aspects of a practice. Although a perfect world may not be a realistic goal, practice leasing certainly offers a balance of security and independence.

—Additional writing and editing by Vera Tweed, in Los Angeles.

By Focusing on Outcomes, Specialists Reduce Automakers' Health Care Costs

James Fontanesi, MD, is a cofounder of Innovative Solutions in Health Care, a disease management company in Chicago, and professor of radiation oncology at the Detroit Medical Center. Richard A. Fisher, also is a cofounder of Innovative Solutions, and chairman of Medical Corp. Inc., an MSO in Chicago. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q: The logo for your company, *Innovative Solutions in Health Care*, describes the company as “payers and providers in a partnership for patients.” Is that your mission statement?

JF: Yes. When we formed the company about four years ago, the three cofounders and I saw that physicians, providers, third-party administrators, and payers of health care were all in adversarial roles. All of them were trying to keep their own piece of the pie, which often meant that the patient was being squeezed. Health care was not at all like it was in the past, when medicine was practiced because it was an honorable profession and physicians did what was best for their patients. We believed it was important for health care payers and providers to join in providing care for patients in a way that is not necessarily new but that accepts the idea that the patient—not economics—is the focal point. But about two years after we formed the company, we recognized that we had a good idea but we did not have a strong business background, so we contacted Richard Fisher to see if he would be interested in working with us.

Q: Richard, please describe your background and why this opportunity appealed to you.

RF: My background has been in health care and health care finance for 30 years. But how I became involved with Innovative Solutions is a personal story that actually starts when my 49-year-old brother-in-law was diagnosed with throat cancer about three years ago. He

sought care in the small community in which he lived—a community in which he couldn't get outcomes information or make any choices regarding his care except for those that were prescribed to him. He went through the traditional approach to treating his condition for about 16 months before he passed away. The treatment he received involved no coordination of care among those who were putting the process together. That experience was fresh in my mind when I was contacted about working with a group of radiation oncologists at Innovative Solutions who had written over 3,500 algorithms or pathways on how to treat cancer patients with full radiation oncology. Intrigued, I met with Fontanesi and Arthur Porter, MD, another cofounder of Innovative Solutions.

Q: At a conference on emerging health care issues, Fontanesi spoke about *Innovative Solutions in Health Care*, which so

minds in our discipline into clinics would provide improved clinical outcomes for patients. We hoped that by identifying for physicians the non-quality-related activities that were being done and by teaching them how to eliminate those activities, we could also show there was a potential to reduce cost while improving the outcomes of care.

GM and Chrysler funded us to show to them over a 15-month period whether that theory could be applied practically. The automobile demonstration projects data have shown that the clinical outcomes we achieved when compared with historical controls for the most frequently diagnosed cancers—lung, colorectal, prostate, bladder, and breast—improved. The rural and community practice centers have now shown outcomes similar to those achieved at our academic centers. For example, our local control rates for patients with breast conserving surgery followed by radiation are the

“We hoped that by teaching physicians to eliminate non-quality-related activities, we could show there was a potential to reduce cost while improving the outcomes of care.”

—James Fontanesi, MD, Innovative Solutions in Health Care

far has been financed only by physician stockholders and has yet to go public. In your presentation, you told a compelling story of winning major contracts from General Motors and Chrysler. Could you elaborate, please?

JF: GM and Chrysler, which both have tremendous health care costs, had over the past several years been looking for new ways to promote improved health care without regard to cost. They wanted to make sure that their salaried and hourly employees had the best care available. We felt—through our scientific advisory board and the information technologies we had developed with our software system—that putting the best information from the best

same as the best published clinical trials. We also found that the rural and community centers were generally more efficient or less costly in the delivery of therapy than the academic medical centers, and that the academic centers that had higher expenses were able to become efficient. So, at least from the perspective of the purchasers—Chrysler and GM—we accomplished our primary goal of showing that we could improve the clinical outcomes for their beneficiaries, as well as everyone else who was treated in the clinics.

Q: In your presentation, you said your benchmark was to reduce the cost by 15% to 17%, but that your initial studies indi-

"We hoped we would reduce costs by 15% to 17%; instead we averaged a 25% savings for the first 300 cases."

—James Fontanesi, MD, Innovative Solutions in Health Care

ated a reduction of 25%. Is that correct?

JF. Right. Our original projection was based on the assumption that by reducing and eliminating nonquality and duplicated services, we would get some cost reduction. We hoped to achieve 15% to 17%; instead we averaged a 25% savings for the first 300 cases that we had full economic information on.

Q. Your business strategy at Innovative Solutions is based on an information system that serves both the payers and the participating providers. Please describe that system.

RF. Jim will talk about the clinical application, and I'll talk about two of our joint venture partners that helped us move forward in this market. The one group that has a radiation oncology background is Varian, a \$1.3 billion New York Stock Exchange company that supplies treatment-related equipment to radiation oncologists and enjoys a dominating position in its field, both nationally and internationally. Our agreement is to work with Varian in this market to improve the efficiency and outcomes in the clinics by using information technology. On the business side, we also needed to be aware of the needs of the payers, from small companies to large multinationals. Arthur Anderson Worldwide, the international accounting and consulting firm, is our joint venture partner for this effort.

JF. I would like to add that Kodak also has been influential in helping us to develop some of the image archiving that we have available. This process helps to decrease cost, time, and effort regarding film review and location. Early on, we realized that with the recent explosion of information technologies, being able to gener-

ate information and get it into clinics on a daily basis was going to become easier. So, rather than engage outside vendors to build an information system for us, we decided to build it ourselves.

We started by looking at what goes on in the clinics. For a couple of weeks, we sat at the front office to see what front office people do. It was a learning experience for me because, as a physician, I'm not used to sitting with insurers, psychologists, nurses, and everybody else who runs a clinic. Once we identified where we could improve daily activities and efficiencies and make improvements that focused on the patient, we started working with a network development company and a software developer.

What we wanted to know was simple: How could we apply our theory? After about 18 months of meetings and reviews, we chose a database developer that had the flexibility to generate reports and superior security for information transfer. The key element in the process of building the system was the involvement of the scientific advisory board. Arthur Porter called many of the leading radiation oncology experts to solicit their opinions about whether it was feasible to develop a program that would—on a mutually beneficial basis—take the best information that was available, from printed articles and from the clinics of leading institutions, and put it in a practical application so that a physician—whether in an academic, a community, or a rural practice—could access that information.

As we were building the hardware and software components of our system, the scientific advisory board spent 18 months developing more than 4,500 individual

guidelines for the top 32 diagnoses of cancer based on the American Cancer Society's registry. After that, we put the data into the information platform, which took about 24 months; then we spent about six months testing and reviewing the system to make sure that it performed as well as we wanted it to. That system testing was taking place at the same time as our negotiations to develop demonstration pilots for GM, Chrysler, and the United Auto Workers. Being able to obtain information through the information platform and to bring it to the physicians, providers, and to GM, Chrysler, and the UAW were key ingredients in their decision to proceed.

Q. I understand that the stakes here are considerable, particularly for GM, because it has such high health care costs.

JF. In terms of financial exposure, about half of GM's retired population is under the Medicare age because of early retirement programs. For this population, GM is at risk for all of the health care costs for these retirees. In other words, about half of GM's retirees are over the age of 55 yet they are not yet eligible for Medicare. So, there is a big reason for GM to want to see improved outcomes because, with cancer and with many other diseases, providing the best care initially results in the best outcomes. And the best outcomes produce the lowest cost. So, in all, this endeavor has been fruitful in that it has been the catalyst for a proactive dialogue between payers and providers. We're now working together for the same principle, which is the betterment of the patient.

Q. Do you think one reason your efforts may be working is that you have a set specialty with a known number of diseases that

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INTERVIEW

(Continued from page 13)

have fairly well-defined outcomes? In other words, you're dealing with measurable and documentable costs and outcomes.

JF: Yes. But I would go further to say that you could probably look at any specialty and achieve comparable results. Take diabetes, for example. We know that a high percentage of diabetic patients don't get yearly eye examinations, yet diabetic retinopathy is one of the leading causes of blindness in the United States. So, just by encouraging diabetics to get a yearly eye exam can result in the same types of documented outcome improvements and cost benefits as we're seeing in the field of cancer.

Q: Do you believe all physicians have something to learn from this experience?

JF: The most important lesson that's been instilled in me throughout all of my education is that there is something that can be said about quality. And until recently, we could not define quality well to the payers of health care or to their intermediaries, and we gave them no choice but to say to everybody in the system, "Whoever does it at the lowest cost is going to get

"We need to deliver the best care for the best outcome, and if we do, the dollars will take care of themselves."

—Richard A. Fisher, Innovative Solutions in Health Care

the contract because we, as the third-party administrators to the payers, assume that everybody provides the same level of quality." But we know that's not true. We're saying quality is the major issue and we're providing the best quality care that is available and taking it into every clinic that wants it.

But an important aspect of this experience for everyone to understand is that the computer cannot treat the patient. It can give recommendations based on scientific criteria, but if the patient does not fit the profile well, or if a physician sees something that is unusual or different or simply has a feeling that what is recommended does not apply to this individual patient, the physician does not have to follow the recommended protocol.

Q: In closing, what would you say that we have not yet addressed?
RF: In recent years, we've all been ratcheting down health care in the wrong manner. We need to deliver the best care for the best outcome, and if we do, the dollars will take care of themselves. We have proven that it is possible in our auto demonstration project. It is worth noting that while that was going on, several major health care companies defaulted because their approach to delivering care was getting them into trouble. They were bidding for the minimum cost of delivering health care, without knowing what the costs and—most important—what the outcomes would be. And that's where the problems of provider companies came from: Many have failed to deliver what they thought they could.

—Edited by Paula D. Grant, in Lincoln, Va.

Issues for Physician-Hospital Affiliations

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

Given the fall of many physician practice management companies, some physician groups are turning to local hospital systems for management and capital resources. As these groups seek to terminate their management agreements with PPMCs, they are negotiating new transactions with local hospital systems.

Austin Regional Clinic, for example, is a 110-physician multispecialty group in Austin, Texas, that recently announced a joint venture with Seton Healthcare, a hospital system in Austin. In structuring these types of transactions, the physician organization should evaluate both the advantages gained and potential conflicts created by partnering with a local hospital.

In such an affiliation, both the physicians and the hospital can realize significant benefits (see table). When contemplating and negotiating an affiliation with a hospital, physicians should consider the following issues carefully:

- Economics of the transaction
- Physician employment arrangements
- Governance
- Noncompete provisions
- Managed care contracting

Economics of the transaction. If the transaction involves a sale of assets or the sale of future earnings of the physician group, a fair purchase price will need to be negotiated. Hospitals typically hire an expert to develop a valuation of the group, based on the terms and structure of the transaction. Physician groups also should engage the assistance of a financial adviser to ensure that the economics of the transaction are consistent with fair market value.

Physician employment arrangements. Historically, hospitals have employed physicians with a fixed, multi-year salary guarantee. Given the poor results this type of arrangement has yielded, many hospitals have begun to structure the affiliations so that physicians are paid based on productiv-

ity or as a percentage of net profit, similar to the model PPMCs use. Other terms of the physician employment agreement—length of the contract, restrictions on competition, and termination—should be consistent with current market terms.

grating an established physician organization with a hospital system that has such competitive services in place, the operations that compete with those offered by the physician group should either be merged as part of the transaction, or explic-

Advantages for Both Parties

When a physician group affiliates with hospitals, benefits accrue to each party

Physician groups get

Access to capital
Additional management resources
Enhanced contracting clout
Broader geographical presence
Economies of scale

Hospitals get

Broader geographical presence
Enhanced contracting clout
Stronger alignment with local physicians
Additional practice management expertise
Economies of scale

Source: Townsend Frew & Co., Durham, N.C., 1998

Governance. If the transaction is structured so that a large component of the physicians' compensation is at risk—meaning it is not guaranteed—physicians should demand a meaningful role in the governance of the new physician organization. Borrowing from the traditional PPMC model, many recent hospital-physician affiliations have included a joint governing board that gives the physicians veto power over strategic and operational issues that affect the physician organization. Issues governed by the joint board typically include strategic planning, budgeting, physician hiring, fee setting, managed care relationships, and ancillary services.

Noncompete provisions. Most large hospital systems have affiliations with physicians. These hospital systems also may employ physicians, and provide certain services that compete with the services commonly provided by physician groups, such as ambulatory surgery and imaging. Given the many complexities associated with inte-

it terms should be established relating to which organization will be given priority to providing such services. It is common to negotiate a right of first refusal, for example, so that if one party elects not to take advantage of an opportunity—such as acquiring another physician group or developing certain ancillary services—the other is not prohibited from pursuing the investment. Physicians also should evaluate the effect a hospital affiliation may have on existing referral patterns.

Managed care contracting. One motive for physician-hospital affiliations is the enhanced contracting clout that the combined organization has with managed care payers. A central issue in negotiating the affiliation is whether one or both parties will be required to contract for hospital or physician services on an exclusive basis. The merits and consequences of exclusivity should be evaluated carefully. A common solution to this complex issue is to have what's called a "favored nations" provision. Under this

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CAPITAL IDEAS

A central issue in negotiating the affiliation is whether one or both parties will be required to contract for hospital or physician services on an exclusive basis.

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type of preferred contracting arrangement, the hospital and the physician group agree not to enter into any agreements with other parties under terms more favorable than those each one gets from each other.

The final terms and conditions of an affiliation will depend on the negotiating and financial strengths of the parties involved, the specific dynamics of the market, and the individual needs and objectives of the hospital and the physician group. A physician group's ability to negotiate a fair deal depends on:

- Carefully examining all strategic and financial options, goals, and challenges prior to approaching potential partners
- Engaging experienced legal and financial advisers
- Determining what items in the transaction are nonnegotiable prior to the negotiation

As hospitals become a more likely partner for physician groups, physicians should seek to be creative in structuring nontraditional physician-hospital affiliations so that such arrangements will be more successful than those of years past, when hospitals lost as much as \$100,000 per physician per year. Obviously, hospitals will not be able to withstand the financial consequences of those types of relationships in the long term. ■

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