

# PHYSICIAN PRACTICE OPTIONS™

May 1998

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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## Entrepreneurs Advocate One-stop Shopping

Concerned about a loss of income due to managed care, physicians are seeking greater control over the money patients spend on health care. One way to do so is to increase patient volume; another is to retain a greater share of the fees patients pay. Creating conveniently located medical practice centers combines both strategies. The idea, say the entrepreneurs developing such centers, is to increase profits by bringing the doctor to the patient and offering consumers the services they want.

"Health care is a mess right now," says William R. Grace, MD, a 54-year-old oncologist in New York. "Doctors aren't satisfied with the care they can give and neither are patients. The best way to take advantage of the mess and make it better is to create a consumer-based delivery system. Today, people are constantly seeking quality, convenience, and value in what they purchase, including health care. We need to rip medicine apart, break the current mold, and rebuild it."

Grace has formed Doctor Depot, a company that will establish "medical superstores." These superstores will consist of group practices of 200 physicians, most of whom will work in facilities of at least 300,000 square feet. The first facility will be in New York City and contain physician offices, laboratories, a retail pharmacy, a surgical supply outlet, as well as imaging, cancer treatment, infusion therapy, day surgery, birthing, eye care, and urgent care centers. The goal is to offer convenience to patients. "It's the 'Field of Dreams' idea," Grace explains. "We will build facilities that offer quality care in an attractive environment, and patients will respond."

The one-stop-shopping concept may be a

viable practice option. It is the basis for a project by Steve Gaunya, a former physical therapist from Chatham, Mass., who is developing Worldwide Wellness Inc. (See sidebar, "Taking Wellness a Step Further.") Also, Armand J. Rigaux, MD, of South Bend, Ind., has adopted the idea of bringing health care services to consumers in grocery stores. Rigaux started SmartCare Medical Centers of America, a company that owns and operates medical clinics in supermarkets. These are walk-in clinics, smaller in scope than the large, multiservice centers of Doctor Depot or Worldwide Wellness, but they represent a commitment to convenience, says Rigaux, especially because they generally are open 12 hours a day.

### Time for a Change

After 33 years as a family practitioner, Rigaux decided it was time for a change. Managed care's emphasis on precertification and paperwork and its limitations on patient referral were destroying his love for medicine. "I couldn't make referrals to doctors whose work I had respected for years," he says. "I spent all my time filling out forms. When I started practicing, doctors made all the decisions about what was good for our patients. Today, insurers and managed care companies make those decisions. I was no longer doing what I enjoyed. I wanted to retire."

But rather than retire, Rigaux sold his family practice in 1993 to a local hospital, St. Joseph's Medical Center in South Bend, Ind., and began "practicing medicine the way it was meant to be practiced, consumer friendly medicine, close to the people we serve," he says. Rigaux formed SmartCare and Explorer Healthcare Inc., a company

(Continued on page 8)

## Media, Managed Care Have an Uneasy Relationship

Lately, the credibility and objectivity of the news coverage of managed care have become news. The January/February issue of the journal *Health Affairs* looked closely at the issue, featuring two articles in particular: "Is There a Negative Bias?" by staff members of the Kaiser Family Foundation, a health care philanthropy in Menlo Park, Calif., and "Covering a Breaking Revolution: The Media and Managed Care," by Karen Ignagni, CEO of the American Association of Health Plans, an HMO trade association in Washington, D.C.

In a study by the foundation, researchers analyzed media reports from 1990 to 1997 and found that "many reports on managed care have a negative tone about managed care." This tone was common both in articles that reported on patients who had been denied care and in short broadcast news reports. Articles about managed care in the business press tended to have a more neutral tone, the researchers said.

### A Revolution in Progress

In her article, Ignagni argued that managed care is a revolution in progress, and therefore is inherently complex and not a black-and-white morality tale. The media have oversimplified stories about managed care, she said, adding that false charges about "drive-through deliveries" damage the industry, and that fee-for-service care has never received the scrutiny that managed care has. HMOs should invite reporters to see how managed care works on the "inside," she said. "Nothing demystifies managed care more effectively than seeing it in action, close up," she added.

Yet, a five-part special report in the *Minneapolis Star Tribune* showed that managed care looks worse when viewed up close (see Market Report, page 4). The series was based on a six-month project featuring polls of more than 1,600 Minnesotans and nearly 1,000 practicing physicians. In one article, "The Closer You Get, the Worse It Looks," the newspaper reported that those most involved with managed care—including the sick, the chronically ill, and the physicians who care for the sick—are most critical of it.

Worse still, is that many physicians and nurses who have deep concerns about managed care in Minnesota told a reporter from the *Star Tribune* that they did not voice their complaints for fear of retribution from their employers. "There are three big companies, and they control 80% of my business," said one physician. If such fear is pervasive beyond Minnesota, then managed care deserves even greater scrutiny than what it has received from the press.

The problem is that what's missing in most media coverage of the issue is that health care purchasers favor managed care because it has controlled costs effectively, at least so far. Physicians should therefore keep in mind that the general-interest media feed on conflicts and may not fully report all sides of the managed care issue. At the same time, Congress and the U.S. public have tired of extreme managed care discipline, and managed care has failed to care for the underinsured and some of the most seriously ill Americans. As a result, the current debate in Congress over the Patient Access to Responsible Care Act of 1997, a bill cosponsored by Sen. Alfonse D'Amato (R-N.Y.) and Sen. Charlie Norwood (R-Ga.), may be more telling about managed care and its future than the media reports we've been getting.



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# Compliance Plans Limit Physician Risk

By Patricia McClelland

## Second of two parts

The risk of the government focusing on a single practitioner for Medicare violations is small, but the stakes are high nonetheless. (See “Medicare Fraud: It’s Costly for the Government and Risky for Physicians,” April.) Since the stakes are high, all physician groups should monitor and audit their internal staff to determine if Medicare billing procedures are being followed. If the physician or physician group outsources Medicare billings, it is imperative that the outsourcing vendor have an effective Medicare compliance program.

If a physician in the Medicare program is part of a joint venture, managed care organization, partnership, or association, or is part of or has a financial agreement with any other provider or vendor, his or her risk of unknowingly violating Medicare fraud and abuse laws and of being audited by the federal government is substantial.

Although the types of business and financial arrangements may vary, the financial, personal, and legal exposure is the same because the individual physician generally has no effective way to:

- Identify problems
- Review policies or procedures
- Oversee billing practices
- Correct improper activities.

A corporate compliance program will reduce the likelihood of criminal and civil wrongdoing by detecting, preventing, and correcting violations. For any compliance program to be effective, it must be supported by the organization’s chief executive and the board of directors. It also needs to be effective, not perfect, and should be designed with the government’s focus in mind. It should include the following seven minimum steps as identified under the Federal Sentencing Guidelines:

1. Develop corporate standards and procedures

Patricia McClelland is a health care compliance consultant with Milliman & Robertson, in Vienna, Va.

## Other Causes of Action

As a result of the federal government’s current crackdown, physicians should be aware of two kinds of lawsuits that could affect them negatively:

First, *the Whistle-blower Lawsuit*. Because Medicare beneficiaries and medical suppliers and providers are in the best position to identify and provide information on possible fraudulent activities, the Health Insurance Portability and Accountability Act of 1996 created a whistle-blower program. The bounty for informants generally does not exceed 10% of the recovered amount.

Second, *the Qui Tam Lawsuit*. The government is also using *Qui Tam* lawsuits in cases involving Medicare fraud and abuse. *Qui Tam* broadly means “who brings the action.” This type of lawsuit allows a private citizen to initiate a false claims action in the name of the government against an individual or organization. Such an action usually arises when a person believes he or she has no alternative but to report an alleged violation to the government because prior reporting to the person in charge or to the organization did not rectify the violation. The bounty could be 15% to 25% of the recovered amount.

2. Institute oversight responsibility
3. Establish employee and agent training and education
4. Develop methods to monitor and audit the program’s performance
5. Create an employee reporting system that allows employees to report without fear of retribution
6. Develop enforcement and discipline standards
7. Develop response and prevention procedures.

### Sentencing Guidelines

After a case has been made and a defendant found guilty or a party enters a settlement agreement with the government, federal judges must follow the Federal Sentencing Guidelines. The guidelines are designed to achieve equity and some degree of uniformity in sentencing, and they control all sentences imposed on individuals and organizations. Every U.S. business, regardless of size, falls under these stringent guidelines.

The guidelines are based on a mathematical point system, and fines have been in double- and triple-digit million dollar amounts. The amount of the fine imposed on an organization found to be operating primarily by criminal means or primarily

for a criminal purpose could deplete the organization’s assets and thus, in effect, be a corporate death sentence.

In addition to penalties under the Federal Sentencing Guidelines, government-designed corporate compliance programs have been imposed in settlement agreements. Requirements of these programs include:

- Annual independent audits to review all practices and providers relating to contracting with physician referral sources
- Annual reporting to the U.S. Department of Health and Human Services
- Mandating the corporate structure of a corporate compliance program
- Prompt reporting of all violations to the government
- Notification to the government of any transfer, reassignment, or dismissal of an employee who is part of the company’s fraud unit
- The retention of all documents relating to compliance activities.

An organization that adopts a compliance program enjoys two immediate benefits. The most important is the reduction of the culpability score under the Federal Sentencing Guidelines; the second is the peace of mind of the at-risk physician. ■

# Minnesota Physicians Struggle as Three Large Payers Dominate the Market

Minnesota, the land of 10,000 lakes, seems to have at least as many unhappy physicians and patients. A survey by the *Minneapolis Star Tribune* and Harvard University has found physician income declining sharply and patient volume increasing. Entitled "Wellness Gap," the survey results were part of a series of articles on health care in Minnesota that did not paint a bright picture.

In the survey of 988 Minnesota physicians, 25% of respondents said their personal income had dropped by 25% over the past five years, and 33% said they had experienced an increase in patient volume of 25% or more in the same period. While patients who were well generally did not complain

about quality, those who were sick or who had chronic conditions reported receiving poor-quality care. The *Star Tribune* and Harvard University surveyed 1,649 adults younger than age 65 by telephone using a random-telephone-dialing system.

"Very substantial economic retrenchments have placed pressure on all parties," says Kent Wilson, MD, president of the Minnesota Medical Association. Wilson is an otolaryngologist who has practiced in St. Paul since 1974. "Reimbursements have been substantially reduced for all physicians. Employed physicians work more hours at the same salary. Fee for service has been offered at below cost of business."

Coincidentally, Minnesota is also the

home of the Buyers' Health Care Action Group (BHCAG), in Minneapolis (see sidebar, "Buyers' Group Offers Hope"), which has begun contracting directly with provider organizations, thus offering hope to physicians otherwise disenfranchised by managed care. But BHCAG represents only about 4% of Minnesota's health services market.

Most physicians seem to struggle under managed care and have a paucity of purpose in the face of the challenges managed care presents. Since many independent physicians in the state lack a shared mission, they are not operating within a common clinical, financial, or business framework, all of which are critical if physicians are to succeed under managed care.

## Physicians Buy Clinics From Health System

Hoping to stem losses in revenue, HealthSystem Minnesota, a physician-hospital organization in St. Louis Park, announced last fall that it would sell four physician clinics. After considering their options, 15 primary care physicians from Mound, Delano, and Maple Plain (all outer-ring suburbs west of Minneapolis) offered to buy three of the clinics, and on April 1, the physicians from the three clinics began operating as Westonka Medical Group, according to *CityBusiness*, a publication in Minneapolis. The fourth clinic was closed.

Previously, the clinics had been run by physicians until they were purchased by Methodist Hospital in 1990. They became part of HealthSystem Minnesota in 1993, when Methodist united with Park Nicollet Clinic, a large physician group practice in St. Louis Park. At the time, physicians believed the strategy of practicing as a larger group was sound given that managed care was fostering the growth of larger provider organizations nationwide.

Larry Mathison, MD, one of the

Westonka physicians, says that when the opportunity came to buy the practice, the participating physicians were eager to practice independently.

Chris Johnson, MD, vice president of HealthSystem Minnesota, who had served as chief operating officer for the physician network that included the Mound group, said the financial performance of all of HealthSystem's clinics had been declining over the last few years. Last year, losses totaled more than \$800,000, he said.

After reviewing the reasons for the clinics' financial problems, HealthSystem attempted to make operational changes by adjusting scheduling to increase afternoon appointments and by introducing a new staffing model for nursing personnel. When clinic physicians resisted the changes, HealthSystem decided to sell.

Jeffrey Schackor, president of HealthLink Minnesota Management Group Inc., physician consultants in Edina, said the physicians believe they can operate the clinics more efficiently and

reduce overhead. To accomplish these goals, the physicians retained Schackor, along with legal and accounting professionals, to advise them.

As with any new clinic, the physicians opening Westonka needed to get financing, hire staff, lease office space, negotiate contracts with participating providers and with managed care payers, and develop relationships with hospitals. They also needed to be concerned about the lack of cash reserves and competition for patients from their former employer.

David Cordes, president of Healthcare Management Resources, physician consultants in St. Paul, believes many physicians will watch the Westonka clinic closely. "It is scary for a group of doctors to begin over," but at the same time, it's exciting that the physicians were willing to do so, he said.

Since April 1, the Westonka physicians have completed all third-part contracting and retained their former patients, said Schackor. "While the long-term picture is not yet clear, early indications are extremely positive," he added.

Having only three large payers, "puts the payers in the position to decide what the market will get in terms of products and what the market will pay in physician reimbursement."

— Rolf Skogerboe, MD,  
Columbia Park Medical Group

One significant reason physicians struggle in Minnesota is that the state's health care market is dominated by three large managed care organizations (MCOs): Blue Cross Blue Shield, in Eagan; Medica Health Plan, in Minnetonka; and HealthPartners, in Bloomington.

Rolf Skogerboe, MD, an otolaryngologist and chairman of Columbia Park Medical Group, a multispecialty group of 60 physicians serving the northwestern metro area of the Twin Cities, believes this number of payers has negatively affected reim-

(Continued on page 6)

## Buyers' Group Offers Hope

The Buyers' Health Care Action Group (BHCAG), a coalition of 28 self-insured employers with a total of about 125,000 employees, made a significant change last year in how it purchases health services: It eliminated insurers and began contracting directly with care systems, which are groups of physicians and other provider organizations, such as hospitals. The provider systems are encouraged to bid on BHCAG contracts.

BHCAG is one of the most innovative of the more than 100 employer coalitions that operate nationwide and has been developing an extensive system in which its employer members contract directly with provider groups, including physicians. Last year, about 7,000 Minnesota physicians, most of whom practice in the Twin Cities, began contracting directly with BHCAG under a health plan named Choice Plus. The plan eliminates managed care utilization reviews and makes the physicians accountable for costs, quality, and patient satisfaction. Also, Choice Plus allows its 125,000 enrollees to choose among 23 provider systems and removes managed care companies as the arbitrators of care. (See "Minnesota Employers Elevate Physicians' Status by Eliminating Middlemen," July.)

Bruce Brenholdt, executive director of the Columbia Park Medical Group, a multispecialty group of 60 physicians with three offices in the northwestern Minneapolis area, reports that as a result of working with BHCAG the group has had an increase in patient volume, much of it resulting from new patients. While it is still too early to make a long-term assessment about the group's participation with BHCAG, "We're glad we decided to participate," Brenholdt says.

# Bridging the Managerial and Capitalization Gap Between Physicians and Financial Partners



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**“Very substantial economic retrenchments have placed pressure on all parties. Reimbursements have been substantially reduced for all physicians, and employed physicians work more hours at the same salary.”**

**— Kent Wilson, MD, Minnesota Medical Association**

(Continued from page 5)

bursements and physician-patient care issues. Having only three large payers, “puts the payers in the position to decide what the market will get in terms of products and what the market will pay in terms of physician reimbursement,” he says. The lack of competition from provider systems of various sizes and capabilities stifles debate, he says.

Michael LaFond, a lawyer with Oppenheimer Wolff & Donnelly LLP, in Minneapolis, says the survey shows that physicians in Minnesota have failed to establish substantive business relationships with each other. The largest MCOs have so dominated the physician market by employing so many of them that physicians have become dependent on these organizations and therefore have missed the chance to develop systems in which clinical and business systems are integrated, as physicians have done in other markets. To date,

physicians in Minnesota have yet to discuss thoughtfully a common business organizational vehicle that would give them leverage with health plans and with the business coalition, LaFond says.

Physicians in markets nationwide are unsettled by the growth of managed care. In many markets, they have reacted by forming large organizations to create some leverage with payers.

### Standards of Care

But the survey simply shows that Minnesota has high expectations for its health care providers, says Chris Johnson, MD. A family practice physician, Johnson is vice president of HealthSystem Minnesota, a physician-hospital organization in St. Louis Park. Johnson also is chief operating officer of the Primary Physician Network, an eight-clinic group of 30 PCPs that is part of HealthSystem Minnesota. Patients require a high degree of accountability for quality and

service despite managed care’s focus on prudent use of health care resources, he says.

“As such, it is normal to expect some discontent,” Johnson explains. Society should demand high levels of accountability from physicians and it should demand that providers deliver excellent service without wasting resources, he adds.

The survey results need to be put into perspective, agrees Richard Simmons, MD, a family physician who serves as the administrative medical director for Medica Health Plan, which is part of the Allina Health System, an integrated delivery system in Minneapolis. “Some of their reactions are broad-brush reactions to managed care, and these reactions reflect the way people think about managed care throughout the country,” he says. In other words, managed care is painful for many parties, but especially for patients and providers. “Over the last year with the increased utilization and increased costs, there has been concern that things weren’t going so great,” says Simmons, who has practiced for 38 years. Such difficulties are not unexpected given the aging of the population, the increased use of costly new technology, and the rising cost of pharmaceuticals.

### Physician Reaction

While there has been no statewide movement to coordinate a response by physicians, some organizations have made limited attempts to counteract the excesses of managed care. Douglas Thorsen, MD, an internist from Stillwater, Minn., and Rebecca Thoman, MD, who specializes in women’s sexual dysfunction, started the Minnesota Physician-Patient Alliance (MPPA), a patient advocacy group. Thorsen and Thoman believe a strong alliance between physicians and patients can be used to apply pressure on lawmakers. The group was started in July and has 800 dues-paying members, all but 50 of whom are physicians. The group is promoting “any-willing-provider” legislation, which

## Reimbursement Levels, Regulations Irk Physicians

**O**ne problem cited almost universally by physicians in Minnesota is low Medicare reimbursement levels.

Rolf Skogerboe, MD, an otolaryngologist and chairman of Columbia Park Medical Group, a multispecialty group of 60 physicians serving the northwestern metro area of the Twin Cities, believes Medicare’s reimbursement scale has historically discriminated against Minnesota physicians. Since reimbursement rates from health insurers tend to mirror Medicare rates in Minnesota, Medicare payments unfairly and directly affect the income of all physicians in the state, he says.

Disparities in Medicare reimbursement rates are not uncommon. Physicians in some parts of Minnesota and other states in the Midwest, Northwest, and New England get much lower reimbursement rates than physicians in New York, Florida, and California. Congress tried to minimize some of these discrepancies last year when it raised reimbursement rates by 2% nationwide, but doing so exacerbated the differences in some places. While annual payments increased by \$431 in St. Paul, they also increased by \$748 in Dade County, Fla., and by \$783 in Staten Island, N.Y. As a result, the disparities actually widened, says Jan Malcom, vice president of public affairs for Allina Health System, Minnesota’s largest HMO.

—D.R.

# An Ounce of Prevention Takes a Ton of Work

Physicians and medical groups that provide the best care to patients of HealthPartners, a managed care organization (MCO) in Bloomington, Minn., will earn additional compensation this summer. Based on how well they manage patient satisfaction and four measures of clinical quality, some 800 physicians in 20 contracted groups may split as much as \$2 million, says Maureen Reed, medical director for contracted care for HealthPartners.

Under a program that began in the fall of 1996, HealthPartners told physicians it would use data it had been collecting for several years to measure their performance. When the data from 1997 are totaled within the next few months, Reed and her staff will issue bonus payments to physician groups that serve at least 2,500 HealthPartners' participants, she says.

The four clinical measures used last year were rates of mammography, pap smears, pediatric immunizations, and smoking-cessation advice. This year, HealthPartners revised the preventive measures, adding diabetes and cholesterol control, and dropping pap smears, Reed says.

HealthPartners' Outcomes Recognition Program is among the first in the nation to pay doctors more based on the quality of care they deliver, Reed says. United HealthCare, a large MCO in Minneapolis, also introduced a program last year to pay physicians more for quality care.

When United HealthCare (UHC) announced its program last year, Lee Newcomer, MD, UHC's chief medical officer, said, "We believe all physicians eventually will be paid by MCOs for clinical

performance and results, rather than for production." Most MCOs pay physicians based on the number of patients they see. While that system will continue, many MCOs will also begin to add programs that pay physicians for meeting certain quality targets.

Since Reed believes the preventive measurement goals should be difficult but not impossible to reach, the standards for HealthPartners physicians are much higher than the national average rates for these measures. For pediatric immunizations, for example, HealthPartners set a goal for physicians of 95%. The national average last year was 65.3%, according to the National Committee for Quality Assurance (NCQA), an organization in Washington, D.C., that accredits health plans. In a report, NCQA said the national average among health plans for breast cancer screening last year was 70.4%, and for advising smokers to quit smoking, it was 61%. HealthPartners wants a mammography screening rate of at least 85%, and it wants at least 80% of its members who smoke to get advice on how to quit.

For diabetes management, NCQA collected data on how many diabetes patients had an eye exam in 1996 and found a national average of 38.4%. HealthPartners goes considerably further in that it is collecting data on HbA1c levels, a measure of effective diabetes management. It wants the HbA1c levels to be at or below 8% in its patients with diabetes.

"We want these goals to be a stretch," says Reed, "and we have evidence that these goals are achievable but they are

not a slam dunk."

To measure whether physicians are achieving its goals, HealthPartners has been collecting information from administrative data and by pulling patient charts in physicians' offices, Reed says. Several additional measures are being developed and will be added so that providers will be paid more for reaching these goals in the coming years. One goal to be added next year is increasing the satisfaction levels of maternity patients, including how well hospitals do in pain control, patient respect, and patient education in infant care.

Reed believes the program has had a positive effect on physicians. "All physician groups are working to improve their performance," Reed says. "And they feel that their hard work is being rewarded." Indeed, the goals are difficult, she says. "One physician told us, 'An ounce of prevention takes a ton of work.'"

HealthPartners worked with its contracted physicians to develop the measures and definitions. They agreed to use the definitions established by NCQA for its Health Plan Employer Data and Information Set (HEDIS), a standard data collection system. The goal was to develop a system that could not be subject to gaming, Reed says.

"Our Outcomes Recognition Program gives our medical group partners an additional reason to improve their performance and our members' health," says Reed. "We have selected goals in each of the measurement areas that are specific, achievable, and will improve the quality of care and the health of our members."

would limit the ability of MCOs to keep some providers out of their networks. It also supports medical savings accounts and is working to get Minnesota counties to contract directly with providers to deliver services under Medicaid.

Richard Mulder, MD, who handles the business affairs of the Ivanhoe Clinic, a two-person family practice in the rural town of Ivanhoe in southwestern Minnesota, supports the legislation. The

law is needed because some 26 rural hospitals have been closed in Minnesota in recent years, meaning many rural residents have trouble getting access to high-quality care, he says.

In another effort to support physicians, the Minnesota Medical Association (MMA) is increasing its efforts to ensure that physicians have a fuller understanding of managed care contracts. In negotiating with managed care companies, small clinics

may find it difficult to survive without a thorough understanding of contract issues, says Mulder.

The MMA has said physicians need to understand such contract language so that they don't find out too late that they have signed away their bargaining power and are powerless to advocate for themselves or for the care patients need.

—Reported and written by David Racer, a business writer in St. Paul, Minn.

(Continued from page 1)

that places physicians in permanent and temporary positions, known as *locum tenens* placements, throughout the United States. He continues to practice medicine, as the national medical director for SmartCare and as a practicing *locum tenens* physician for Explorer, traveling throughout the country to fill positions for physicians on vacation or for hospitals using temporary medical staff while they seek to fill a full-time position.

"The idea for SmartCare just hit me one day," Rigaux says. "Pharmacies have been in supermarkets for years. Why not clinics?"

**"Pharmacies have been in supermarkets for years. Why not clinics? The idea is to go where the patients go."**

**—Armand J. Rigaux, MD, SmartCare**

The idea is to go where the patients go. And where do patients go? To the grocery store."

Based in South Bend, SmartCare has two clinics in the Phoenix, Ariz., area. "In Arizona, retirees use a lot of the basic services, like blood work, that we offer," he says.

Convenience is the key. Both SmartCare clinics are in supermarkets owned by the Kroger Co., of Cincinnati. The nation's largest supermarket chain, Kroger has pharmacy outlets in almost all of its locations. "Kroger saw the potential," Rigaux says.

"It's all one-stop shopping," Rigaux explains. "We opened our first clinics in Arizona, where elderly retirees appreciate being able to get regular medical tests, pick up their medications, and do their food shopping with one trip out of the house."

Michael Donnelly, a Kroger vice president of marketing in Phoenix, says the concept of medical clinics in supermarkets is "not an idea we were used to; that is, putting something in the store that doesn't have merchandising potential. It's more of a convenience we've added for our customers. So far, they seem to like it."

Since the clinics are enclosed, Rigaux says, "once you're in the office you wouldn't know you're in a supermarket. It is a doctor's office. But the service concept is 'no waiting room.' We do have small waiting areas, but if patients are ahead of you, we

give you a beeper so you can go shopping, and we page you when you can be seen by the medical staff."

#### Savings in Aisle Five

Each clinic is open 12 hours Monday through Saturday (from 8 a.m. to 8 p.m.) and nine hours on Sunday. The clinics are staffed by a nurse practitioner, and a physician is on call for consultation throughout the week and in the clinics one day a week. "About 95% of family medicine is routine procedures, such as physical exams, blood pressure checks, blood sugar checks, that

very well, and we think that's because people like to be seen right away, and at their convenience." About 55% of each clinic's patient volume is from walk-ins, and the balance by appointment, he adds.

Opening each clinic, including the purchase of equipment and leasing space from Kroger for a year, cost about \$95,000, Rigaux says. He shared the initial investment cost with Diversified Holdings Inc., an investment firm in Chicago. Subsequently, other investors were brought in, Rigaux says. Each clinic contains about 700 square feet of space for three examining rooms, a bathroom, a small laboratory, and a reception area. The clinics each employ two nurse practitioners, a medical assistant, and a receptionist. "The way medicine is going today, doctors are becoming lost in the shuffle," Rigaux says. "Opening up these facilities meant I could practice the kind of medicine I wanted to practice."

#### Doctor Depot

Grace's Doctor Depot fits a more traditional health care delivery mold than SmartCare Medical Centers. Grace says, "We want to stick with well-proven treatments, but we'll see what the consumer wants over time." Although he calls his company Doctor Depot, the facilities "won't look like warehouses," Grace explains. "They will have an

sort of thing," Rigaux says. "Of the people I have seen over the years, fewer than 5% were seriously ill. Our clinics serve people by providing service for the medical care they need, at the hours they see us.

"Access and convenience are what we provide," Rigaux continues. "These are nearly forgotten goals in health care in this country today. So far, the concept is working out

## Taking Wellness a Step Further

An entrepreneur in Massachusetts is taking the idea of offering consumers convenient access to health care and combining it with another growing trend: alternative medicine. Steve Gaunya, a former physical therapist from Chatham, Mass., plans to develop medical centers along the East Coast that will offer outpatient surgery, physical therapy clinics, imaging centers, and other ancillary services, as well as traditional physician care. In addition to these medical services, Gaunya's company, Worldwide Wellness Inc., will offer fitness and wellness programs and alternative medicine, including acupuncture, massage therapy, and chiropractic services.

"We want to create a complete delivery system, based on what the consumer wants," Gaunya says. "In 1996, more than \$96 billion was spent on alternative medicine. Physicians should be able to capture some of that income through investing in centers that offer those services."

Gaunya is seeking investors and sites for Worldwide Wellness facilities. "The key is to go to where the patients are, and to offer them what they are looking for: quality service, convenience, and choice. That's the definition of value," Gaunya says. He plans to open facilities near shopping malls and adjacent to large motels so patients can use the motel fitness centers and have somewhere to stay if they need to return for next-day treatment.

**“Health care is a mess right now. The best way for doctors to take advantage of the mess and make it better is to create a consumer-based delivery system.”**

**— William R. Grace, MD, Doctor Depot**

upscale look, reflecting the standards and tastes of the physicians who practice there.”

Grace hopes to open the first Doctor Depot in Manhattan next year, and several more in and near New York City after that. The superstores will be owned and run by their physicians. “We will return the focus of health care to the patient, and create a physician corporate culture with appropriate incentives to motivate physicians to create less expensive, out-of-hospital care,” says Grace. “It’s basically a one-stop-shopping concept.”

Grace believes a 200-member group practice that offers one-stop shopping will be attractive to payers, including managed care plans. “A 200-doctor center where enormous numbers of patients are treated, and which demonstrates its ability to control overall health care costs by directing patients to outpatient services rather than to expensive hospital care, will be attractive to managed care plans and will have the leverage to negotiate managed care contracts that are favorable to doctors,” he says.

While the offices may have a conventional physician-practice look, the concept may up-end the traditional physician dependence on hospitals, Grace believes. Care delivered in hospitals is changing, he says, because so many procedures are being done on an outpatient basis. Just 10 years ago, most procedures were done on an inpatient basis. “We’re creating what will replace that culture,” Grace says. “And as we do, we will be demonstrating to purchasers, including managed care plans, that we provide value and quality service without the huge costs associated with inpatient settings.”

Physicians are beginning to realize the power they have in controlling spending on health care, Grace says. “For a while, doctors were looking to hospitals to rescue them from managed care,” he says. “So they were selling their practices to hospitals, often at significantly reduced values. It was not working out for the hospitals either because once the physicians

became employees, productivity dropped. Now doctors are beginning to wake up to the fact that through referrals they control 80% of the money spent on health care and that they could get a lot of that money back.”

One-stop shopping de-emphasizes hospital referrals and is based largely on what Regina Herzlinger, PhD, a professor of business administration at the Harvard Business School, calls focused factories, Grace says. In her book, *Market-Driven Health Care* (Addison-Wesley: 1997), Herzlinger advocates that providers build patient-centered and disease-oriented medical centers to replace hospitals. Such centers should offer health care services packaged from the consumer’s point of view, she says.

Initially, Grace’s Doctor Depots will offer a wider range of services than the focused factories Herzlinger envisions, he says. They will not focus on a single chronic disease, for example. Instead, they will be organized as 150- to 200-member multispecialty groups, generating income by referring patients to group-owned ancillary services, such as laboratories and imaging centers. “Eventually, as we open more centers, we’ll move closer to the focused factory concept,” Grace says. “But in the beginning we will need to develop the income base and infrastructure to support the one-stop-shopping concept. That will mean drawing in patients with a wide variety of complaints. But we will offer all the services that patients need and we will emphasize outpatient, ambulatory care.”

#### Eliminating Hospital Care

One key element of the financial success of Doctor Depot will be capturing much of the money patients and insurers now pay to hospitals, Grace says. “Hospital beds are perceived by consumers as the worst value in America today. That’s why they’re disappearing,” he says. “Most of the people in hospitals overnight don’t need to be there.”

In addition to making use of the outpa-

tient services they own, Doctor Depot physicians will increase their profits by becoming their own landlords, Grace says. “We’ll organize the physicians into a real estate syndicate that will buy the building and lease it back to the doctors. This will reduce a physician’s rent from \$35 a square foot per year, which is what the average Manhattan doctor is paying now, to \$20 a square foot, and allow the physicians to shelter the difference through property depreciation. Each physician could shelter almost \$20,000 a year,” he says.

Sharing space will also reduce overhead, Grace says. “We figure that when 200 physicians share the cost of office space, receptionists, clerical staff, and other office costs, overhead will be reduced by an estimated 40%,” he says. Grace has been asking physicians interested in the concept to pay \$1,000 as an initial investment. That money provides membership in a management services organization (MSO) he has created that will own ancillary services, such as imaging centers and laboratories. To date, 60 physicians have joined his MSO. He expects to have enough physicians signed up to purchase a building for the first depot to open by next year.

Physicians will be offered the option of either moving into the new facility or continuing to work from their current offices. For the one-stop-shopping concept to work successfully, all of the ancillary services owned by the MSO will be located at the new facility, as will most of the physicians, Grace says. The physicians who retain other offices will not get reduced overhead or the patient convenience of one-stop shopping, he says.

“We think most of our members will take advantage of this concept by working in a single, upscale environment,” Grace says. “They’ll understand the value of patient convenience. It’s how doctors will regain control of health care.”

—Reported and written by Martin Sipkoff, a health care writer in Gettysburg, Pa.

# PSOs Offer Huge Opportunities for Physicians, Says Health Care Executive



Jacque Sokolov, MD, is chief executive officer of JJS Inc., which develops integrated health systems, and PSO Development Corp., in Los Angeles, Calif. Previously, he was vice president and medical director at Edison

International (formerly Southern California Edison Co.), an electric utility holding company in Rosemead, Calif. Sokolov serves on the boards of the Washington Business Group on Health, the National Fund for Medical Education, the National Health Foundation, the National Health Policy Council, the National Resource Center on Worksite Health Promotion, the White House Health Project, and on the editorial Advisory Board of Physician Practice Options. Sokolov received a B.A. in medicine from the University of Southern California and an M.D. with honors from USC School of Medicine. He completed his residency in internal medicine at the Mayo Graduate School of Medicine and his fellowship in cardiovascular diseases from the University of Texas-Southwestern Medical School.

**Q.** Dr. Sokolov, you are clearly a leader in the development of provider-sponsored organizations (PSOs) and have formed a company aimed specifically at encouraging the growth of PSOs. Could you explain what PSOs are and what excites you about them?

**A.** PSOs are among the Medicare+Choice plan options created by the Balanced Budget Act of 1997. They allow for direct contracting with doctors and hospitals in ways that, until now, doctors and hospitals could only dream about. Delivery systems in many parts of the country were built to accept a variety of different contracts, but because many health care fiduciaries and HMOs have refused to contract with them, these systems, which doctors and hospitals have spent a great deal of time putting together, have essentially been all

dressed up with no place to go. The Medicare+Choice plans, of which the PSO is one type, provide a dance for these integrated delivery systems to attend.

**Q.** The Balanced Budget Act has a provision stating that "providers" must be 51% owners of PSOs. Does this provision give physicians the opportunity to be owners of, or at least to have a substantial equity stake in, a new health care delivery system in their own communities?

**A.** Absolutely. This provision is clearly an effort by Congress, supported by the administration, to allow doctors and hospitals to sponsor their own health plans, and more important, in these health plans, the physicians would be responsible for the care and well-being of their patients.

**Q.** You have said primary care physicians (PCPs) should be the owners of PSOs. Where does that leave the specialists?

**A.** PCPs should not be the sole owners of PSOs. In fact, it is the health care community that should own the PSO, which means there probably should be PCPs, specialists, hospitals, and other licensed providers who clearly have a stake in the equation. In looking at the current relationship between PCPs and specialists, you see a situation in which the role of PCPs in the health care system is being redefined. Historically, PCPs were thought of as gatekeepers or care managers, and specialists felt that they were being left out.

effect, whether they are episode-of-care-oriented or population-based, specialists will play an increasing role in the physician-oriented approach to managing care.

**Q.** You have said that the Balanced Budget Act represents the "ERISA-fication" of Medicare [ERISA is the acronym for the Employee Retirement Income Security Act of 1974]. What do you mean by that?

**A.** The ERISA-fication of Medicare is a term that I use to characterize the Medicare+Choice managed care plans. There are five different plans in the Medicare+Choice program that Medicare beneficiaries will be able to choose from. Some of them will have risk at the HMO or PSO level; others will be an indemnity-type product, such as preferred provider organizations or private fee-for-service health plans; and some will have catastrophic care, like medical savings accounts. Combined, they make up a continuum of plans that are far from the bread-and-butter HMO. Many people think Medicare beneficiaries won't give up their private doctor to go to an HMO. They may be right. But it isn't a one-size-fits-all situation; they have other options and their private doctor most likely will be in one or more of these plans.

**Q.** Is the federal Department of Health and Human Services (HHS) now accepting proposals for PSO development?

**A.** That is correct. Originally, HHS had stated that it would not accept PSO

**"The Medicare+Choice plans, of which PSO is one type, provide a dance for these integrated delivery systems to attend."**

Now, we believe specialists have a discrete and important role in the system, and that role may very well involve primary care for complex cases. Also, it will certainly involve both population and episode-of-care management for the types of patients whom they are best trained to serve. In

proposals until after June 1, 1998. In February, however, it said that it would begin accepting PSO proposals that meet the waiver requirements. A PSO is eligible for a waiver if the state to which it submitted its application failed to act on that application within 90 days, or is eligible for the

waiver based on other more technical reasons. These waivers will be granted under these circumstances until Jan. 1, 2003.

**Q.** *In your papers and presentations on PSOs, you have said that PSOs represent a “fundamental realignment” of the health care delivery system. For emphasis, you’ve added the metaphorical flourish that PSOs are not just “a drop in the ocean but a sea change.” Do you believe that PSOs are the wave of the immediate future and it’s better to be at the top, rather than the bottom, of that wave? Or am I overstating your beliefs?*

**A.** It’s important to understand that there are five types of Medicare+Choice plans, of which PSOs are only one. As much as 50% of the Medicare population will be in one of these plans by the middle of the next decade. So, while PSOs are extremely important, and I’m excited about them, they should be viewed in the context of the other Medicare+Choice plans.

**Q.** *You’ve also said that PSOs are a “sustainable alternative” to Medicare HMOs even though many, perhaps most, hospitals don’t have the capital reserves to start up, much less sustain, a PSO. What’s more, many people have criticized physician-hospital relationships because the hospital is usually the dominant partner in such relationships, as it is in most physician-hospital organizations (PHOs). Why should PSOs be any different than PHOs?*

**A.** I concur completely with the validity of your question, but you have to differentiate between a contracting entity like a PHO—which has little medical management experience, infrastructure, ability to handle reserves, and so on—and what I’ll call second- and third-generation PSOs or integrated delivery systems—which are structured to build risk plans and handle some type of capitation, preferably global capitation or a large percentage of premium capitation. The latter types of plans go the extra mile in managing many of these complex issues that the historical first-generation PHOs did not.

**Q.** *Some argue that PSOs are a formula for “instant integration” because the stakes are so high when 40% to 60% of the revenue of hospitals and many specialists—particularly those who care for the elderly—stems from Medicare. Do you agree with the “instant integration” scenario?*

## “Combined, Medicare+Choice plans make up a continuum of plans that are far from the bread-and-butter HMO.”

**A.** Speaking from over a decade of experience with integrating physicians, hospitals, and fiduciaries, I can say there is no such thing as instant integration, although clearly the Medicare+Choice revenue stream will create an impetus to integrate.

**Q.** *What do you say to critics who assert that PSOs are another S&L crisis about to happen? Will PSOs be another financial train wreck—with taxpayers left to handle the cleanup and with abandoned patients seeking another source of care?*

**A.** Those who are concerned about the operating requirements that PSOs will have to meet have speculated that the federal government may be getting in over its head in terms of sanctioning and supervising PSOs, and have drawn comparisons with the S&L crisis in the 1980s. I think few parallels can be drawn in these comparisons. In certifying PSOs that can meet the needs of Medicare beneficiaries, HHS is focusing on a number of requirements involving licensing, certification, solvency, and ongoing operating and compliance requirements. In fact, there is far more governmental supervision of these PSOs than there ever was for the S&L industry in the 1980s.

**Q.** *How much has the consumer backlash against traditional HMOs driven the PSO movement? Some have argued that HMOs are commanded by heartless out-of-town executives, while PSOs will be owned by community hospitals and physicians who have to look their fellow citizens in the eye every day.*

**A.** There are excellent HMOs that operate with the patient’s best interest at heart, but there are also HMOs that are simply mediocre. So, to answer your question without stereotyping all HMOs as bad or all PSOs as good, I think you need to look at the basic mission, vision, and values of all these organizations, which basically are trying to put the patient first.

**Q.** *In your presentations, you point out the enormous business opportunities the Medicare market will create for hospitals and*

*local physicians. Would you elaborate on that point here?*

**A.** It’s important not to overgeneralize, but it is perhaps realistic to take an example of 10,000 Medicare beneficiaries over a three-to-five year period. You’re looking at a \$50 million revenue stream at \$5,000 per beneficiary. As a result, the amounts of money going through PSOs could be substantial and will require significant expertise in health plan operations and medical management. There is a huge opportunity here for doctors and hospitals to do well by managing patient care effectively and in ways that they have historically been very knowledgeable about. The Achilles heel in all this is that they will need to have an administrative infrastructure that allows them to manage that care actively in a way that is both accountable and defensible in terms of all the federal requirements attached to these types of plans.

**Q.** *You have stated that the new PSOs should be fairly easy to start because the government is encouraging them and removing obstacles to their formation, such as having fewer solvency requirements than HMOs, readily available consulting and managed care expertise, dropping of the 50:50 rule, and the modest requirement of having to sign up only 1,500 Medicare beneficiaries in urban areas and 500 in rural areas. Would you elaborate?*

**A.** All of the factors listed in your question clearly allow PSOs to accelerate the process by which they take on Medicare+Choice risk contracts. The single biggest issue is the ability to hold the state licensing authority to only 90 days in terms of the application process. Historically, state licensing agencies have rarely been able to certify a plan for risk contracts in that period. As a result, if the state fails to act, the federal government then has only 60 days by which to accept or not accept the entity’s application for a waiver. Then, too, there is the four-to-six month process by which that

*(Continued on page 12)*

**“The Achilles heel in all this is that physicians will need to have an administrative infrastructure that allows them to manage care actively in a way that is both accountable and defensible.”**

*(Continued from page 11)*

entity has to meet all sorts of rules and regulations. So, clearly, this will be an accelerated route that is much more rapid than the historical HMO process.

**Q.** *Why are PSOs different from Medicare HMOs, and why do they deserve to have different solvency requirements?*

**A.** First, because PSOs, by definition, must be 51% owned by the providers that are actually delivering care to the patients they are serving in a particular geographic region, the doctors and the hospitals have an intimate stake in both the community and the patients they are serving. This requirement clearly separates PSOs from investor-owned HMOs, which, from an ownership perspective, may or may not have a direct relationship with the communities they serve. As a result, the affiliated providers are closer to the actual delivery of care than fiduciaries that have historically operated under a centralized management structure in a far-away locale, as opposed to the decentralized manage-

**“The 78 million baby boomers currently in the pipeline to enter Medicare in the first quarter of the next century will clearly have health care expenditures and expectations that outstrip the Medicare+Choice program.”**

ment structure of many local delivery systems. Even so, the solvency requirements should be fair and relatively even in terms of both the HMO fiduciaries and the PSOs. The problems we have seen occur in states that have high solvency requirements that are disproportionate to what doctors and hospitals can afford to pay. So I am not a proponent of having substantially different solvency requirements, but rather of having fair, relatively affordable solvency requirements for all risk-bearing entities, whether they are PSOs or HMOs.

**Q.** *What does the Medicare+Choice program in general and the PSO movement in particular have to do with the tidal wave of 78 million baby boomers about to break through the Medicare floodgates?*

**A.** I would like to tell you that the Medicare+Choice program, and PSOs in particular, will be the solution for those 78 million baby boomers, but I would be wrong in saying that. The 78 million baby boomers currently in the pipeline to enter Medicare in the first quarter of the next century will clearly have health care expenditures and expectations that outstrip the Medicare+Choice program. In 2003, we will have to revisit what we want to do to keep the trust fund solvent and have to create incentives for new Medicare beneficiaries to enter new and different programs. But by the time we reach 2003, we will have learned from this Medicare+Choice program and be better able to identify the kinds of options to make available to those 78 million baby boomers and to assess the impact those options will have on retiree structures, pensions and pen-

sion funds, and postretirement funding liabilities for large corporations.

**Q.** *There are some 3,100 counties in the United States, each with a different AAPCC [average annual per capita charge] for Medicare beneficiaries. The average AAPCC in 1997 was \$395, per month, but it varied from \$221 in Arthur County, Nebraska, to \$767 in Richmond County (Staten Island), New York. Only 289 counties (9%) had a rate over \$500. What does it take to make a PSO profitable, and will this rate change over the next five years?*

**A.** The federal government has articulated three Medicare+Choice AAPCC-like reimbursement formulas. But, in fact, the AAPCC is technically a thing of the past, having been replaced by the new Medicare+Choice reimbursement rates, mainly because now no AAPCC will be less than \$367. Essentially, an artificial floor has been created so that the AAPCC, which used to be based on calculations, is not a calculation any longer. This means an increase in the AAPCC from the \$200-\$300 range to \$367 in 1998. There will clearly be an opportunity in some of them for increased reimbursement for doctors and hospitals if they are part of Medicare+Choice plans, but they will not benefit from this increase if they remain in fee-for-service medicine based on RBRVS [resource-based relative value scale reimbursements] or DRGs [diagnosis-related groups] as it is today.

**Q.** *You have predicted that as many as 800 PSO requests for proposals will be filed before the PSO closing date at the end of 2002. Are you being realistic?*

**A.** What I said is that there will be 800 Medicare+Choice health plan proposals submitted for the five kinds of health plans in the program, at least twice the number of what we see in terms of Medicare HMOs today. So, I think I'm being realistic by including all the different plans. A good number of them will be PSOs, but I doubt all 800 of them will be PSO applications.

**Q.** *You have written that PSOs offer doctors the opportunity for an optimal physician strategy. What is an “optimal physician strategy?”*

**A.** An optimal physician strategy allows physicians to do what they do best: practice the highest quality medicine for the largest number of patients at the lowest possible cost, meaning the highest possible value. These are the kinds of goals that corporate America sets for many of its programs. They are also the goals now being set by HHS. Most important, they are the goals that individual patients think are reasonable and sustainable over time. ■

# PSO Solvency Standards Recommended

By Edward B. Hirshfeld, JD

Under the Balanced Budget Act of 1997, Congress created the Medicare+Choice program, which allows Medicare patients to select from a variety of health plans as an alternative to traditional Medicare fee for service. Among the health plans that patients may select are provider-sponsored organizations (PSOs) established and operated by providers.

PSOs must be licensed in the state of operation or obtain a waiver from state licensure (see "PSO Regulations Will Be Demanding," February). In addition, PSOs must meet solvency standards developed by the federal Department of Health and Human Services (HHS). PSOs that obtain a waiver must comply with all state consumer protection statutes other than the state solvency standards and related licensure requirements.

The act required HHS to convene a negotiated rule-making committee to make recommendations for federal solvency standards. The committee convened last fall, and consisted of representatives from provider associations, including the American Medical Association (AMA), payer associations, patient advocacy groups, and government regulators. The rule-making process required committee members to agree unanimously on a recommendation that all members could "live with," even if it were not to their complete satisfaction. HHS will use the recommendation as the basis for a rule setting forth federal PSO solvency standards, which was scheduled for publication last month.

The committee finished its work on March 5. Its recommended standards have two parts: standards that must be met when a PSO applies for a waiver (initial application), and those that must be met after a waiver has been granted (ongoing operations).

## Initial Standards

For the initial application, the PSO must have a minimum initial net worth of \$1.5

*Edward B. Hirshfeld, JD, is a vice president in the AMA's Health Law Division.*

## Comparing Federal and State Standards

Federal Standards Are	Than Standards in These States
Less rigorous	Florida, Idaho, Maine, New Hampshire, New York, Pennsylvania, South Carolina, Tennessee, Virginia, Washington, Wisconsin
May be less rigorous*	Hawaii, Indiana, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New Mexico, Vermont
Roughly equivalent	Colorado, Illinois, Minnesota, Missouri, North Carolina, North Dakota, Ohio, Texas, West Virginia
More rigorous	Alabama, Alaska, Arizona, Arkansas, Connecticut, Delaware, Iowa, Kansas, Maryland, Montana, Oregon, Utah
May be more rigorous*	California, Georgia, Massachusetts, Michigan, Nevada, North Dakota, Oklahoma, Rhode Island, Wyoming

\* Depends on discretionary requirements of the states.  
Source: AMA, Chicago, 1998.

million, which may be reduced to \$1 million if the PSO contracts with a parent or a vendor to supply administrative and managerial services instead of investing in the infrastructure necessary to handle those functions itself. The PSO also must have sufficient cash to meet obligations as they come due, and \$750,000 of the net worth amount must be in cash or cash equivalents.

The PSO also must file financial projections that show when the PSO will break even or show a profit for 12 consecutive months. The first six months of any projected operating losses must be prefunded, and there must be adequate security, such as a parental guarantee or a letter of credit, to cover the balance of the losses up to the break-even point. Finally, the PSO must deposit \$100,000 with HHS, which may be counted toward net worth.

Tangible health care delivery assets may be counted toward net worth calculations at 100% of their book value under generally accepted accounting principles (GAAP) issued by the Financial Accounting Standards Board (FASB). In addition, 20% of the net worth amount may consist of goodwill recognized under GAAP if the PSO has at least \$1 million in cash, but no more than 10% may consist of goodwill if

the PSO is eligible to have a minimum net worth of less than \$1.5 million or has less than \$1 million in cash.

## Ongoing Standards

The minimum ongoing net worth is calculated according to one of four tests. The PSO must have a net worth that is greater than at least one of

1. \$1 million
2. 2% of annual premium revenue on the first \$150 million of premium, and 1% of premium in excess of \$150 million
3. An amount equal to three months' worth of uncovered expenditures
4. An amount equal to 8% of health care expenses paid to nonaffiliated providers on a noncapitated basis, plus 4% of health care expenditures paid to nonaffiliated providers on a capitated basis and paid to affiliated providers on a noncapitated basis, plus 0% of health care expenditures paid to affiliated providers on a capitated basis.

The cash requirements for the ongoing net worth calculations are similar to those of the initial application in that the PSO must have sufficient cash to meet obligations as they come due. But the require-

(Continued on page 14)

(Continued from page 13)

ments for ongoing calculations are different in that the PSO needs to have the greater of \$750,000 or 40% of minimum net worth requirements in cash.

To determine cash sufficiency, HHS will consider the timeliness of claims payments, the extent to which the current ratio is maintained at 1:1; whether there is a change in the current ratio over time; and the availability of outside financial resources. If the PSO fails to pay obligations when they come due, HHS will require the PSO to initiate corrective action to pay all overdue obligations. HHS also may require corrective action if the PSO's current ratio declines significantly or shows a continuing downward trend. Corrective actions may include:

- A change in the distribution of assets,
- A reduction of liabilities, or
- Use of alternative arrangements to secure additional funding to restore the current ratio to 1:1.

### Easing Requirements

The recommended standards also allow a PSO to use a technique that makes it easier to meet net worth requirements. The PSO may ask its affiliated providers to agree to have withheld a portion of the amount owed to them by the PSO for services rendered to PSO beneficiaries during every quarter. At the end of the quarter, the PSO may retain the amount withheld if the PSO is not able to meet its net worth requirements. If the providers subordinate their claims on the withheld amount to the liabilities owed to all other creditors, HHS will not treat the claims as liabilities on the balance sheet. This reduction of liabilities to affiliated providers makes it easier for the PSO to meet net worth requirements because available cash is not offset by liabilities to pay affiliated providers.

An example of how the liability reduction can work is as follows. PSOx withholds 25% of payments owed to affiliated providers for services provided to PSOx beneficiaries, and makes payment contingent on PSOx meeting its net worth requirements at the end of each quarter. The providers agree to subordinate their claims to the withheld amount to all other liabilities of PSOx. The withheld amount comes to \$250,000. At the end of the third quarter, PSOx falls short of its net worth requirement by \$250,000. It has

enough cash and other assets to meet the requirement, but those assets are offset by its liabilities in the calculation of net worth. PSOx then retains the withheld amount and the claims for payment are not treated as a liability. Therefore, the liabilities of PSOx are reduced by \$250,000, and PSOx meets its net worth requirement.

### New PSOs

New PSOs that project losses must prefund losses with cash or cash equivalents up to the projected break-even point. An irrevocable, clean, unconditional letter of credit may be used in place of cash. Guarantees also may be used in lieu of cash if the guarantor meets standards developed by HHS. The guarantor must commit that throughout the first year of operations, it will provide the PSO with enough cash at the beginning of each quarter to cover its projected losses for two quarters ahead and one quarter ahead at the

beginning of the third quarter. If the guarantor has met these obligations in the first year, the PSO may notify HHS that it intends to stop prefunding projected losses for two quarters ahead and simply provide cash as needed to assure timely payment of the PSO's obligations. HHS must notify the PSO within 60 days if it wants prefunding to continue. A PSO may use lines of credit from regulated financial institutions, legally binding agreements for capital contributions, or other legally binding contracts of a similar level of reliability to fund projected losses after the first year.

compared with state standards, providers may want to form Medicare+Choice PSOs. If the standards are unfavorable compared with those of the states, few providers will want to participate. In this regard, it is difficult to compare federal PSO solvency standards to state HMO standards for two reasons. First, there is wide variation among the states. Net worth requirements listed in state statutes range from \$100,000 (Alabama) to \$6 million (New Hampshire). Second, most states give the insurance commissioner discretion to add to or waive statutory net worth requirements. In recent years, many commissioners have added requirements to reflect the large investments necessary to form a new successful health plan. Most state solvency standards have not been changed in many years, and do not reflect the current amount of investment necessary.

The AMA has compared the recommended standards to statutory and discre-

## **New PSOs that project losses must prefund losses with cash or cash equivalents up to the projected break-even point.**

tionary requirements of the states. It appears that the federal PSO standards are less rigorous than the standards in 11 states (see table). Federal standards are roughly equivalent to the standards in nine states. In nine states, the federal standards are less rigorous than the state statutory standards, but the AMA does not have sufficient information about discretionary requirements to determine whether the standards are less rigorous overall. In nine states, the federal standards are more rigorous than the state statutory standards, but, again, the AMA lacks sufficient information on discretionary requirements. It is likely that the standards in some states that appear to be less rigorous than the federal standards are in fact more rigorous. Finally, in 12 states it appears that the federal standards are more rigorous than the state standards.

Later this spring, HHS is expected to issue other rules about the structure of PSOs and criteria for health plans that want to participate in the Medicare+Choice program. As rules are discussed we will continue to follow the developments. ■

### Federal Versus State

How federal and state standards compare with each other is important to the success of PSOs. If the federal standards are favorable

# PPMCs Continue to Raise Public Capital

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

While the market for stock in physician practice management companies has been turbulent recently, PPMCs continue to raise capital in the public markets, allowing them to acquire practices and improve their operating structures.

Two PPMCs have completed initial public offerings in 1998, and several others are waiting to price their offerings. BMJ Medical Management Inc., in Boca Raton, Fla., completed an IPO on Feb. 4, raising \$28 million to repay outstanding debt. Its 4 million shares were priced at \$7 each, which was less than the \$9 to \$11 range stated in its preliminary prospectus. BMJ is a single-specialty PPMC focused on muscu-

loskeletal care consisting of orthopedic surgery, physiatry, rheumatology, and podiatry. As of February, it was affiliated with 25 physician practices, including 117 physicians in Arizona, California, Florida, Pennsylvania, New Jersey, and Texas and one independent practice association with 42 physicians in Arizona.

On Feb. 11, Birner Dental Management Services Inc., in Denver, Colo., offered 1.8 million shares priced at \$7 per share, raising \$12.8 million in an IPO. Birner will use the proceeds for working capital and to repay debt, make acquisitions, and develop new dental offices. The company manages 34 dental offices in Colorado and New Mexico.

One PPMC has completed a secondary offering in 1998, and another is waiting to price its shares. Complete Management Inc., a PPMC in New York, completed the sale of 2 million shares for \$21.5 million on Feb. 10. The company also announced that it was in discussions with a bank for secured credit that would include a term loan and revolving credit. The company provides practice management services to medical practices and hospitals in Connecticut, New Jersey, and New York, and it owns Consumer Health Network, the largest PPO in New Jersey. Omega Health Systems Inc., in Memphis, is a PPMC specializing in ophthalmology that is waiting to price its shares. ■

## PPMC Offerings Completed or Planned

Company	Location	Specialty	Offer or File Date*	Size (\$ in millions)
<b>Initial Public Offerings</b>				
BMJ Medical Management Inc.	Boca Raton, Fla.	Musculoskeletal	Feb. 4	28.0
Birner Dental Management Services Inc.	Denver	Dental	Feb. 11	12.8
<b>Secondary Offerings</b>				
Complete Management Inc.	New York	Multispecialty	Feb. 10	21.5
<b>Initial Public Offerings in Registration</b>				
DentalCo, Inc.	Baltimore	Dental	Sept. 10	50.0 **
Pentegra Dental Group Inc.	Phoenix	Dental	Oct. 14	40.3 **
U.S. Physicians Inc.	Fort Washington, Pa.	Multispecialty	Nov. 12	50.0 **
Physician Health Corp.	Atlanta	Multispecialty	Nov. 13	69.0 **
<b>Secondary Offerings in Registration</b>				
Omega Health Systems Inc.	Memphis	Ophthalmology	Oct. 23	22.5 **

\* All dates for completed offerings are this year; dates for offerings in registration were filed in 1997.

\*\* Size is an estimate.

Source: Townsend Frew & Co., Durham, N.C., and company reports.

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### Disability Claims Rise Sharply Among Physicians

Some 10,000 physicians filed disability claims within the last year, about five times more than the number of physicians who filed such claims 10 years ago, according to *The Boston Globe*. Physicians are quitting the profession earlier than they had in the past, according to James Johnson, a spokesman for Provident Life & Accident, a disability insurer for physicians. "Now, physicians are calling it quits, and they're using their disability policy in place of a retirement program," he said.

Disability claims from physicians began to rise in 1988, and in one six-month period, rose by 60%, said a spokesman for UNUM Life Insurance, a disability insurer. The rise in disability claims by physicians has been sharpest in the 1990s, UNUM said.

The loss ratio, a measure of insurance claim payments versus premium income, from physicians and other medical professionals has risen sharply while the loss ratio from other professionals has been stable, according to Northwestern Mutual Life, a disability insurer. In some cases, claims from medical professionals are double those of other professionals, Northwestern said.

The trend is especially surprising because physicians had been among the professionals who rarely filed disability insurance claims, the *Globe* reported. "Suddenly that rare occurrence where a doctor went on disability was happening as much as four to five times as often as anticipated," one insurance broker told the *Globe*. It doesn't take long before the problem becomes one costing hundreds of millions of dollars, the broker said.

**Comment:** Insurers believe dissatisfaction as a result of managed care is the reason many physicians file disability claims, the *Globe* reported. In response, insurers have increased premiums, cut benefits, and placed physicians among other high-risk occupations.

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