

PHYSICIAN PRACTICE OPTIONS™

April 1997

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

Features

Strategies

Ob-gyns See Significant
Market Advantages in
Group Formation 3

Interview

New Strategies
Needed to Survive
Under Managed Care 10

Departments

Editorial

Focusing on the
Fundamentals 2

Information Systems

Electronic Medical
Records—Now or Later? 6

Current Trends

Pace of PPMC
Acquisitions
Continues Unabated 13

News and Commentary 15

UHC to Link Pay to Clinical Performance MCO Hopes to Make Physicians More Accountable, Autonomous

United HealthCare, the nation's largest managed care organization, plans to issue standardized reports on physicians' clinical performance beginning this fall, says Lee Newcomer, MD, United's chief medical officer. The reports will be based on clinical measures, and not on the more traditional production standards, such as the number of patients referred for specialty care. The performance standards eventually will be used to determine bonus payments, says Newcomer, a member of the advisory board of *Physician Practice Options*.

The move marks a significant shift in the relationship between physicians and managed care organizations by changing how the performance of physicians is measured and reported, according to Newcomer and others. Most managed care organizations (MCOs) gather performance data at the health plan level. The MCO is insulated from the work physicians do because most HMOs are network-model health plans that contract with many different physician groups, and each physician group has its own procedures and protocols. As a result, most MCOs do not measure physician performance directly.

MCOs may determine, for example, how many of a health plan's female patients have had mammograms. But few—if any—measure how many of an individual physician's female patients have had mammograms.

"We believe we are the first managed care organization to do serious measurements on clinical performance and to issue individual clinical reports relating those measurements to network doctors," Newcomer says. "Our

measurement of performance is based on delivery of the right treatment in the right place at the right time. Such measures will place a professional emphasis on quality, rather than cost. We believe all physicians eventually are going to be paid by managed care organizations for clinical performance and results, rather than production."

Performance measures delivered at the doctors' level can be a highly effective tool for improving the quality of health care, says Martin Merry, MD, an associate professor of health care management and policy at the University of New Hampshire and a health care quality management

(Continued on page 7)

Table: Largest Managed Care Organizations

(By enrollment in millions)

	Membership
United HealthCare	4.7
Cigna	4.4
Aetna-U.S. Healthcare	4.1
PacifiCare	4.0
Health Systems International	3.5
Wellpoint	3.4
Humana	3.0
Oxford Health Plans	1.7
Physician Corp. of America	1.0
Healthsource	0.9

Source: Sanford C. Bernstein & Co., New York.

Focusing on the Fundamentals

A California physician on the board of a local hospital called us recently to ask about the issues surrounding provider-sponsored networks. His hospital, he said, was developing a provider-sponsored organization (PSO) to contract directly with employers. "The HMOs don't like it, and the more I read about this, the more confused I get. Can you help me sort it out?"

His confusion is understandable. The fundamentals of market-driven health care are much different than they were just 10 years ago. Today, the health care market can be divided into four camps, and at least the first three are positioning themselves for more clout:

1. Health care purchasers, which include large and small employers, and federal and state governments. As they become more knowledgeable about managed care, these buyers are forming group purchasing organizations to negotiate with managed care organizations.
2. Third-party insurers, including HMOs, PPOs, and point-of-service plans. Large health plans are merging with and buying other plans so that when bargaining with employers, they have more clout.
3. Provider groups, such as physicians, hospitals, pharmaceutical companies, subacute care facilities, and home care companies. Many providers are forming alliances with other providers, again, for a negotiating advantage.
4. Consumers.

A Power Struggle


What the California physician is describing typifies the power struggle between third parties and providers as they jockey behind buyers for the number-two position. By forming PSOs, hospitals and physicians seek to contract directly with buyers to eliminate middlemen, such as HMOs and other insurers. This emerging trend has HMOs worried, which is why they want PSOs to be treated as insurers and be required to meet the same capital and solvency requirements that they are. Many state insurance commissioners agree with the HMOs, saying that the capital and solvency requirements are in place to protect consumers if a PSO fails.

The National Association of Insurance Commissioners (NAIC) is drafting model solvency language that could be used in every state and that could be completed by year end. NAIC model rules are not binding, although federal and state regulators may use them as guides when drafting their own rules on PSO solvency.

Reaching consensus on the regulatory issue will be difficult. Facing stiff opposition from state insurance commissioners, PSOs want the federal government to issue rules that would override state regulation of PSOs. Last year, a federal bill that would have eliminated the state's role in regulating PSOs failed. Some federal regulators who support PSOs argue that they would compete with HMOs and thus help to control federal health spending.

The federal Physician Payment Review Commission, which makes recommendations on federal health care spending, said recently that federal regulation of PSOs is unnecessary because many states have been flexible in allowing PSOs to operate. Hospital groups disagree, saying the states have been inflexible.

The issue is complicated, but this much is not: PSOs should be allowed to compete with HMOs and they should have to meet solvency requirements. Those requirements need not be the ones HMOs and other insurers face, but rather requirements that account for the difference in the structure of PSOs and that are fair to consumers.



Richard L. Reece, MD
Editor-in-chief
15 Banbury Crossing
Old Saybrook CT 06475-2362

Toll-free phone: 888/457-8800
Fax: 860/395-1512
E-mail: RReece1500@AOL.Com

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

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

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

Nathan Kaufman
President
The Kaufman Group
Physician and Hospital Consultants
San Diego, CA

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

Peter Kongstvedt, MD
Partner
Ernst & Young
Washington, DC

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

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

James B. Nuckolls, MD
Chief Executive Officer
Blue Ridge Primary Care
Galax, VA

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

Bernard Rineberg, MD
Physician Consultant
BAR Health Strategies
New Brunswick, NJ

Carl Schramm
President
Greenspring Advisors, Inc.
Towson, MD

Jacque Sokolov, MD
Chairman of the Board
Coastal Physicians Group, Inc.
Los Angeles, CA

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

Physician Practice Options is published 12 times annually by Premier Healthcare Resource, Inc., Chatham, NJ

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

Publisher
Premier Healthcare Resource, Inc.
888/457-8800
E-mail: PHRinfo@aol.com
Publishing Address: Premier Healthcare Resource, Inc.
49 Van Doren Avenue
Chatham, NJ 07928

Editor
Joseph Burns
508/495-0246
E-mail: JoeBurns@CapeCod.Net

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

Ob-gyns See Significant Market Advantages in Group Formation

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

Unlike most medical specialties, which are struggling to adjust to new demands under managed care, ob-gyns are finding opportunities abound. In particular, the nation's 28,700 obstetricians and gynecologists are finding favorable fiscal and professional opportunities by forming ob-gyn groups without walls, management service organizations (MSOs), independent practice associations, large integrated groups, and single-specialty physician practice management companies. (See Table: Defining Practice Options.)

"We see unique opportunities in ob-gyn," says G. William Bates, MD, an obstetrician and executive vice president and chief medical officer of PrincipalCare Inc., in Brentwood, Tenn., a physician practice management company (PPMC) serving ob-gyns exclusively. "Although many specialties are finding it difficult to sustain themselves because of a physician surplus, there is actually a shortage of roughly 6,500 ob-gyn physicians nationwide."

A 1996 survey by the Sachs Group, a health care marketing and consulting company in Evanston, Ill., showed that by 2000 the number of ob-gyns will fall 22% short of the total number needed, and the number of primary care physicians will have a similar demand shortfall. (See Table: Physician Supply and Demand.) Because managed care companies have an increasing demand for primary care physicians, that gap between the number of physicians needed and the number available is not expected to narrow significantly over the next several years.

In addition to experiencing strong market demand, ob-gyns as specialists are building business by offering new services. "Obstetricians and gynecologists are learning to be less procedural and practice more preventive health care," says William LaHew, MD, an obstetrician in Norfolk, Va. LaHew recently led an effort to organize 11 ob-gyn groups in Norfolk into a 52-member physician group named Women's Health Centers. "We are extending our thinking

beyond treatment of the uterus, which is reflected in an expanded understanding of the woman as the heart of the family and as the one who makes health care decisions for herself, her husband, and her children." Among the services LaHew's groups offer are mammograms, educational health pro-

For comparison, the AMA reports that the median income for general and family practice physicians was \$117,000 in 1995.

As a result of their income, ob-gyns are attractive to companies whose management fees are based on a percentage of revenue. As a rule of thumb, Bates says,

Table: Physician Supply and Demand

Expected demand assumes all Americans enrolled in HMOs

	1995	2000	Shortfall or Surplus
Primary care	152,000	186,000	-22.4% (-34,000)
Ob-gyn	28,700	35,000	-22.0% (-6,300)
Other specialists	193,650	156,300	+19.3% (+37,350)
U.S. Total	374,350	377,300	+0.8% (+2,950)

NOTES:

All figures include nonfederal, direct patient care physicians.

Primary care includes internal medicine, pediatrics, and general and family practice. Radiologists, pathologists, and anesthesiologists are excluded from this analysis.

Source: The Sachs Group, Evanston, Ill.

grams tailored specifically to women, and osteoporosis treatment.

Ob-gyn groups are well positioned to thrive in a capitated managed care market, Bates says. Ob-gyn practices are an attractive nucleus for the formation of multispecialty PPMCs because of the relative ease of capitating their fees for a limited number of well-defined procedures. Ob-gyn physicians often help bring pediatricians into the groups because they have well-established relationships with them. In addition, they can easily add preventive health procedures, such as mammography services and wellness programs, that offer a potential for ancillary revenue.

PPMCs See an Opportunity

PPMCs find ob-gyns attractive because they have high earning power and are primary-care oriented, and because women generally make health care decisions for their families, says Bates. The American Medical Association says the median income of ob-gyn physicians is \$222,000.

PPMCs consider the average gross income of an ob-gyn physician to be \$500,000, of which about half is the average take-home pay. In addition, ob-gyn procedures account for 20% to 40% of a community hospital's annual revenue.

Bates believes PPMCs also can neutralize "the divide-and-conquer tactics of insurance companies." PPMCs allow physicians to negotiate as a group, while insurers prefer that physicians practice individually or in small groups in order to contract with them separately and exclude those who may charge more than others. A PPMC also can relieve physicians of the worries of running a small business.

At least six publicly traded multispecialty PPMCs are actively acquiring or partnering with ob-gyn practices, according to Brooks O'Neil, managing director of Piper Jaffray, investment bankers, in Minneapolis. They include PhyCor, in Nashville, Tenn.; Medical Asset Management Inc., in Mesa, Ariz.; MedPartners, in Birmingham, Ala.;

(Continued on page 4)

Table: Defining Practice Options

Group without walls	A single legal identity whose members continue to practice in individual offices.
Management services organization (MSO)	A form of integrated delivery system that serves as a service bureau for doctors' offices or purchases the hard assets of practices and provides management services to help physicians contract more effectively with managed care organizations.
Independent practice association (IPA)	A physician organization that contracts with managed care plans to deliver services in return for a single capitation rate. The IPA in turn contracts with individual providers to deliver care on a capitated or fee-for-service basis.
Large integrated group	A group of physicians who practice in one legal entity, have a single governance structure, and who sign contracts under a single signature, in which one person's signature represents all physicians. A large group generally has 10 or more physicians.
Single-specialty physician practice management company (PPMC)	A practice management company whose member physicians and groups practice in a single medical specialty.

Source: Peter R. Kongstvedt, *The Managed Health Care Handbook*, Aspen Publishers, Gaithersburg, Md. (3rd ed., 1996).

(Continued from page 3)

Medisphere Corp., in Birmingham, Ala.; PhyMatrix, in West Palm Beach, Fla.; and Complete Management Inc., in New York.

Two Approaches

At least one privately held PPMC, HealthCap, in San Diego, also is acquiring ob-gyn practices. HealthCap President C. Michael Wright, MD, says his company develops multispecialty groups that compete against HMOs and hospital-based integrated delivery systems, such as the Henry Ford Health System in Detroit, Sentara Health System in Norfolk, Va., and Sharp HealthCare in San Diego. The company has more than 800 primary care physicians and specialists in California and Georgia and provides care for more than 250,000 individuals.

Spectrascan Inc., in Windsor, Conn., has developed another approach. It sells and manages imaging equipment for some 500 ob-gyn practices and owns women's health clinics in California, Connecticut, Georgia, and Maryland. It seeks to establish a business partnership with physicians who wish to remain independent and helps them develop an MSO in which they retain equity while Spectrascan manages their ancillary services, such as mammograms, PAP smears, ultrasound, and X-rays.

As yet, there are no publicly traded single-specialty obstetrical and gynecology companies. A number of companies are preparing to sell stock, however, and are

focusing entirely on ob-gyn and women's health issues. In addition to PrincipalCare, they include Amerigyn Inc., Symmetry Health Partners, and WJH Healthcare, all in Nashville, Tenn.; US Medical Alliance, Egg Harbor Township, N.J.; and Women's Health Partners, Brentwood, Tenn.

PrincipalCare is organizing groups of obstetricians in key markets by looking closely at markets of 400,000 to 1.5 million lives. "Our strategy," says Bates, "is to form a partnership with a minimum of 20% of the obstetricians in those areas, and to go for the top 20% based on educational background, community reputation, and the result of our own due diligence research into individual practice methods. We will go to 35%, but our initial target is 20%. That's how we qualify physicians and that's how we determine our markets."

PrincipalCare will either buy a physician's practice outright or offer a combination of cash and equity in the PrincipalCare group. Since every group operates under PrincipalCare's provider number, the PPMC removes all back-office functions, such as billing and collection.

"Ob-gyn physicians have been very receptive to our concept," Bates says. "They are beginning to see that as individual practitioners, they have limited leverage in the marketplace, and to have leverage they need a company with an infrastructure that can negotiate on their behalf. They realize that they need a managing partner to help them manage their practices."

A Word of Caution

Not everyone views these entrepreneurial and consolidation activities with enthusiasm. Larry Griffin, MD, director of program services for the American College of Obstetrics and Gynecology, in Washington, D.C., has adopted a wait-and-see attitude. "The good PPMCs say they will increase the doctor's profitability, and the bad PPMCs merely say they will decrease the losses. So I tell our ob-gyn members to ask the PPMCs if they plan to put in more than they take out. That's the true measure of performance."

Also, putting physician practices together may be more difficult than it seems, Griffin says. "Every practice has its own practice style, its own leaders, its own favorite employees, and its own favorite interior decorating style," he comments. "These differences can destroy mergers. Individualism always creeps back in, and it takes a strong leader to beat it back."

Bates agrees that physicians' practices need strong physician leadership. Also, Bates believes ob-gyns can meet patients' needs while also taking advantage of opportunities in the market. "Because of the surplus of physicians in a number of fields," he says, "there is going to be increased competition among physicians; some will be underemployed, some perhaps even unemployed. But I see some wonderful opportunities for many parties, including academic institutions that may want to affiliate with companies such as ours, as well as joint-venture opportunities. I think I'm going to be having a lot of fun for the next decade." ■

Case Study: Ob-gyns Form a Group Practice Without Walls

Richard Ruben, MD, an obstetrician in an eight-member group named Physicians for Women, in Danbury, Conn., is heading a statewide effort to form a large group without walls, tentatively named Women's Health Services (WHS). WHS currently has 177 ob-gyn physicians in 43 groups. That represents 20% of all the ob-gyns in Connecticut and about 40% of ob-gyn health care delivered in the state.

Working with two other ob-gyns, James Xenophon, MD, and Kevin Mitchell, MD, both of Candlewood Ob-gyn Associates, in Danbury, Ruben began forming WHS last year by convening a meeting of 27 ob-gyns. Over several months, in 24 meetings totaling more than 100 hours, the group set goals, developed articles of governance, and began seeking financial partners to provide the capital necessary for the staffing and information systems required for management services, such as billing, quality assurance, and utilization review.

Ruben hopes to have WHS, under a still undetermined new name, in operation this summer. Physicians will be able to invest in the group, and those who invest can either leave their current practices and participate as contractors or continue working in their own practices and simply buy management services from the group. Also, physicians who chose not to invest can remain in their own practices and affiliate with the group as any member of an independent practice association would do.

In addition, the group will serve as a single contracting agency with payers and hospitals, often on a capitated, or risk-sharing, basis. Ruben and colleagues have divided the state into 14 divisions, each having a professional services relationship with a single local hospital. This divisional structure affords WHS the market clout of a large physician group, and it uses that clout to negotiate a statewide rate with individual payers, such as managed care organizations. WHS will pay its members within their divisions, at a rate that reflects the number of patients served and the regional differences in costs.

"We believe this will be a tremendous opportunity for the state's ob-gyns," Ruben says. "It will serve to control costs more effectively through centralization of management services, while offering the financial opportunity to expand services." Those expanded services could include mammography, osteoporosis screening, cytology screening, infertility evaluations, exercise, educational, and women's wellness programs.

WHS is continuing to seek a capital partner to raise the money needed to pay lawyers, auditors, and marketing and management costs. The group's search has been met with strong interest from several investors, Ruben says.

"Our purpose is simple," Ruben concludes. "We want to maintain our ability to practice good medicine, to establish standards, and to capture the managed care initiative." ■

SPECIAL INVITATION TO SUBSCRIBE TO PHYSICIAN PRACTICE OPTIONS™

A one-year subscription to **Physician Practice Options**, (12 issues) regularly \$220, is being offered for a limited time at \$110. **A savings of 50%** off the regular subscription price.

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

Name _____

Address _____

City _____ State ____ Zip _____

Medical specialty _____

Please send check for \$110 payable to:
Premier Healthcare Resource, Inc.

6 Old Mine Drift Road

Chester, NJ 07930

Attn: Alex Davidson

or

To order, call toll free: 888/457-8800

Fax orders: 908/879-0776

Act now, to begin your 1997 subscription and get the information you need to succeed in health care. Our editorial focuses on:

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



Electronic Medical Records— Now or Later?

By Carl J. Schramm

Any discussion about the future of medicine inevitably leads to the subject of electronic medical records (EMRs). Professional newsletters and journals are swirling with stories about EMRs and how “smart” hospitals and clinics have already installed systems to produce and manage such records. These stories are often peppered with examples of doctors who thrive in the new world of electronically supplied patient information.

Take the example of a diligent practitioner who, on an airplane headed back from Europe, calls up his patients’ records to prepare for the next day’s office visits. The fact is, however, that most physicians neither practice with an electronic record nor know colleagues who do. This discrepancy between what we read is supposed to be hap-

pening and what we see is actually happening merits further consideration.

Speed and Power

The technology to use EMRs has been available for many years. LDS Hospital in Salt Lake City, which has been a paperless hospital for more than 10 years, is a case in point. It has dedicated computers, uses tandem processing, and nurtures an environment in which doctors and nurses are required to keep records on the computer. But not many other hospitals are following LDS’s lead. Why?

There are many possible answers to this question. Doctors don’t like computers. Doctors don’t like typing. Doctors prefer to use dictaphones. Doctors don’t trust computers when it comes to safeguarding their patients’ privacy. One line of reasoning even suggests that doctors have resisted using EMR technology because they think it will lead to the housing of patient records in a centralized bank in Washington.

The real answer to the question of why EMRs aren’t more widespread involves the economics of record keeping and the absence of a clinical need for them. First, these systems are simply too expensive for hospitals and doctors alike. The typical system vendor charges anywhere from \$10 million to \$30 million to rewire a hospital and to populate it with terminals—a hefty sum for even the most profitable hospital. Doctors in office settings also can’t afford the tens of thousands of dollars required to set up an electronic record system. What’s more, EMR systems fail as a money-saving tool. Yes, they do displace paper, but paper is cheap and EMRs are expensive. Second, the argument that having instant access to a complete medical record is important—the principal reason EMR advocates suggest that an EMR environment is inevitable—just doesn’t hold water because physicians seldom need or use a full historical record for each patient.

As a consultant to venture capitalists seeking to support a winning EMR strategy and to hospitals and clinical groups faced with

technology purchasing decisions, I am struck by what appears to be a world populated by physician-entrepreneurs who claim to have personally developed the last word in patient record software. In fact, it’s easy to be driven to distraction in a market brimming with companies claiming to be the best providers of EMR systems and with physicians trying to develop EMR companies.

For now, choosing the right system in such a world is almost a betting game, and the dilemma is whether to bet on a generic patient record that suits all practice environments or on a specific record that is being adopted for limited uses in specialty practice. My bet is on the specific record. Companies such as Summit and LifeRate, both in Minneapolis, do outcomes analysis of patients in various specialties. These vendors have imposed a uniform data set in similar practices across the country in an effort to develop the highest common level of data needed to impose practice norms and other clinical processes that will improve outcomes. Thus, one could argue that we can find a good EMR technology in cardiology, eye care, orthopedics, and ob-gyn, but not much in other specialties.

Fixtures of the Past?

So, whether file cabinets in doctors’ offices will become fixtures of the past, like fluoroscopes, depends. On what? First, if capitation forces a much higher real time sense of resource control on physicians, the presence of a computer-assisted encounter will become critical. Second, as the next generation of doctors emerges, the likelihood that they will insist on using the computer as a practice tool will grow since so many have honed computer skills in college and are much more familiar with the language than any of their predecessors. Third, when data standards emerge that are universal for all practice sites, the cost of innovation and development will drop radically, consolidation will occur, and standard EMR products will become omnipresent. Until then, expect more dictating and bad handwriting.



Carl J. Schramm is president of Greenspring Advisors Inc., a business development firm in Towson, Md., that specializes in health care information systems. Its clients include physician practices, insurers, pharmaceutical

companies, Blue Cross plans, and venture capital funds. From 1993 to 1995, Schramm served as executive vice president of Fortis Inc., in Milwaukee, an insurance and financial services company. From 1987 to 1992, Schramm was president of the Health Insurance Association of America, in Washington, D.C., a trade association of commercial health underwriters. Before joining the insurance industry, Schramm taught health policy and management at Johns Hopkins University, in Baltimore, from 1972 to 1987. In 1980, he founded the Center for Hospital Finance and Management at Hopkins. In 1985, Schramm organized HCIA Inc., a health care data services company in Baltimore. A member of the Advisory Board of Physician Practice Options, Schramm has a law degree from Georgetown University and a doctorate in economics from the University of Wisconsin.

PRODUCT REVIEW

Certitude Inc.
Bethesda, Md.
Lisa Kolker Max at
301/654-8999

As capitation continues to displace indemnity payment, more and more physicians will need to assess contract proposals from insurers, Blue plans, and other managed care organizations. In doing so, they must ask: Does the economics of the proposed capitation deal make sense and who will make money under its terms. Unfortunately, most doctors, clinic managers, and hospital administrators are in the dark when it comes to evaluating contract proposals that are becoming increasingly more complex and innovative.

Certitude Inc. has developed user-friendly software to help doctors and clinic managers make decisions about capitation contracts. Working with Reden & Anders, an actuarial consulting firm in Minneapolis, Certitude has two products to help physicians assess contract proposals: Capitation Calculator for specialists who are solo practitioners, and Managed Care Expert for multispecialty clinics. Because these products were designed by Jonathan Javitt, MD, an ophthalmologist and epidemiologist who has been working with the federal Health Care Financing Administration for several years, they are particularly well fashioned for physicians seeking to understand how capitation contract price regimens will affect their practice decisions on a daily basis.

Like many companies in health information, Certitude is a young enterprise. With sales of over \$2 million in 1996, it anticipates as many as 300 new provider installations this year. ■

(Continued from page 1)

consultant in Exeter, N.H.

"The more systematic clinical information physicians have, the more they are empowered to practice high-quality medicine," says Merry. "I am unequivocally in favor of physicians having this type of information, and most physicians do not have the kind of internal information systems necessary to monitor the type of data UHC is planning to provide," Merry says. "I am not aware of any other MCO providing that kind of data at the doctors' level."

Physician Autonomy

Moving performance measures away from production issues and toward clinical data creates physician autonomy, Newcomer says. "We will set clinical goals based on our research, and if doctors meet those performance standards, how they get there will be their business," he says. "We're not into micromanagement. They won't have to call

for permission to do procedures or make referrals if they show compliance with our clinical performance measures."

The clinical measures UHC will report to its physicians this fall will reflect service delivery protocols and procedures, such as the number of mammograms for women and of blood tests for diabetics patients. UHC believes that if used sufficiently and appropriately, these performance measures will lower overall medical costs and improve the health of individual patients.

"We have always measured physician performance, collected data, and shared that data with our individual health plans," Newcomer says. "And our plans have used that data for quality improvement throughout their networks. But now we are going to take that data and tell our individual physicians what they can be doing to improve the quality of their individual medical care."

UHC's performance reports will begin with

(Continued on page 8)

Solving Problems May Require One-on-One Meetings

Once a problem is identified under United HealthCare's physician profiling system, the only effective way to address it is to have a health plan's medical director speak directly with the physician involved, says Lee Newcomer, MD, United's chief medical officer. The health plan's medical director may find the problem is not what it seemed at first, he says.

"We have an extremely good profiling system on physicians and a mature physician network that's committed to improving the quality and cost of care they're delivering," Newcomer explains. "The profiling capabilities are absolutely essential. You have to have the data that tell you what and where the problems are in a quick fashion so you can go there and share that data with physicians and hospitals."

But even the best systems cannot identify all problems correctly. "Two years ago, we had an obstetrician who, on profiling, had a 100% Cesarean section rate on 36 patients," says Newcomer. "That obviously caught our attention. After all, we're trying to lower our average C-section rate to 18%. In any event, we went

out and talked to him. We discovered that he was in a group of seven family practitioners who did their own vaginal deliveries. The obstetrician was called in only when the case needed a C-section. So we went back and recalculated his rate. We discussed it further and the rate dropped."

Other times, a health plan medical director may have to work with more than one physician, Newcomer says. "Sometimes, we have to re-educate the whole physician network," he says. "We discovered in Columbus, Ohio, that our network had performed 6,000 tine tests [a form of skin test for tuberculosis] on children. A year earlier, the American Academy of Pediatrics had said the tine test was worthless and that the PPD test, another form of skin test, was an appropriate replacement." Without effective screening, United HealthCare would not have been aware that an ineffective test was being performed. After being informed of the academy's recommendations, the health plan changed its TB screening protocol. ■

(Continued from page 7)

about 18 clinical measures, relevant to physician specialties. An individual physician in UHC's network of contracted physicians may receive a report on, for example, the number of mammograms ordered for his female patients between the ages of 50 and 74. The report will list the names of individual patients covered by UHC who have not received mammograms and urge the physicians to encourage their patients to have this diagnostic test.

UHC's research over the last six years has demonstrated that the national average mammography rate is about 40%. Since mammograms have been shown to be effective in reducing breast cancer mortality

rates, UHC wants its network physicians to refer 80% to 90% of female patients aged 50 to 74 for annual mammograms. Physicians who meet target goals will be rewarded with bonus payments, and those who do not will be encouraged to meet UHC's standard.

Data should be used as a tool to improve performance, not as a punitive or sanctioning weapon, Newcomer says. "Our philosophy is that physicians need the data in order to know what to do and how to improve it. We do not plan to use penalties if physicians fail to meet these measures. The only physician we will sanction is the one who says, 'So what? I don't care.'"

Also, UHC has not yet determined how

a bonus system will work. "We do hope to have a bonus system for compliance in place sometime next year," Newcomer says. "In two or three of our plans, we have already been experimenting with bonus payment systems. We want to make sure our measures are good, then we'll limit our bonuses to clinical performance. For example, we're developing report cards for six specialties. We want to know how well they are doing clinical measurements in their practices. Of all the patients they have on diuretics, how many of those patients get their potassium levels checked once a year? The number turns out to be about 35% around the country. We think that number

Specialist Referrals Several Health Plans Are Lifting Restrictions

Several managed care organizations and health plans are offering programs that allow patients access to specialists without a referral from a primary care physician. Two of the largest such groups to do so are United HealthCare, in Minneapolis, the nation's largest MCO, and Blue Shield of California, in San Francisco.

United HealthCare (UHC) has been using the "open access model" since 1982. "If we can measure and reward the best specialists, why have gatekeepers?" asks Lee Newcomer, MD, UHC's chief medical officer. Besides, he notes, keeping patients away from specialists has been overblown as a problem, since about 80% of all patients visit a family practitioner before seeing a specialist anyway.

The key to managing physicians successfully, Newcomer says, is not by micro-managing with gatekeepers, but by developing systems that allow plans to collect data on specialists' performance. Once a physician has been added to a health plan's roster, the plan should collect data on performance and report those results to physicians. Good information corrects most bad behavior, Newcomer says.

Even HMOs that require referrals from primary care physicians for specialist care are simplifying the process. Rather than forcing patients to see a primary care physician, a number of plans let members

get approval by telephone, often using nurses to review the appropriateness of referrals.

Simplifying Procedures

The shift toward more direct access to specialists is in response to a number of market pressures. Today's sophisticated consumers are intelligent enough to know when they need a specialist and do not want the hassle of needing to see a primary care physician for referral. In a survey of 85,000 health plan members last year, 30% of those who responded said they were not satisfied with their HMO's current referral process, according to the Sachs Group, a health care marketing and consulting company in Evanston, Ill. In New York and Los Angeles, some 40% of respondents were dissatisfied with the process; in Chicago, the proportion was 50%.

Increased competition among health plans seeking to expand into new markets is also contributing to differentiated offerings. Kaiser Permanente, a large managed care organization in Oakland, Calif., permits direct access to specialists for allergies, certain vision problems, and drug and alcohol problems. In some regions, it allows direct access to specialists for sports medicine, dermatology, and podiatry.

Health plans also find it easier to convert fee-for-service customers to managed care plans that offer direct access to specialists

because these plans are more similar to fee-for-service than are managed care plans that are managed more tightly.

J. Daniel Beckham, a hospital and physician consultant in Whitefish Bay, Wis., says that in a number of markets, such as Charlotte, N.C., and Indianapolis, there are not enough PCPs to handle primary care and specialty referrals. In addition, the number of PCPs nationwide is expected to fall short of the demand by more than 20% by 2000. The only choice for ambitious plans bent on growth is to refer directly to specialists.

In some markets where managed care dominates, such as Seattle, health plans are shifting patients to provider teams. These teams may include nurses who use clinical algorithms to determine the appropriate level of care and who refer patients to disease management specialists or to physicians dedicated to handling only the most ill patients.

Francine R. Gaillour, MD, medical director for Phamis Inc., in Seattle, writing in the December 1996 issue of the *Group Practice Journal*, Alexandria, Va., said that as health plans use more sophisticated information systems, they can make direct referrals to the proper specialist more easily and that workers and other patients are increasingly intolerant of cuts in benefits. Reduced choices for specialists and delays in getting to specialists are perceived as cuts in benefits.

Several large health insurers, including

ought to be about 80%. The future bonus will depend on the physician hitting a threshold number for good quality care.”

Avoiding compliance penalties and developing a bonus system are positive steps, Merry comments. “There is, historically, an adversarial relationship between doctors and third-party payers, such as MCOs,” Merry says. “The information physicians receive from MCOs is often perceived as working against them, as a means of controlling how they treat their patients or of determining whether they comply with certain standards. The bonus incentives are certainly the approach I’d advise for encouraging compliance with performance measures.”

those run by the Prudential Insurance Co. of America, Aetna-U.S. Healthcare, and Health Systems International, are considering offering HMOs without restrictions on visits to specialists, according to an article in the *The New York Times* on Feb. 2.

The most recent report from Foster Higgins, benefits consultants in New York, shows that employers favor plans that allow direct access to specialists. Enrollment in point-of-service plans, which allow patients to seek care in network or go out of network, usually for a fee, to a specialist or to another PCP, grew from 14% in 1995 to 19% in 1996, Foster Higgins said. In the Northeast, enrollment in POS plans rose from 23% to 38%.

United HealthCare has had a direct access program since its inception, says Newcomer. “The idea is that patients can access any physician who’s contracted with us without having to go through a gatekeeper or any ‘other barrier,’ he explains. “To make it work, you need two things: an extremely good profiling system on physicians and a mature physician network that’s committed to improving the quality and cost of care the physicians are delivering. The profiling capabilities are absolutely essential. You have to have the data that tell you what and where the problems are in a quick fashion so you can go there and share that data with physicians and hospitals.” ■

Determining Effectiveness

To identify which performance measures should be used to determine clinical standards, UHC gathered a panel of its network physicians last year. They determined

“Physicians should be saying, ‘Okay, we’re going to measure how we do, and then we’re going to improve that performance if it isn’t good.’ ”

which procedures, such as mammograms, were effective and which, such as tine tests (a skin test used to detect tuberculosis) were not. “We started with approximately 60 measures, and then ranked them,” Newcomer explains. “More than anything else, we wanted to come up with quality measurements that are relevant to doctors’ everyday practice.

“We don’t measure physicians on things where there’s too much controversy about the science,” he says. “We don’t stop a physician, for example, from ordering a mammogram for women between age 40 and age 50 because there are times when it’s appropriate, and the literature there is controversial. We’re measuring physicians only on their mammography rate for women 50 to 74 where the evidence is pretty solid. I think that’s important. As you do physician performance measurement, you have to distinguish between what is hard science and simple opinion. Then what we’re measuring for is variation.”

UHC wants its physicians to think in terms of patient populations, not just individual patients. When Newcomer was a practicing oncologist, he measured his own performance in terms of the number of patients who died, for example, of Hodgkin’s disease. “Physicians tend to judge their performance based on very, very subjective measures,” he explains. “What do my peers think of me? Have I had a disaster case in the last five years? The point I’m trying to make is that I thought in terms of individual failure, but I had no idea what my overall survival rate for Hodgkin’s disease was. I needed objective, not subjective, measures.”

As professionals, physicians are not being accountable for their performance, Newcomer says. “Physicians should be saying, ‘Okay, we’re going to measure how we

do, and then we’re going to improve that performance if it isn’t good.’ ”

Newcomer offers an example. “We’ve now measured hypertensive patients on diuretics as therapy just to see if they’ve had

their potassium checked in the last year,” he says. “If two-thirds of the patients on diuretics have not had their potassium checked for more than a year, that’s mediocre medicine. That’s the only way we could describe that. I don’t think it’s because we’ve got bad doctors. I think it’s because doctors have never measured that particular performance item. They don’t have a way to track it in their charts and they don’t have a way to identify patients on diuretics who don’t come in once a year for a checkup or for an evaluation. But if they were picking something and measuring it, they’d discover the problem and then figure out a way to solve it. Medicine hasn’t taken on that responsibility. American medicine can become much more efficient.”

Another way that UHC can measure physician performance is through prescribing patterns. “The pharmacy data base is linked with our physician office charges and also the hospital data base,” Newcomer says. “It’s a critical piece because we find that almost all of our measures involve pharmacy in some ways. We identify diabetics by their prescription. We can very accurately track our diabetic population through the pharmaceutical data base. We glean much of our information from the bills submitted to us. We know the patients’ names, their physicians, the drugs they’re receiving, what their hospital and office charges are.”

Through appropriate use of such data, Newcomer feels that health plans no longer need to rely on gatekeepers to reduce costs. Plans can emphasize quality, not just costs. They can also pay physicians based on performance, rather than on production. Given the data on quality measurement, outcomes, and patient satisfaction, all physicians—primary care and specialists alike—can monitor their own practices. ■

New Strategies Needed to Survive Under Managed Care



Richard Liliedahl, MD, has been a health care management consultant with Milliman & Robertson since 1994. Prior to joining M&R, he served as medical director for two HMOs, Group Health Cooperative of Puget Sound and FHP

Inc. Also, he served as a family practice physician for 18 years. A member of the Advisory Board of Physician Practice Options, Liliedahl has extensive experience in helping physician groups to work in managed care settings by establishing quality management and effective utilization management procedures. In addition, he has developed and negotiated capitation contracts that include practice guidelines. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Part one of two parts

Q. Let's begin with a brief discussion of the work your company does. Can you tell us what M&R is noted for?

A. There are two significant areas in which we work. First, we produce health care cost guidelines, which are actuarial costs and charges down to a three-digit Zip Code for communities back to 1954. Based on the data we have, for example, we can tell you what the statistical likelihood is for you in your community to have a prostatectomy this year and what the likely charges would be for that procedure. With that kind of information, which is updated yearly, M&R can make risk management, rate-setting, and capitation work for managed care companies and other providers across the country.

Second, M&R is known for its health care management guidelines, which are care paths for providers. The M&R guidelines, specifically the in-patient ones, are used widely across the country for the care of approximately 40 million patients. The guidelines include information on how long a patient should remain in the hospital for a given condition and are often used by

HMOs and other managed care companies in their utilization review and cost-containment efforts.

We have also developed guidelines for home health, primary and pharmaceutical care, recovery facilities, and workers' compensation.

Q. So, if I'm in a group practice anywhere in the United States, and I receive a capitated contract, and I don't know if I'm likely to lose my shirt on the capitation rates, I could call Milliman & Robertson, and you could tell me if the contract makes economic sense for my region of the country, for my specific city, and even for my Zip Code.

A. Yes, absolutely, in fact one of my primary personal interests is figuring out how to help physicians survive in this turmoil of managed care today. I find that physicians often accept any contract from the latest managed care plan. The physicians believe they must accept all comers if they are to stay in business.

Consequently, physicians often do things they wish they hadn't. They may go for

arial work so that everything we do is clinically sound and actuarially sound. So, if we're working on a capitation contract or helping doctors figure one out, we make sure that they can provide the clinical care and services under the contract.

Q. At what pace is capitation spreading? Is it all over the country? Is it spotty? Is it greater on the West Coast?

A. Capitation differs in various regions of the country, and it's obviously market specific and community specific. Also, there's much more of it on the West Coast. You'll even find in certain communities, such as a large city in Indiana, which is not necessarily a mature market, that most specialists are already capitated there. Every community is unique in its market structure, and, since we have a vast catalog of capitation data from all parts of the country, we can tell you what's happening in each of these markets.

Q. If you, as a consultant were addressing an audience of mostly practicing physicians in fee for service, what would be your

"Physicians often do things they wish they hadn't. They may go for years under capitation before they find out they're not making any money."

years under capitation before they find out they're not making any money. We work with them to help them figure out what rates they can afford and what kinds of utilization management and clinic systems they need. We want them to succeed under managed care.

Q. Can you also provide physicians with clinical and hospital guidelines? Is it true that M&R has a storehouse of cost information that it's been accumulating for 40 years or so?

A. The health care management guidelines have been around only since 1984, but we've studied costs since 1954. The other thing I didn't say is that we combine our clinical information with the actu-

advice on how they should move their practices to a future of managed care?

A. First, they would need to get someone who has been there, and who can tell them what needs to be done. They need to have someone from some outside source help them to understand what managed care looks like and how markets are changing. They need to understand that it's going to happen in their community. They need to talk through the issues, which include reimbursement, changing practice structure, and acquiring the new skills they will need to succeed under managed care.

They also need to learn about capitation. Specifically, they need to learn about uti-

“Many physicians won’t change until managed care hits them in the face or hits their pocketbook. So they can hear what people say a thousand times, but until physicians understand managed care by experience, they don’t change the way they do things.”

lization management so that they can manage the service units once they’re capitated. Sooner or later they will have to function under capitation, or some global budget, whatever it is. We find it very helpful to take real-life clinical examples from the doctors’ own environment and show them how they could have managed those cases more effectively or efficiently. It all comes down to good management of patient care.

Many physicians won’t change until managed care hits them in the face or hits their pocketbook. So they can hear what people say a thousand times, but until physicians understand managed care by experience, they don’t change the way they do things.

Q. *Yet many physicians still maintain a reactive rather than a proactive stance toward managed care.*

A. Yes, absolutely. Some physicians will remain reactive until they go out of business. Out here on the West Coast, they end up out of a job and look to relocate somewhere else in the country. That’s happened to many specialists in California, and that certainly happened in the Seattle community. Under the theory that there are five market stages of managed care, this community is in a stage-three marketplace. It’s not yet the most mature market in the country. There’s physician excess and hospital excess here to the extent that primary care doctors, such as good family practitioners or pediatricians, can’t get a job. So some of the established people are going to hold on or hold out until it’s too late for them, even though they have been in

business for a long time.

Q. *That brings to mind what some people call the three Rs of managed care for physicians. If you’re a physician operating under managed care, you have three choices: You can reengineer, relocate, or retire. And, if you’re going to stay in the community, you’d better reengineer.*

A. That’s sad but true, and, from a personal point of view, I feel rotten about it. As a physician at heart, I feel sad about it because many of these people are dedicated professionals who have invested huge amounts of time to become good physicians and who simply wanted to be good doctors and take care of people. Unfortunately, medicine’s become a big business. It’s no longer a profession, and some of these physicians don’t get it yet. They’re the ones who are going to get burned.

Q. *When you say they don’t get it, you mean that they don’t quite realize that the forces of the market are greater than the forces of physician resistance.*

A. That’s right. In general, physicians, including people like me, are slow to understand that this change in medicine is driven by the market forces within individual communities. They don’t get that we’re in a market-based business at this time in this country. If you’re a young physician, you’re going to have live with a market-driven health system for the rest of your career. If you’re 60 or older, you may be able to ride it out. I’m 51, and I’m fortunate to have a solid background and an understanding of managed care. Not all of my colleagues are so fortunate.

Q. *From the questions you hear physicians ask, can you tell us what doctors want most?*

A. The biggest pressure physicians face is how to deal with managed care. That can involve physicians in myriad ways. They may be losing business to a competitor, for example. They may have an opportunity to contract with a new managed care organization in their town and want some advice on whether to do so. They may have signed a capitated contract with someone, and now they’re trying to figure out how to provide good health care and stay in business with the amount of money they’re getting.

They know they need to get into managed care or restructure their group. Or, maybe they want to create a program, for example, that a managed care organization will buy. We had an instance in which a neurosurgery group was trying to figure out how to make its services attractive to managed care. That is an example of the kinds of requests that we get from physician groups.

Q. *Do you find the changes occurring right now dramatic and escalating?*

A. The change is exponentially explosive in most parts of the country. There are a few pockets left that are as yet untouched by managed care. There are communities in Ohio, for example, that are relatively unaffected by managed care. But each market can change quickly. I had a call recently from a company in Illinois, where there had been no managed care at all. But suddenly, because of the penetration of a couple of Medicare-risk HMOs, and the thought that the state was going to capitate all providers working with Medicaid beneficiaries, the situation had changed almost overnight.

All states are likely to move most Medicaid patients into managed care within two years. So even in isolated communities, capitation can take place dramatically and traumatically in a short time.

Q. *I heard someone say that if Medicare and Medicaid risk contracting takes off, it will result in hospitals and physicians moving*

into provider-sponsored organizations because hospitals and physicians will require a quantum leap in computer skills and systems under capitation. Do you agree with that assessment?

A. That's speculative because only 10% of the 40 million Medicare beneficiaries are currently in Medicare-risk health plans, and it's hard for me to figure out how fast that's going to change. Some observers predict that Medicare-risk plans will provide care for 50% of beneficiaries by 2000, but I'm not so sure that'll affect the integration of systems like you're talking about. Every part of the country is different. In many sections, the system and the market are driven totally by hospitals. Hospitals have all the capital, and they're still doing well. Integrated systems will continue to develop, but I'm not so sure they will create as much integration as you mentioned. I don't see instant integration happening.

The current largest growth in managed care is in IPA-model health plans because of the desire among employees and patients for local access. It's hard to understand how these small physician offices will evolve into integrated systems.

Q. *There's evidence now that the so-called vertically integrated systems are not the wave of the future. Many are becoming dysfunctional, even divorcing, and it's apparent there's no magic answer to integrating hospitals and physicians. Indeed, in some quarters, particularly in California, some observers are saying hospitals and physicians ought to be in totally different organizations, because running a hospital and running a physician group require different competencies.*

A. I've sometimes thought the same thing, but I wasn't as blunt about it. I think what should be may not be what is. We must remember the market is driving the issue in most areas of the country.

Q. *There's also mounting evidence that staff-model HMOs are in trouble.*

A. Yes, I agree. In 1990 there were 35 staff-model HMOs. Now there are 22 in the whole country. The ebbing of staff-model HMOs is real.

Q. *Who calls you for your services?*

"Unfortunately, medicine's become a big business. It's no longer a profession, and some physicians don't understand that yet. They're the ones who are going to get burned."

A. We have hospitals, we have big physician groups, small physician groups, newly formed integrated systems, and some PHOs that have come and gone already. We have new IPA networks. We have health plans that have been spun off from existing hospitals that really are small HMOs. We have huge managed care organizations, such as Kaiser, Humana, and United HealthCare.

We also work with people who sell products, such as total hip prostheses, just to take one example. We help them to create care pathways that are clinically sound, which they can then offer as a service to the hospital or the client. They're providing the total hip prostheses, too.

We will not work with all companies or organizations, however, since we need to remain at arm's length from some companies because of the material we're developing. We have written primary care and pharmacy guidelines, for example, which were published last fall. The guidelines describe the optimal way to diagnose and treat conditions that one would see in a primary care practice. They offer a point of referral that's indicated for common out-patient diagnoses. The authors who produced these guidelines within M&R have not worked with pharmaceutical companies or PBMs in order to maintain their objectivity.

Q. *Do you consult with academic medical centers?*

A. Yes, we've worked in many academic medical centers. I wouldn't say it's a primary focus, but we've done work with our actuaries to figure out how to help them create a managed care business. They don't have the revenue they had formerly. We've been involved extensively with five or six university hospital centers. I've consulted in

three or four of them myself. They have unique problems. It's hard for them to be efficient because of the teaching and research, and they can't compete economically with community hospitals.

Also, academic centers are structured by departments. As such, they're not organized to do business with managed care organizations. So when someone tries to capitate them across departments for a population, it becomes difficult for the various departments to decide where to allocate the funds. We're working with a university right now that just took on a new Medicare-risk contract. The unfortunate part is it has 30 primary care physicians and 500 specialists! The university is trying to figure out how to do managed care with that physician network. It doesn't compute.

Q. *You seem to be saying that managed care realities come as a culture shock to academic centers. Their power pyramid has always put the specialist on the top and the primary care physician on the bottom. Suddenly the pyramid is inverted, and they have a difficult time coming to grips with the psychic shock of role reversal.*

A. That's right. Academic medical centers seem to be slower than most to adapt to managed care. We can tell them many times, for example, that they need more primary care physicians, and some don't get it. Some have to fail before they understand that they need to change their structure. Even though it's hard for old established academia to deal with the primary care physician issue in some settings, we have helped some of them do so very well. ■

Next month: What physicians need to know about Milliman & Robertson's primary care practice guidelines.

Pace of PPMC Acquisitions Continues Unabated

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

The pace at which physician groups are consolidating continues to accelerate. Forty-two transactions were announced between Jan. 1 and Feb. 20, 1997. For the 12-month period ended Feb. 28, 1997, there have been 239 announced acquisitions by physician practice management companies (PPMCs), an 11% increase over calendar 1996 activity (Table 1).

The prices PPMC's pay for acquisitions as a multiple of the clinic's revenue have increased slightly over the last three years (Table 2). The higher purchase price multiples are due largely to an increase in the number of single-specialty clinic acquisitions. Single-specialty clinics produce more revenue per physician and typically generate higher profit margins than multispecialty or primary care clinics. Multispecialty-focused PPMC's have an average pre-tax margin of 4% to 5%, versus single-specialty PPMC's, which average 15% to 20%. Since acquirers typically base their valuations on earnings (versus revenue), the resulting revenue multiples for single-specialty groups are generally higher than they are for other physician groups.

At the same time, price-to-earnings multiples for most PPMC's have declined since the beginning of 1996 (Table 3). The downward trend began when many health care services companies did not meet Wall Street's earnings expectations for the second quarter last year due to increased medical utilization and drug costs. Consequently, a PPMC's stock is now a less valuable currency for making acquisitions than it has been in the past.

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

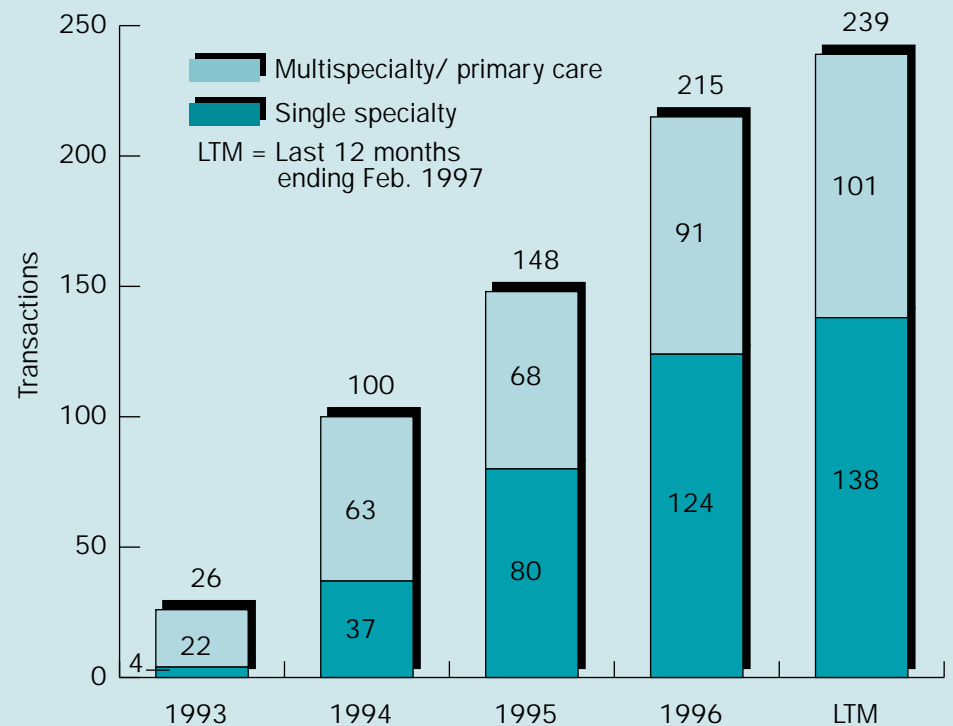
Large Transactions

This year's largest transaction to date is the acquisition of InPhyNet Medical Management Inc., in Fort Lauderdale, Fla., by MedPartners Inc., in Birmingham, Ala. InPhyNet provides practice management services to capitated, hospital-based physician networks and manages various primary care physicians, hospitals, HMOs, and correctional institutions. MedPartners develops, consolidates, and manages health care delivery systems. Valued at \$453 million, the acquisition was announced on Jan. 21 (Tables 4 and 5).

Expected to close near the end of the third quarter of this year, the acquisition will create the nation's largest provider of hospital-based physician services. Combined, MedPartners' Team Health division and InPhyNet's hospi-

tal-based physician services are expected to produce \$500 million in annual revenues. Furthermore, the acquisition significantly strengthens MedPartners' position in Florida, where InPhyNet employs 43 physicians. Upon the announcement of the transaction, MedPartners' stock fell \$1.75, or 8%, largely because of concerns over MedPartners' strategy of rapid growth through acquisition (Table 6). The InPhyNet transaction represents MedPartners' seventh acquisition in the past year, including its \$1.9 billion acquisition of Caremark International Inc., in Northbrook, Ill., a prescription benefits management company that provides services nationwide. MedPartners says, however, that it expects to continue its expansion through acquisitions. Including InPhyNet, it has announced three acquisitions this year. ■

Table 1: Physician Practice Acquisitions (Announced number)



CURRENT TRENDS

Table 2: Purchase Price as a Multiple of Revenue

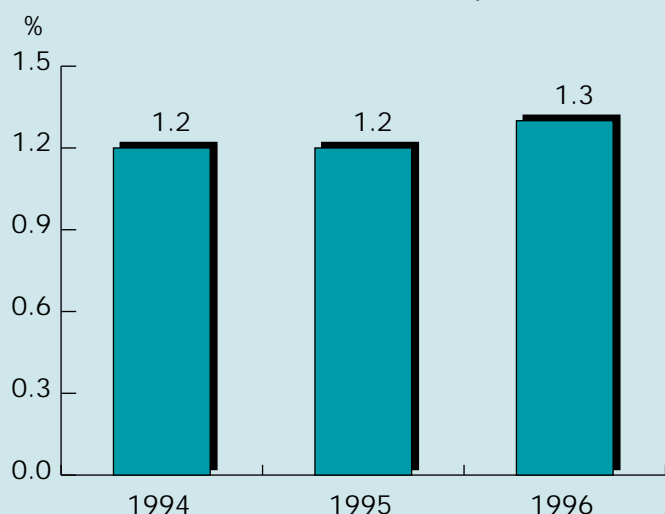


Table 3: Price to Next-12-Months Earnings Multiples (Selected publicly traded PPMCs*)

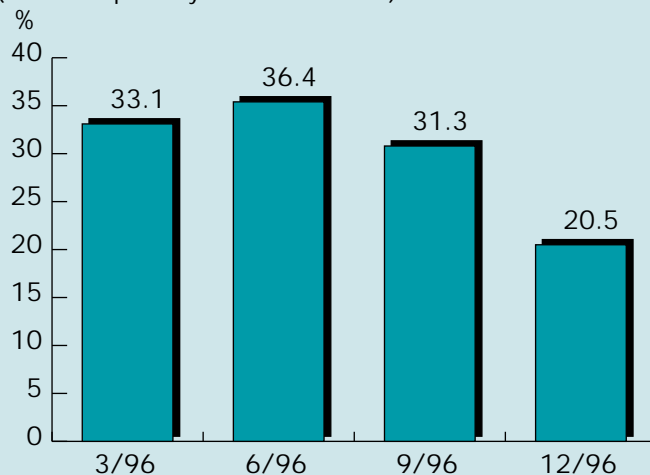


Table 4: MedPartners Acquires InPhyNet (Transaction highlights)

Purchase Price	\$453 million
Purchase Price Multiples:	
Revenue	1.0x
Earnings before interest and taxes.....	14.5x
1996 estimated earnings per share	26.5x
1997 estimated earnings per share	21.8x
Premium to Market	24.6%

Table 5: MedPartners–In PhyNet Pro Forma Statistical Data (As of Jan. 21, 1997)

(In millions of dollars)	MedPartners	InPhyNet	Combined
Revenue (third quarter 1996 annualized)	\$4,728	\$453	\$5,181
Physicians			
Group	2,590	43	2,633
IPA	5,261	385	5,646
Hospital based	959	1,450	2,409
Total	8,810	1,878	10,688
Total states	25	26	36
PPM prepaid members	1,629,655	116,372	1,746,027
Hospital contracts	142	131	273
Correctional facility contracts	0	40	40

Table 6: Five Most Acquisitive Physician Practice Management Companies (Through Feb 20)

	Location	Line of Business	1997 Acquisitions
Physicians Resource Group Inc.	Dallas	Provides practice management services to ophthalmologists and optometrists.	8
PrimeVision Health	Raleigh, N.C.	Provides practice management services to ophthalmologists and optometrists.	6
CareSelect Group Inc.	Dallas	Provides management services to cardiology, ob-gyn, orthopedics, and other specialty groups.	3
MedPartners Inc.	Birmingham, Ala.	Develops, consolidates, and manages health care delivery systems. Prescription benefits management division provides services nationwide.	3
Complete Management Inc.	New York	Provides management and support services to medical practice groups and hospitals in New York State.	2

*PPMCs selected are MedPartners Inc., PhyCor Inc., Pediatrix Medical Group Inc., OccuSystems Inc., Orthodontic Centers of America Inc., FPA Medical Management Inc., InPhyNet Medical Management Inc., Physicians Resource Group Inc., EinCare Holdings Inc., and American Oncology Resources Inc. Earnings estimates are from IBES Analyst's Earnings Estimates, New York, and from Zack's Investment Research, Chicago.

Experts Seek More Oversight of Nonprofit Conversions

Last year, 63 nonprofit hospitals were converted to for-profit status and nonprofit Blues plans also converted substantial assets to for-profit control, according to the newsletter *State Initiatives in Health Care Reform*, published by the Alpha Center, a health policy organization in Washington, D.C. Although for-profit hospitals represent only about 15% of all hospitals, the number of conversions to for-profit is unprecedented, the newsletter said in its February issue.

Some health policy observers have called the trend the largest potential redeployment of charitable assets in U.S. history. Three states—California, Colorado, and Nebraska—have enacted laws recently that direct regulators to oversee conversions of for-profit hospitals, and other states are considering such legislation. In lieu of state laws, these observers are asking state attorneys general to assume a larger role in overseeing conversions, *State Initiatives* said.

In a recent case, California Attorney General Dan Lundgren had opposed a joint venture agreement between

Columbia/HCA Healthcare Corp., of Nashville, Tenn., and Sharp HealthCare, of San Diego, a nonprofit hospital organization that controls 30% of the San Diego market. On Feb. 21, the two sides ended discussions, a setback for Columbia's plans to expand in California. Lundgren hailed the decision, saying, "We felt the proposed plan did not comply with charitable trust law."

A California law that went into effect on Jan. 1 mandates a public hearing and independent evaluation of charitable assets whenever an investor-owned company seeks to align with a nonprofit hospital. Lundgren said Columbia/HCA offered \$202 million to control Sharp's assets, which undervalued the assets by \$100 million to \$200 million based on higher prices offered by Tenet Healthcare Corp. and OrNda Healthcorp.

Comment: Last year Columbia acquired nonprofit Good Samaritan Health Systems in San Jose, Calif., and signed a letter of intent with the parent of nonprofit Riverside Community Hospital in Riverside, Calif. Columbia/HCA currently has 342 hospitals nationwide and is acquiring physician practices in many markets.

Cigna's Purchase Would Make It No. 1 in Enrollment

The Cigna Corp., of Philadelphia, has agreed to buy Healthsource, an HMO in Hooksett, N.H., for \$1.45 billion in cash and \$250 million in assumed Healthsource debt. The deal would make Cigna the nation's number one managed care organization in terms of members, with 5.3 million. It has operations in Arkansas, Maine, New Hampshire, North Carolina, and South

Carolina, but Healthsource's managed care membership is widespread in many of these areas. Healthsource has memberships in many small cities that have only one or two hospitals, meaning competition among hospitals in these areas is difficult to foster. MCOs prefer concentrations of members so that they have more bargaining power with both hospitals and physician groups.

In terms of members, United HealthCare was number one nationwide with 4.7 million, and Aetna-U.S. Healthcare was number 3 with 4.1 million, according to Sanford C. Bernstein & Co., stock analysts, in New York.

Comment: The deal leaves only Prudential Insurance Co. of America, of Newark, N.J., the only large MCO that has not taken a partner recently.

Diabetes Association to Help Consumers Choose Doctors

The American Diabetes Association (ADA) launched a physician recognition program in February to help consumers select physicians based on a physicians' ability to meet specific standards of diabetes care. Eventually, the ADA wants to help consumers choose providers based on outcomes, and estimates that more than half of all who apply will be recognized as those who deliver the best care to diabetics. Any physician who cares for patients with diabetes, including primary care physicians, internists, and endocrinologists, may apply. Applicants must submit

abstracted information from a random sample of at least 35 of their patients' medical records and pass review on 11 factors.

1. Glycosylated hemoglobin tests
2. Eye exams
3. Foot exams
4. Blood pressure measurement
5. Urinary protein measurement
6. Lipid profiles
7. Self-management education
8. Medical nutrition therapy
9. Self-monitoring of glucose
10. Identification of tobacco use and referral for counseling

11. Patient satisfaction

The measures were selected by a nine-member multidisciplinary panel, which included family practice physicians and endocrinologists, nurses, diabetes educators, and dietitians. The standards were designed to evaluate care for all patients with diabetes, but do not address the specific needs of severely ill patients, such as those with end-stage renal disease.

Comment: The ADA will issue certificates of recognition, and list recognized physicians' names on its Internet site and in *Diabetes Forecast* magazine.

Cardiologists Examine Which Interventions Produce the Best Medical Outcomes

Digitalis has been used for over 200 years to treat heart failure, but now cardiologists are trying to determine if it is cost effective and safe. In the *New England Journal of Medicine* (Feb. 20), the Digitalis Investigation Group, organized by the National Heart, Lung, and Blood Institute and the federal Department of Veterans Affairs, reported on a study of the effects of digitalis on mortality and hospitalization in a randomized clinical trial of 3,397 patients. After more than three years of study, the researchers concluded that digitalis relieves symptoms but does not extend life. It is safe but no miracle drug.

In a study reported in *NEJM* (Dec. 19), researchers at Duke University found that board-certified cardiologists achieved better results than primary care physicians. After one year, researchers examined 8,244 Medicare patients with a diagnosis of myocardial infarction (MI). Patients admitted by a cardiologist were 12% less likely to die within a year than those admitted by a primary care physician.

In a separate study reported in the same issue of *NEJM*, researchers at Kaiser Permanente found that post-MI patients treated at hospitals with high rates of angiography have more favorable outcomes than those treated at hospitals with lower rates of angiography.

Comment: *The journal concluded in an editorial that using specialists may be more costly initially but over time is more effective and thus less costly. Managed care supporters believe specialists using high technology are needlessly costly, inefficient, and don't improve outcomes. By addressing these issues, cardiologists are working to ensure that costly interventions are used appropriately.*

A Toll-free Line for Physicians 888/457-8800

Our mission at *Physician Practice Options* is to be a practical information resource for physicians seeking to thrive in health care. In a search for new practice options, physicians are asking themselves a variety of questions, including:

- Should I sell my practice?
- Should my colleagues and I form a physician organization?
- Where should I go to get capital?

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

To reach us, readers are invited to call this toll-free number: **888/457-8800**. The service is *free* to readers. Also, readers are invited to call our editors directly:

Richard L. Reece, MD

Editor-in-chief

Physician Practice Options

15 Banbury Crossing

Old Saybrook, CT 06475-2362

Phone: 860/395-1501

Fax: 860/395-1512

E-mail: RReece1500@AOL.Com

Joseph Burns

Editor

21 Stone Wall Lane

Falmouth, MA 02540

508/495-0246

Fax: 508/495-0247

JoeBurns@CapeCod.Net

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

April 1997



Premier Healthcare Resource
49 Van Doren Avenue
Chatham, NJ 07928

Sponsored by
an educational
grant from
Bayer
Corporation,
Pharmaceutical
Division

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