

PHYSICIAN PRACTICE OPTIONS™

June 1997

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

Case Study: Primary Care Group Finds Success With Health System Partner

Through an uncommon degree of collaboration between physicians and a hospital system, one of the nation's largest primary care medical groups and a regional health system have created a medical management company capable of entering into full-risk managed care contracts. The company, Premier Health Services, in Fairfax, Va., has about 30,000 covered lives. It is equally owned by Fairfax Family Practice Centers, a group of about 55 primary care physicians in Fairfax, and Inova Health System of Springfield, Va., a not-for-profit hospital system with four acute care facilities, including Inova Fairfax Hospital.

"There is an historic mistrust between

"Owning the means of production, with little or no help from nonphysician investors, can restore to physicians influence over health care delivery they have been losing to managed care and hospitals."

—William Carter, MD, Fairfax Family Practice Centers

physicians and hospitals," says David Kibbe, Inova's senior vice president for managed care. "To a large measure, we've overcome that." He describes FFPC as "progressive, with a long-standing ability to accept risk and a strong willingness to work within an

integrated system. We don't always agree on everything, but through regular meetings and recognition of our mutual commitment to the quality of care delivered, we've worked hard to overcome distrust and to develop a managed care system with FFPC that emphasizes the physician-patient relationship."

William H. Carter, MD, the group's president and CEO, says, "There are many horror stories doctors tell about working with hospitals, especially hospitals that view the groups they affiliate with as employees and which have no interest in developing an integrated system of care. Inova is very, very sincere about focusing on the quality of service delivered, and that is the most important issue to us, especially in a cost-conscious managed care environment.

"We had a number of partnership choices," Carter continues. "We could have gone with any one of a number of physician practice management companies or a large for-profit system like Columbia/HCA, but we wanted to be in business with a system that's not solely motivated by quarterly share returns and whose decisions are filtered through a value system based on quality health care that respects the physician-patient relationship."

CONTENTS

Features

Commentary
Are Clinical Performance Measures a Tool for De-selection? 3

Interview
Gastroenterologists Struggle With Managed Care 8

Departments

Editorial:
Opportunity Knocks for Physicians with Business Skills 2

Capital Ideas
How Selling to a PPMC Affects Physician Compensation 12

Current Trends
A Look at How MCOs Pay Providers 13

News & Commentary 15

(Continued on page 5)

Opportunity Knocks for Physicians with Business Skills

Physicians are discovering that they need more than a solid medical background. In markets dominated by managed care, they need business acumen. To get an idea of how much they need to learn about business, consider how some business professionals view physicians.

Recently, I met with a group of investors who put money only into health care enterprises that promise returns of 40% to 50% within two years. Anyone seeking such aggressive returns knows exactly what success factors to look for before investing:

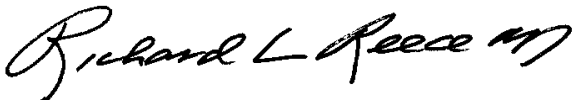
1. A credible physician leader with business experience who can articulate both clinical and financial strategies.
2. A management team with experience in managed care, capitation contracting, marketing, and business information systems.
3. A market share of 20% and revenue of at least \$50 million annually.
4. A group strategy, focused on a physician network or on a multispecialty, a single-specialty, a primary care, or a hospital-based practice.
5. Appropriate equity incentives and strategies to induce physicians to change their clinical behavior so that they focus on cutting costs, promoting disease prevention, and improving the health of plan participants.

Investors, in general, believe that physicians lack the ability and the experience to act as prudent business professionals and to do what is needed to become more efficient practitioners. "Doctors will never change enough to make rational business decisions," one investor commented. "They are simply not rational business animals."

It's true; most physicians don't market their skills, grow their practices, or invest for the future, all routine business practices. But even though physicians have been trained to be advocates for their patients, not business professionals, it is possible for them to be both a good patient advocate and a good business person. In fact, many physicians are becoming more attuned to business matters.

At least 80% of graduating residents are joining groups, allowing physicians to pool their business and clinical skills. The American College of Physician Executives in Tampa, Fla., has 12,827 members and has trained 11,000 physicians in a variety of management courses. More needs to be done, however. Martin Merry, MD, a physician consultant in Exeter, N.H., says physicians have opportunities today unlike any that they have had in the past. In "Physician Leadership: The Time is Now," an article published by ACPE in the September issue of *Physician Executive*, he wrote: "Mainstream physician leaders now stand on the threshold of a historic opportunity to regain influence over their profession's future and to become architects of core elements of the future health system."

If physicians quickly acquire the business skills they need to compete under managed care and combine those skills with their clinical skills, they could easily become a major force in reshaping the health care system and in directing its future. But first physicians must accept that their lack of business skills under the current structure can be a handicap.



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Are Clinical Performance Measures a Tool for De-selection?

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

Physicians want managed health plans to emphasize quality over cost. But standardized clinical performance measures, which will do just that, are unnerving doctors.

This fall, United HealthCare Corp., in Minneapolis, the nation's largest managed care organization (MCO), will issue reports on clinical performance to thousands of paneled physicians in four of its health plans. "Many doctors fear these measures will be used as de-selection tools, not necessarily by United HealthCare, but generally," says Manuel T. Lowenhaupt, MD, an expert on clinical effectiveness and principal with William M. Mercer Inc., health care consultants in Boston. "They wonder whether these measures will be used as an excuse to drop them when an HMO trims its panel if their scores are not high enough."

Jonathan Seltzer, MD, director of health systems research for Premier Research Worldwide, researchers in Philadelphia, says, "Many physicians are not entirely convinced that managed care's motives are honorable. They aren't sure what's going to happen with these quality measures. The danger is that there is a possibility of abuse if performance data are not used to improve the quality of care, but instead are used only as a compliance tool."

An important issue is how performance is defined, 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 consultant in Exeter, N.H. "How measures are defined—as production measures or as part of a clinical support system—can have a profound effect on the overall quality of health care."

Correction

Our cover article in March reported incorrectly what physicians are paid. The article should have said that in the East, the premium paid for physician services is \$120 to \$140 per member per month. On the West Coast, the premium paid for physician services is \$90 to \$110.

Seltzer agrees, saying clinical performance measures will drive the growth of third-party audits. "The key to avoiding that is to design data collection as part of a larger scheme dedicated to improving care," he explains.

Changing Relationships

Reports from United HealthCare (UHC) that are based on clinical measures, not on production standards, will be issued directly to physicians. The company has not yet decided which of its 40 plans will be the first four to issue the performance measures, but eventually all of its more than 200,000 physicians will receive individualized reports, says Lee Newcomer, MD, UHC's chief medical officer and a member of the advisory board of *Physician Practice Options*. "These measures are an additional profiling tool," says

used for de-selection, Newcomer contends, unless "there was a total lack of cooperation on the part of the doctors in attempting to achieve these standards. The reason we're giving these data to physicians is to improve their practice, not for punitive reasons. It is not our philosophy to terminate doctors."

Simply issuing such reports directly to physicians represents a significant change in the relationship between physicians and MCOs. Most MCOs gather performance data at the health plan level, and most HMOs are network-model health plans that contract with many different physician groups. Since each physician group has its own procedures and protocols, most MCOs have not measured physician performance directly and, in fact, manage physicians only indirectly.

"We believe all physicians eventually will be paid by MCOs for clinical performance and results, rather than for production."

—Lee Newcomer, MD, United HealthCare

Newcomer. "Their intent is to improve the quality of health care. Performance measures always make people uneasy, so the anxiety of some physicians doesn't surprise me. But de-selection and punitive measures resulting from these reports is contrary to UHC's philosophy and business practices."

UHC may be the first MCO to measure clinical performance and report the results to individual physicians in its network. "Our performance measurements are based on delivering the right treatment, in the right place, at the right time," Newcomer explains. "These measures place a professional emphasis on quality, rather than on cost. We believe all physicians eventually will be accountable for clinical performance and results, rather than for production."

Clinical performance reports will not be

Experts expect performance measurement at the physician level to become standard among MCOs. (See box.) "The reality is physicians will need to become familiar with being accountable to a third party for the quality of the clinical care given to patients," says Seltzer. "It is very important that MCOs begin to collect patient-level data and report that data to physicians because such information is critical to the delivery of quality health care in the 21st century."

A Systems Approach

UHC's first measurement sets will contain about 18 clinical measures relevant to physician specialties. An individual physician in UHC's network may receive a report on, for example, the number of

(Continued on page 4)

(Continued from page 3)

mammograms ordered for female patients between the ages 50 and 74. The report will list the names of individual patients covered by UHC who have not received mammograms and urge the physician to encourage his or her patients to have this diagnostic test.

If used properly, physician performance measurement can be a highly effective tool for improving health care quality and health plan performance, says Merry. "The more systematic clinical information physicians have, the more able they are to practice high-quality medicine," he explains. "I am unequivocally in favor of physicians having this type of information, but most physicians do not have the kind of internal information systems necessary to monitor the type of data UHC is planning to provide."

For performance measures to be used as effective quality-improvement tools requires a comprehensive approach. "This is truly a systems issue," says Merry. "Each performance measure in and of itself is com-

plex, reflecting social practices and especially reporting issues. It's a good first step, but simultaneously there must be a plan to improve performance and that requires a systems approach."

Degree of Compliance

Commenting on UHC's physician-level reports, Lowenhaupt says, "It's an interesting and probably appropriate direction for improving the quality of care and physician accountability. The questions are: Who owns the data? What degree of compliance will trigger clinical audits? And how will information be collected and reported?"

Newcomer responds that UHC is aware that some physicians may lack the infrastructure to make compliance with UHC's standards smooth and uncomplicated. Therefore, the MCO will help these physicians acquire the necessary systems. "But we are not talking about hard things to do," Newcomer explains. "These reports identify patients who missed certain tests and measures by name, birth date, and patient

number. We will provide the lists to the physicians, who can then have their nurses use the lists to contact and encourage patients who need the tests to get them. We are already sending out notices to our health plan members about the need for immunizations and mammograms. But we can't do that for everything we measure. We need the physicians to help. And they don't have to report back to us. We will be able to measure their compliance through their current billing systems."

UHC does not expect overnight improvement, Newcomer says. "Next year we will be looking for improvement," he says. "The folks who show no improvement or get worse are the ones we'd visit to ask what's going on, and we would try to work with them."

Some observers may criticize UHC's approach, but Newcomer believes the performance reports will improve health care quality. "We are not trying to run physicians' practices. We are trying to help them improve the quality of care." ■

Components of an Effective Physician-Performance System

Clinical performance measures can be an important part of physician profiling, a measure of outcomes at the physician level, say health care experts. Indeed, measuring physician-specific outcomes may be the only way to assess whether the goals of a health care organization are being achieved and whether quality care is being rendered by physicians, according to Jonathan Seltzer, MD, and David B. Nash, MD, editors of *Models for Measuring Quality in Managed Care: Analysis and Impact*, published this year by Faulkner & Gray, New York. Seltzer and Nash list the following components of an effective physician-level analysis:

- A standard outcome, representing outcomes that are ordinarily achieved;
- An expected outcome, calculated from the rate at which the standard outcome occurs and then adjusted for differences unique to the physician's group of patients being assessed;
- A measurement of the actual outcome of the physician's practice;
- A comparison of the actual outcome with the expected outcome; and
- An analysis to determine whether the difference is too small to be important or solely due to chance.

The most important aspect of a profile is the actual outcome measures selected for inclusion, say Seltzer and Nash. Therefore, choosing the outcomes and the standards for the outcomes is the

foundation of the entire profile, they say. The selected outcome measures should summarize important aspects of care and should not be selected based only on ease of measurement.

Moreover, physician-specific outcomes should measure events physicians can control. They should summarize the care being evaluated and be valid reflections of the aspects of care they measure. They should also reflect occurrences that can be observed readily and can be reproduced.

An ideal physician profile would be nonjudgmental and the outcome measures involved would be:

- Based on the physician's patient panel;
- Disease-specific;
- Adjusted for the severity of illness present in the population being served; and
- Based on accurate data.

In addition, the results of any outcomes data collection

- Would be reported to physicians in the form of user-friendly reports that include a thorough explanation of methodology and terms;
- Would allow physicians to improve quality;
- Would not be released to the public without also educating the public adequately about the limitations of the methodologies involved; and
- Would not identify individual physicians for problems that may be more indicative of system inadequacies.

COVER STORY

(Continued from page 1)

The Inova-FFPC relationship is somewhat uncommon, in part because doctors and hospitals are not in the same business, says J. Daniel Beckham, president of the Beckham Co., physician and hospital consultants in Whitefish Bay, Wis. "Medical practice is a retail business. Hospitals are a manufacturing business. Hospitals tend to view doctors as employees, and they view employees as subordinates. Many doctors don't take well to that kind of relationship," explains Beckham, a member of the board of advisers of *Physician Practice Options*.

"The truth is the relationship between doctors and hospitals is never going to be easy," Beckham adds. "For one thing, managed care fragments relationships between hospitals and doctors, even doctors and doctors. It interjects conflict. In their minds, these doctors were selling the business side of their practices to hospitals to protect the clinical side. Now, they bristle to realize that the manu-

"Premier proves hospitals and doctors can build a business that is not hospital-driven nor physician-driven, but is driven financially by meeting the medical needs of the community."

—William Carter, MD

facturing side is intruding on the clinical side."

Increasingly, physicians view nonprofit hospitals, in particular, as being unwilling to create real partnerships. Many nonprofit hospitals are uncomfortable with the concept of giving physicians an ownership stake in the business, Beckham says. "They tend to view the concept as an affront to their not-for-profit values."

Mutual Interests

Addressing these and other issues, FFPC and Inova had discussions for three years before they formed Premier in 1993. "It took time for Inova to understand who we are and what direction we were headed in," Carter says. "They had to understand that we were committed to dealing with patients effectively at the population level, and at the global budget level, and not at the level of any particular facility. That was a change for people who are facility-oriented, like those in a hospital system." For their part, Inova executives needed to think beyond the hospital itself so that they expanded their vision of health care to focus on the population being served in the community at large, Kibbe says. "We are working to shape a full health system of community care as opposed to a health care delivery system," Kibbe explains. "The key to holding down health care costs is to provide necessary care as early as possible, not seeking to avoid providing care."

"The real reason for all of this is that it's a better way to take care of patients," Carter says. "Premier is clinically focused, focused on

(Continued on page 6)

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(Continued from page 5)

outcomes for the entire community." As a medical management company, Premier is similar to a management services organization in that it provides utilization review, precertification, appointment, billing, and other management services, but Premier also delivers medical care. "FFPC physicians participate in community-based services, such as Inova's clinic for indigent children and a smoking-prevention program in the public schools. These endeavors serve to control our population's overall health care costs by treating people before they become ill," Carter says.

Premier Health Services

The first global capitation contract was signed by Premier in 1993 with Aetna (now

reimbursement is not based on the number of services provided, providers are at-risk for the cost of care above the monthly fee. If care for each patient costs less than the fee, the provider, or in this instance, Premier, keeps the difference. If care costs more, the providers pay. Full-risk capitation means Premier has full financial management responsibility for planning and delivering primary care, specialty care, hospitalization, and ancillary services, such as home care and rehabilitation. Capitation contracting requires information systems, experienced managers, and accounting expertise to determine competitive rates that allow providers to make a profit.

FFPC manages Premier's medical services and receives a fee from Premier for those services. Both FFPC and Inova provide

cially by meeting the medical needs of the community."

Premier is developing risk-sharing relationships with specialist groups, something FFPC has been planning for several years. "We look to FFPC for leadership in developing medical care arrangements," Kibbe says. "It has been involved in risk assumption for many years."

In 1995, Inova strengthened its ties to FFPC by becoming a minority investor in the medical group. That investment provided FFPC with the capital necessary to continue expansion while allowing FFPC's physicians to maintain influence over their future, Carter says. The investment also was used to retire debt and to establish supplemental retirement funds for FFPC member physicians. Until Inova's investment, the group's expansion was funded entirely by member investment. "Physicians can thrive from ownership of group practices they finance themselves," Carter says. "Owning the means of production, with little or no help from nonphysician investors, can restore to physicians the control over health care delivery they have been losing to managed care and hospitals."

The decision to allow Inova to purchase a minority share of FFPC was not an easy one, Carter says. The group met with insurers and Wall Street investors before making its decision. "The reason we chose to affiliate with Inova had more to do with our belief that its not-for-profit organization and commitment to the community were in keeping with the value system of our physician group," Carter explains. "Linking with Inova was not the best financial arrangement we could have made, but we chose it because it is also mission oriented."

Fairfax Family Practice Centers

One of the largest family practice groups in the country, FFPC serves an estimated 90,000 covered lives. It began as a two-physician unincorporated practice at one site in 1969, and has grown into a 55-physician primary care group with nine sites. FFPC's evolution into an autonomous multisite group practice began in 1982. That year the four physicians in the practice at a single site in Vienna, Va., faced what Carter called two critical precipitating factors that led to expansion: the retirement of one of its two

Success Factors for Physician Groups Planning to Expand

Fairfax Family Practice Centers is an example of a medical group that has experienced growth by demonstrating the ability to meet the demands of managed care by accepting risk. Also, it has been successful by entering into relationships with a large hospital system.

W.L. Townsend Jr., managing director and CEO of Townsend Frew & Co., in Durham, N.C., investment bankers specializing in health care, says group practices that are good candidates for expansion like that of FFPC exhibit the following characteristics:

- Strong clinical leadership,
- A sound, well-developed business plan endorsed by physicians,
- The ability to make decisions quickly,
- An average age of member physicians that is less than 45 years,
- A strong desire among member physicians to maintain autonomy,
- Access to capital, and
- A focus on building organizational versus personal wealth.

Aetna-U.S. Healthcare). Subsequent contracts have taken a year to 15 months to negotiate, primarily because "health plans need to feel comfortable that physician groups and health systems have the ability to manage care, that they have the necessary systems in place to survive financially while providing quality managed care," says Kibbe. Premier has full-risk contracts with Aetna-U.S. Healthcare in Tysons Corner, Va., Trigon/Blue Cross of Virginia in Richmond, and NYLCare of the MidAtlantic in Greenbelt, Md.

Under capitated contracts, purchasers pay providers a fixed, or capitated, monthly fee for each health plan member. Since

medical care. The hospital system provides most, but not all, of the inpatient care to Premier patients, Carter says. FFPC provides most of the primary care, but also uses outside practices. Premier uses regional specialists, most of which are affiliated with Inova's hospitals. Inova and FFPC share equally in the governance of Premier while a joint operating committee develops strategy.

"This is a true sharing of power, and a truly integrated system of care," Carter says. "It proves that a collaboration between hospitals and doctors with a real strategy can build a business that is not hospital-driven nor physician-driven, but is driven finan-

founders, which meant a change in leadership, and the perception that managed care was inevitably coming to their market.

An inaugural step in the physicians' strategic planning was developing a mission

The practice signed its first capitated contract in 1983, and currently about 60% of its business is capitated. "In 1982, there was virtually no managed care in Northern Virginia," Carter says, "but we

pared, FFPC and Inova can assume the financial risk of delivering care, allowing Premier to "maintain income levels comparable with those of the past," Kibbe says.

"Fee-for-service payments by insurers and other payers, including Medicare, are falling all the time for hospitals and physicians," Kibbe explains. "When you compare full-risk capitated contracts with that alternative, there really isn't much choice if a provider wants to sustain an income level."

"Risk should be managed by physicians, the people closest to the delivery of care. If physicians don't manage risk, then care is managed by an outside organization or by a health plan. That is not best for the patient, and not best for the providers."

—David Kibbe, Inova Health System

Looking Forward

In recent years, Inova has made a multimillion dollar investment in physician groups. "We look for strong physician leadership, clear governance and decision-making processes, a willingness to accept risk-based contracts, and the necessary infrastructure, such as the ability to do utilization and clinical reviews," Kibbe says.

Currently, Inova owns 80% of each of eight physician practices in eastern and southern Fairfax County, Va., and is consolidating those practices into one group, to be called Inova Medical Group. Inova also has an investment in a medical group named General Internal Medicine, consisting of eight internists in Fairfax and Arlington, that Kibbe says will result in the formation of another medical management company such as Premier. It will be named Internal Medicine Associates.

When problems arise, such as friction about referrals and utilization patterns, the parties involved meet to identify solutions, Kibbe says. "Problems require discussions with the individual groups, including FFPC, about how they can work together most effectively," Kibbe says. "But we find that most groups are willing to hold those discussions. For example, some of our own specialists expressed concern about why Premier was sending patients to others instead of them. When I approached Dr. Carter about this problem, he said he would be glad to talk with them about how those decisions are made.

"Our purpose is to create alignment," Kibbe explains. "We don't believe in the single-model physician-hospital organization, but in creating several aligned ventures that can, over time, work together. Premier is an excellent example of how such alignments can lead to opportunities for physicians and hospitals." ■

statement. That statement, which has remained virtually unchanged since its adoption in 1983, reads: "The mission of Fairfax Family Practice Centers is to provide high quality continuous family medical care, to educate family physicians to provide that care, and to assure personal and professional nurturing of the people responsible for delivering that service and education."

All decisions about expansion, capital investment, infrastructure, and potential partnerships have been predicated on the mission statement. "Its importance cannot be overstated," Carter says. "Every time we make a decision, we return to that statement."

FFPC is a teaching medical practice. It operates a longitudinal residency program in an affiliation with the Medical College of Virginia, the medical school of Virginia Commonwealth University in Richmond, and Inova. In longitudinal educational programs, residents do most of their work in an office setting rather than in a hospital. "Our teaching mission has been a driving force in our decision-making," Carter says. "Running a residential program is costly and requires careful financial planning. In addition, we knew what the future of health care was going to be, and that was managed care. We felt we had an obligation to prepare our residents." FFPC operates the family practice residency program at one of its nine sites, Fair Oaks Hospital in Fairfax, and all of its physicians are qualified as assistant, associate, or full professors of clinical family practice.

certainly knew it was coming. We could see what was happening in California, Minnesota, and Colorado, and knew that these changes were being driven by employer dissatisfaction with the current health care delivery system. The societal issues in those states were not significantly different from those in Virginia. We knew it was just a matter of time." The planning required for expansion and for developing the strategies and practices necessary to prosper under managed care took nearly three years, from 1982 until 1985. "It was like any planning process. We imagined the future, then positioned ourselves to become part of that future by creating the infrastructure, such as the information system, required to accept risk contracts," Carter says.

FFPC's familiarity with managed care and its commitment to community-based medicine, exemplified by its teaching program and multisite structure, were attractive to Inova, Kibbe said. "We believe that risk should be managed by physicians, the people closest to the delivery of that care," he says. "If physicians don't manage risk, then care is managed by an outside organization or a health plan, and it tells providers where to make referrals, who to use for ancillary services, and so on," he says. "That is not best for the patient, and not best for the providers."

By preparing for managed care, FFPC and Inova have not lost income, as often happens when provider organizations are not prepared for managed care. By being pre-

Gastroenterologists Struggle With Managed Care

Q. *Dr. Groisser, let's begin by discussing how managed care has affected your practice.*

Groisser: Over the last few years, my practice has had a yearly increase in the number of managed care patients we see. In fact, on some days, almost all of our consults are managed care patients. Overall, I estimate the level of managed care penetration in my



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He is director of The Marvin M. Schuster Center for Gastrointestinal Motility and Digestive Disorders in Baltimore and is a fellow of the American College of Physicians, the American Psychiatric Association, and the Royal Society of Medicine in England.



Victor W. Groisser, MD, is chairman of the Ad Hoc Committee on Managed Care for the American College of Gastroenterology, in Arlington, Va. A practicing physician for 37 years, Groisser is a member of a six-physician practice,

The Gastroenterology Group of New Jersey, in Montclair, N.J. He also is a clinical professor of medicine at the University of Medicine and Dentistry of New Jersey, in Newark, and chief of the Division of Gastroenterology at The Mountainside Hospital, in Montclair. He received his medical degree from the State University College of Medicine in Brooklyn, N.Y., and is certified by the American Board of Internal Medicine and the American Board of Gastroenterology. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

practice is at least 25% to 30%.

Q. *In the three years that you have been on the Ad Hoc Committee on Managed Care for the American College of Gastroenterology, have you noticed an increase in the level of managed care activity in gastroenterology? In other words, is managed care having an increasing effect on gastroenterologists?*

Groisser: Managed care is affecting gastroenterologists substantially. Overall, the amount of managed care material that flows through the college has increased considerably. Just two years ago, managed care was barely included as a topic in our annual scientific meetings. In the past two years, it has had a significant place even in our scientific discussions, and we have had one or two large managed care symposia at our national meetings held twice a year on the effect of managed care on specialists. Additionally, we have a one to two day annual practice management course devoted almost exclusively to managed care.

The American College of Gastroenterology (ACG) also has four or five regional symposia annually, held in different places around the country. We also have a managed care newsletter and in our ACG monthly bulletin we have a column devoted to managed care. In addition, we have published a manual for gastroenterologists on managed care, and have distributed gastrointestinal practice guidelines.

As you may know, the college is an international organization for physicians who have a specific interest in gastroenterology, whether they be gastroenterologists, surgeons, radiologists, or PhDs. Most of the members are from the United States, and about 5,000 practice in this country.

Our primary mission is to allow gastroenterologists to continue their education through annual and regional scientific meetings, and newsletters. Recent membership surveys have shown that our members have a strong interest in problems related to managed care and practical practice problems, such as relationships

with insurance companies, Medicare coding, outcome studies, issues concerning the value of mergers, and the horizontal or vertical integration of groups.

Schuster: The managed care issue also is being addressed by other committees as well, including the Patient Care Committee and the Practice Management Committee.

Q. *What specific issues about managed care concern gastroenterologists?*

Groisser: There are several. One concerns the issue of quality. Quality concerns have been an important point for us because the mission of the ACG is to educate and enhance the skills of our members. So, we ask: How does managed care approach quality and how can we get involved? In general, we, like other physicians, have been disappointed in where managed care organizations place the emphasis in quality issues.

Evaluations of quality for most managed care companies have, to date, centered on such factors as whether patients were able to make appointments with a specialist in a timely manner, whether receptionists were cordial to patients and treated them properly, or whether the doctor spoke with patients and explained their disease clearly. As physicians, we don't deny that these factors are important, but these matters do not focus on true clinical quality.

Q. *Are you saying that managed care focuses more on patient satisfaction than on technical excellence?*

Groisser: Yes, absolutely. We want to be judged on the basis of true quality, and we think that eventually an attempt will be made to establish outcomes analysis as an index of quality, as has been done in some fields, such as cardiac surgery. But because most of the diseases in gastroenterology don't lend themselves easily to outcomes, our outcomes are somewhat based on subjective evaluation. There has been an attempt to develop scientific data-analysis systems, but these systems do not yet dominate our field. We are judged more on patient satisfaction

than other specialists are.

Another big issue is reimbursement. There has been a tremendous drop—about 50% to 55%—in reimbursement for gastroenterological procedures in the last five to six years. At the same time, the amount of paperwork for precertifications, for example in hospitalization, has increased significantly. As a result, physicians have had to hire additional staff to deal with managed care companies. Our insurance and billing personnel call insurance companies two or three times to give an indication as to why a procedure is being done, where it is being done, and so forth, and to provide background information for managed care, ID numbers, age, and so on. What's happening is that physicians are getting less reimbursement and have to hire more staff to handle these requests from managed care companies.

Q. *When you do an endoscopic procedure, do you have to get precertification, and is it usually approved?*

Groisser: Yes. Gastroenterologists almost always have to seek precertification for endoscopic procedures, and, over time, most are usually approved, although the process is arduous. Indications for the procedures are becoming better understood and established so the physicians schedule patients who meet the requirements of these indications.

Q. *Managed care proponents argue that there are far too many procedurally oriented specialists and too few primary care physicians. In any given field, such as gastroenterology, in a fully capitated environment there may be 50% too many specialists. Do you buy that argument?*

Groisser: I understand that having too many physicians in any field probably leads to an excess of various procedures being performed. Historically, doctors cared for patients on a fee-for-service basis and the insurer paid whatever was charged, and this led in some instances, with some physicians, to the performance of excess procedures.

I also believe that there are some scoundrels in medicine, although probably fewer than in most professions, and in the past, insurers simply paid even the most excessive, the most absurd fees. I agree that there are too many specialists and that in a capitated world we will need even fewer specialists than we have now. Some health plans project that they will need only one gastroenterologist for every 50,000 people. By that measure, we are overpopulated with specialists, and some physicians won't be able to practice their specialty.

I also feel that the training programs have turned out too many specialists. I

the number of training slots at academic medical centers by 25% as soon as possible and another 25% over the next five years.

Q. *Many gastroenterologists are double-boarded internists, meaning they can practice general internal medicine and gastroenterology. Do you find many gastroenterologists abandoning gastroenterology to practice only primary care or internal medicine?*

Groisser: In my community, some gastroenterologists are listed in some managed care books as both a primary care physician and a specialist, although some primary care organizations don't allow that. Since these physicians are probably

“For most managed care companies, indices of quality have centered on whether receptionists were cordial and a patient was treated properly in the waiting room. As physicians, we don't deny these factors are important, but they do not focus on clinical quality.”

have been in the academic environment in a full-time position. Training programs do get more powerful and appear more successful if they have more residents and a large clinical and research program. Increasingly, the number of residents and fellows in specialty programs add to the problem of oversupply. We need to reduce the size of many gastrointestinal training programs. The urologists did that years ago. They recognized the problem and did not oversupply their field with more physicians than are needed to meet demand.

Schuster: The American College of Gastroenterology, along with some of its sister societies, commissioned a study on oversupply about four years ago. They determined that we are training 50% more gastroenterologists than they anticipated there would be a need for under managed care. Their recommendation was to cut

not filling their offices with only gastroenterology patients, they are practicing a certain amount of internal medicine.

Schuster: There are a lot of gastroenterologists in double practice as internists and gastroenterologists, or in a combined internal medicine and gastroenterology practice. One of my great concerns about managed care is that we may be losing a generation of excellence and doctors dedicated to research as well as in clinical practice. They are going to have to make a living. There is also an exodus of gastroenterologists from California, for example, where managed care is rampant. They are leaving the state because they don't have jobs. They can't find jobs. I haven't heard of any of them driving taxi cabs yet, but many gastroenterologists have stopped practicing medicine and have gone into administrative positions.

(Continued on page 10)

"Eventually, there will be an attempt to establish outcomes analysis as an index of quality, as has been done in some fields, such as cardiac surgery. However, most of the diseases in gastroenterology don't lend themselves easily to outcomes."

Q. *What strategies have gastroenterologists adopted to adjust to managed care?*

Groisser: In my experience and as chairman of the college's managed care committee, it appears to me that the gastroenterologists who seem to be the most satisfied are in large, multispecialty groups. They don't have to fuss too much with administration or with contracting. Administration and contracting are done through a front office within their organization. They have a large group so that they can negotiate with managed care organizations and are in a much better position to negotiate discounted fee-for-service or capitated rates than are individual gastroenterologists or smaller groups of four to seven members, for example.

Having said that, all of the messages we're receiving are that managed care is here. You can't escape it. You should not try to exclude yourself. You should join the managed care panels that you can. Also, some believe, it is of value to get to know what managed care organizations are looking for, and it is wise to cooperate, to get to know medical directors, to sit on utilization committees, and not to take an antagonistic point of view.

Q. *Some believe managed care is a process in which two forces are at work. One force is professional, meaning do the job better; the other is fiduciary, meaning do the job at a profit. Yet, isn't it true that those two forces are often in conflict, whether one should increase the level of quality or decrease the cost?*

Groisser: We are absolutely forced to be part of the reduced-cost formula. But eventually, it's the good doctor who will sur-

vive, the doctor who knows how to deliver good medicine, who does not overutilize, who is skilled procedurally. So the advice is, if you are a good doctor, try to show it by outcome studies. But one of the problems interfering with good patient care is referral patterns.

You get a patient on referral from a primary care physician, and the primary care physician says, "You're allowed one visit." You see this patient in consultation and send the patient back to the primary care physician. In the old days, if that patient came directly to you or if the patient had been referred, you would hang in until you

get patients out of the hospital. We do get patients out of the hospital earlier than ever before, and I think in some cases we do so to the detriment of the patient.

Q. *One tenet of managed care holds that by standardizing medical practice, one can improve quality and decrease the cost. Toward that end, some managed care organizations have recommended clinical guidelines and outcomes measures. Has the college begun to formulate guidelines and outcomes measures?*

Groisser: Our ACG committees are active in that work. The clinical parameters committee that produces guidelines hones its work scientifically, taking up to two years to write guidelines that to the best of its abilities are unimpeachable.

Despite clinical guidelines and algorithms, physicians understand that since both patients and settings vary, one must modify guidelines where available, and adapt them to each situation. The guidelines are not meant to be absolute so that they tell you what you must do with every

"The good doctor will survive, the doctor who knows how to deliver good medicine, does not overutilize, who is skilled procedurally. If you are a good doctor, try to show it by even meager outcome studies that you can establish."

established a diagnosis or until you effectuated a reasonable management plan, and then sent the patient back to the primary care physician. Now you may be able to see the patient once, twice, three times, often not much more. That restricts the wisdom that the specialist can bring to case management, which is a shame.

Also, we are constantly being pressured to decrease length of stay, which is a measurable parameter that managed care companies use to evaluate doctors as to whether we can work within the system to

case.

Nevertheless, the ACG pushed to distribute guidelines and algorithms to every gastroenterologist. Having done so, I am not certain that we, as individual gastroenterologists, are following each one rigorously. As a physician, you must always bring your past experience to each situation. So, in that sense, guidelines are educational.

Perhaps with more capitation and over time they'll be used more widely. Hospitals have developed guidelines and so have

managed care organizations. But we're at such an early stage with the measurements of outcomes, that we can't be sure we are achieving the most that we can through

What is interesting, however, is the attempt to form GI networks. We formed a network of gastroenterologists in New Jersey, but we haven't been able to get

gastroenterologists. Where there is a multispecialty group, that's a different story.

Q. *One reason gastroenterology has not succeeded in carving out that specialty in marketing to the HMOs is that it is an inextinguishable part of internal medicine.*

Groisser: Yes, we're not as clearly defined as even cardiology is, for example. We have learned that when managed care organizations look for networks, they are more interested in radiology, cardiology, orthopedics, the so-called big spenders. And where managed care wants to save, it will do it first with the big spenders. If they do it successfully, then they'll look around for the less costly specialties.

The net effect of managed care on gastroenterologists—in fact on most physicians—is that it's truly a discouraging phenomenon. Doctors are much more restricted in their ability to care for their patients and worry that their patients are not

“Managed care organizations are less interested in carving out care to a network than they are in making their panels larger.”

the use of the guidelines.

Q. *Are you saying that we're at such an early stage, that there isn't any tangible evidence that guidelines reduce cost or increase quality?*

Groisser: That's right. In most of the diseases that we manage, we would want the guidelines to help us reduce cost or increase quality, but we do not yet have computer systems that are affordable that allow us to collect all the data we need on all of the various conditions and patients we see.

Q. *You mentioned earlier that gastroenterologists in multispecialty groups can devote more time to the practice of their specialty and spend less time on the business side. One development Physician Practice Options is following is the evolution of physician practice management companies. Supposedly, these companies have empowered physicians by helping them to acquire capital and management expertise. Have you seen the development of specialty companies, or gastroenterology groups being bought by practice management companies?*

Groisser: I don't see a lot of it. But when our committee meets, one question I always ask the members—who come from all over the United States—is what's happening in their regions in terms of network development. I ask if networks and large groups of gastroenterologists are being bought out by these companies. And so far it doesn't seem to be happening in gastroenterology.

They do buy primary care and oncology practices. But for the most part, they are not buying up gastroenterology practices.

any substantive contracts as yet, and that's the general experience throughout the country. The managed care organizations are less interested in carving out care to a network than they are in making their panels larger. They say to the employer that most of the employees in their health plan have a wide choice of doctors, rather than saying, “We have this small group of doctors who will be dedicated to cutting costs and who have

“We are constantly being pressured to decrease length of stay, which is a measurable parameter that managed care companies use to evaluate physicians as to whether we can work within the system and get patients out of the hospital. And we do get patients out of the hospital earlier than ever before, and in some cases, we do so to the detriment to the patient.”

the highest quality so we're going to divert you to that group” or, for the most part, carving out gastroenterologic care.

Q. *One reason for that may be that HMOs and others prefer to deal with multispecialty groups so they can get one-stop shopping. In fact, there are only a few specialties that are natural carve-outs: oncology, radiology, and sometimes orthopedics and dialysis groups.*

Groisser: They're not going after the

receiving the best care and that a reasonably good system is being distorted. Reimbursement levels are going down. In too many instances, the pleasure has been taken out of the practice of medicine. There is an enormous hassle factor. The pervasive concern is significant, not only for gastroenterologists, but for all physicians. There is a lot of fat in the system. But managed care is throwing out the baby with the bath water. ■

How Selling to a PPMC Affects Physician Compensation

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

An individual physician's income can be significantly affected when a physician group sells its practice to a physician practice management company (PPMC). When contemplating a transaction with a PPMC, physician shareholders should carefully analyze the specific terms of the sales contract in order to compare their future compensation under a variety of scenarios.

Physicians must consider whether their future income would be greater as a result of affiliating with, and paying a management fee to, a PPMC or whether their income would be greater if they were to keep their practice unchanged.

The primary economic driver of a PPMC transaction is the management fee, which is typically 15% to 30% of net revenue minus all non-provider-related clinic expenses. In exchange for the management fee, the PPMC provides management and administrative support, as well as capital for clinic expansion. By paying a management fee, the physicians are, in effect, selling a por-

tion of their income in exchange for the services they receive.

Obviously, both sides in this transaction—the PPMC and the clinic—expect the clinic to have greater revenue growth and overhead savings as a result of their affiliation. Although clinic revenue may grow, however, the individual physicians are likely to experience a decline in income in the first few years following their affiliation with a PPMC.

Here's an example. Assume a 15-physician group sells its practice to a PPMC. In the first year, the physicians' income declines by 15% (Figure 1). In the second year, the physicians' income increases by 14% over its pretransaction level. To achieve this result, the clinic's revenue must increase by only 15% and its expenses must decline by 4%. The PPMC can help the clinic achieve these results by securing managed care contracts, adding ancillary services, making the clinic's administrative functions more efficient, and leveraging national purchasing contracts.

To offset the initial decline in physician income, some PPMCs may offer to allocate a portion of the purchase price to supplement physicians' postaffiliation income. PPMCs also may provide a loan to physicians for an amount that offsets any decline in physician income related to the PPMC management fee. Such a loan would be

repaid in future years through an increase in the management fee. Many PPMCs seek to increase revenue or reduce overhead enough to offset the amount of the management fee within two to three years of the transaction (Figure 2). Note that if managed care continues to grow at its current pace, it is likely that physicians who do not seek a partner or join a group will see their income decline steadily.

Many PPMCs receive a supplementary share of the profits generated from investments that are made specifically by the PPMC. If the PPMC invests in ancillary services, for example, it may take some of the profits that result from that investment. Also, PPMCs may take a higher percentage of the profits generated from managed care risk pools because it is likely that the PPMC will secure risk contracts for the clinic and help the clinic manage those contracts. The PPMC may take as much as 50% of the profits generated by risk pools and ancillary services. These additional sources of earnings, which the PPMC helps bring to the clinic, are generally expected to account for a large portion of the clinic's cash flow in the long term and are central to the clinic's strategic growth plans.

Given the complexity of the transaction, physicians should carefully consider all options and get good financial advice when making any decisions about selling to a PPMC. ■

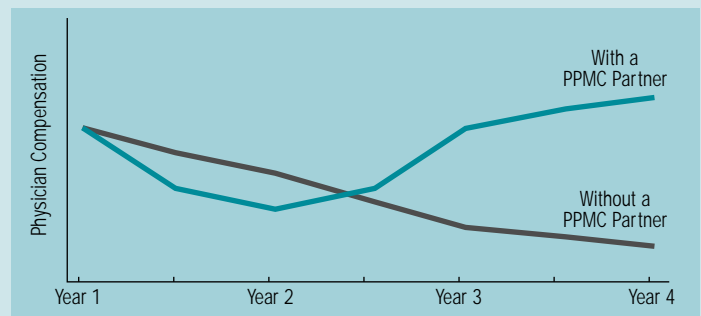
W.L. Douglas Townsend Jr. is managing director and CEO of Townsend Frew & Co., an investment banking firm in Durham, N.C., specializing in health care transactions. He is also a member of the advisory board of Physician Practice Options. Jill S. Frew is managing director of Townsend Frew & Co.

Figure 1: Physician Income
Projected income following acquisition by a PPMC

(\$ in 000s)	Pretransaction	Posttransaction (Year 1)	Posttransaction (Year 2)
Revenue	\$10,000	\$10,000	\$11,500
Clinic expenses	5,000	5,000	4,800
Predistribution fund	5,000	5,000	6,700
PPMC management fee (15%)	NA	750	1,005
Available for physician compensation	\$5,000	\$4,250	\$5,695
Per MD compensation (assume 15 physicians)	\$333	\$283	\$380
Percentage change	NM	(15%)	14%

Source: Townsend & Frew & Co., Durham, N.C., 1997.

Figure 2: Projected Physician Income



Source: Townsend & Frew & Co., Durham, N.C., 1997.

A Look at How MCOs Pay Providers

A recently released analysis showed that HMOs use a variety of methods to pay providers and provider organizations, including fees, discounted fee schedules, and capitation. Among the 266 HMOs that responded to a survey by InterStudy Publications, in Minneapolis, 70.6% use fees or discounted fee schedules when contracting with hospitals. In addition,

48.9% of HMOs contracting with hospitals also use capitation.

The survey also shows that per-diem rates are the most predominant method of reimbursement (47.3% of HMO respondents) for hospitals contracting with HMOs (Figure 1).

When HMOs contract with primary care physicians in multispecialty groups, 57.3%

of enrollees are treated by PCPs who work under capitated arrangements with HMOs. Some 24.7% of enrollees receive care from PCPs in multispecialty groups paid a fee or from a discounted fee schedule.

When HMOs contract with PCPs in solo or single-specialty practices, only 45.7% of patients are treated by a physician working under capitation and 33.7% are treated by a physician paid a fee or from a discounted fee schedule.

When HMOs contract with specialists in multispecialty groups, 45.3% of patients are treated by a physician paid a fee or from a discounted fee schedule. At the same time, 31.8% are treated by a physician working under capitation. When HMOs contract with specialists in solo or single-specialty practices, 49.9% of patients are treated by a physician paid a fee or from a discounted fee schedule. Only 17.7% of patients treated by a specialist in a solo or single-specialty group receive care from a capitated specialist. (Continued on page 14)

Figure 1: Reimbursement Methods

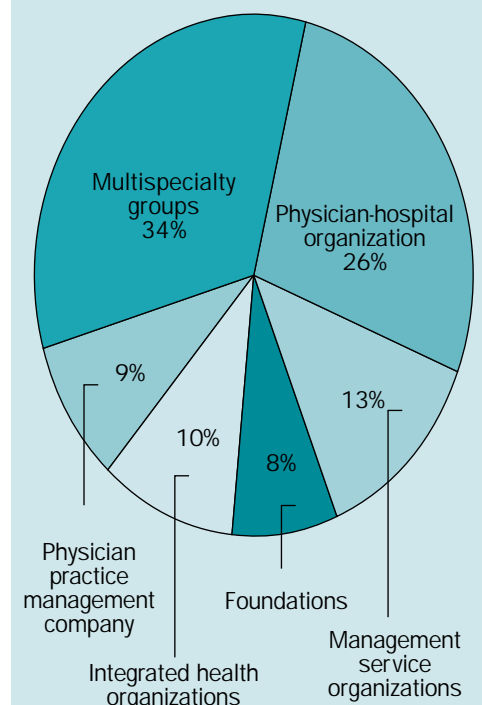
	Number of HMOs		Estimated Enrollees Served	
Hospitals				
Fees or discounted fee schedules	187	70.6%	4,480,888	15.4%
Per-diem rates	239	89.8%	13,776,641	47.3%
Diagnosis-related groups	128	48.9%	5,164,043	17.7%
Capitation	94	35.6%	4,238,356	14.6%
Primary Care Physicians				
Multispecialty Group Settings				
Fees or discounted fee schedules	114	48.5%	6,069,680	24.7%
Relative value scales	63	23.7%	1,997,764	8.1%
Capitation	165	70.2%	14,053,446	57.3%
Salary*	26	11.1%	2,352,965	9.6%
Solo or Single Specialty Practices				
Fees or discounted fee schedules	153	60.7%	8,713,447	33.7%
Relative value scales	82	32.5%	4,727,435	18.3%
Capitation	178	70.6%	11,805,465	45.7%
Salary	12	4.8%	505,651	2.0%
Specialty Care Physicians				
Multispecialty Group Settings				
Fees or discounted fee schedules	154	66.7%	10,170,807	45.3%
Relative value scales	76	32.9%	4,048,463	18.0%
Capitation	108	46.7%	7,138,354	31.8%
Salary*	18	7.8%	1,095,364	4.9%
Solo or Single-Specialty Practices				
Fees or discounted fee schedules	187	75.7%	12,288,416	49.9%
Relative value scales	93	37.6%	7,873,800	32.0%
Capitation	96	38.9%	4,354,205	17.7%
Salary	8	3.2%	89,957	0.4%

* Respondents may have reported how the physician was paid by a group practice rather than how the HMO pays the multispecialty group.

Note: 266 HMOs reponded

Source: The InterStudy Competitive Edge: HMO Industry Report 7.1, InterStudy Publications, Minneapolis, 1997.

Figure 2: Delivery Systems
Estimated percentage of contracts (by type of organized delivery system)



CURRENT TRENDS

In the same survey, InterStudy asked HMOs about which delivery systems they use. Some 34% of HMOs contract with large multispecialty group practices, the most common type of organized delivery system under contract (Figure 2). Physician-hospital organizations (PHOs) have emerged as rivals to multispecialty groups, InterStudy says. Some 26% of

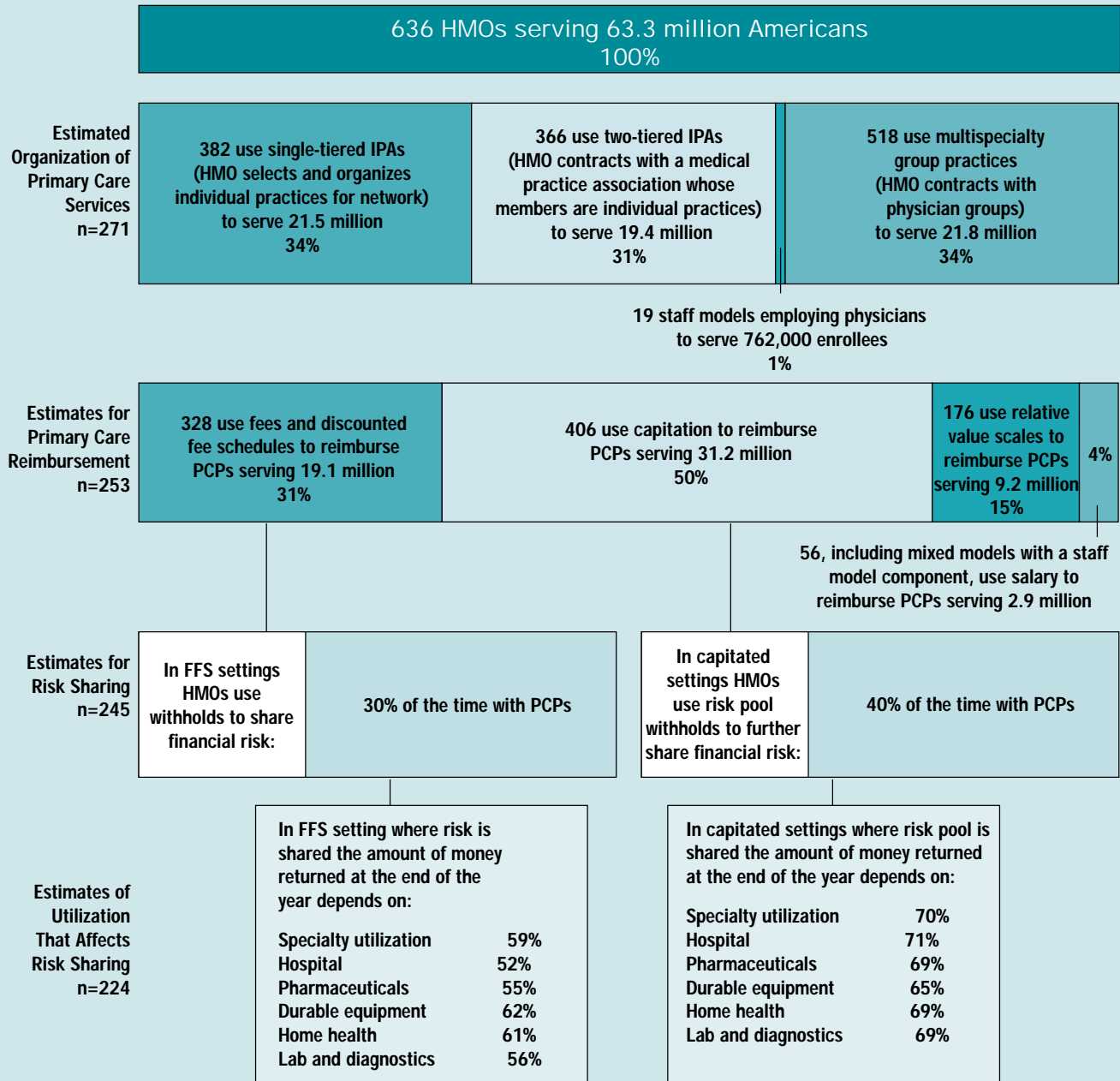
HMOs contract with PHOs.

Figure 3 shows how HMOs organize and pay for the delivery of primary care services. Some 34% of HMOs' enrollees receive care through a single-tiered IPA, in which an HMO selects and organizes individual practices for a network. Some 31% of HMOs' enrollees receive care through a two-tiered IPA, in which the

HMO contracts with a medical practice association whose members are individual practices.

InterStudy also reports that 31% of HMO enrollees receive care from a health plan that uses fees and discounted fee schedules; 50% of HMO enrollees are in plans that use capitation to reimburse PCPs. ■

Figure 3: HMOs and the Organization of Primary Care



Note: An estimated 38.3% of all HMOs use all three types of primary care network organization described here. This includes five staff models that report using single-tiered IPAs and multispecialty groups for their PCP network.

Source: The *InterStudy Competitive Edge: HMO Industry Report 7.1*, InterStudy Publications, Minneapolis, 1997.

Nine Clinics Form a Physician Practice Management Company

Nine physician groups have formed a physician practice management company (PPMC) called Stratum Med, in Urbana, Ill., according to *Modern Healthcare* magazine. Representing 887 physicians, the groups will combine purchasing, physician recruitment, information systems, telecommunications, and malpractice liability insurance. All of the groups are in Illinois except the McFarland Clinic, which is in Ames, Iowa. Two of the groups also are physician hospital organizations: Illini Clinic Partners and the McDonough District Hospital.

Gerry Tresslar, Stratum Med's president and CEO, says the new company aims to lower costs so physicians can stay competitive. The combination may lower costs by 8% to 10%. Stratum Med raised \$2.5 million, or roughly \$3,000 per physician, to set up the organization.

One of the clinics, the Rock Falls Clinic, had been approached by a large PPMC, but the physicians affiliated with the clinic did not want to set aside 15% of earnings. Of that amount, 7.5% would have been spent at the PPMC's discretion and 7.5% would have been for the management fee.

Robert Parker, MD, the CEO of the Carle Clinic, said none of the nine groups is fully prepared as yet for managed care, since none use midlevel providers, clinical protocols, or telephone triage systems. One of the first tasks for the PPMC will be to prepare the physicians for managed care.

Comment: *Physician consolidation is a significant trend nationwide, but typically the headlines go to acquisitions by PPMCs. It is much more unusual for groups of physicians to form their own management company.* ■

Stratum Med

	Number of Physicians
Carle Clinic, Urbana	300
Springfield Clinic, Springfield	110
Quincy Medical Group, Quincy	60
Methodist Hospital PHO, Peoria	78
Rock Falls Clinic, Sterling	34
DeKalb Clinic, DeKalb	30
Illini Clinic Partners, Silvis	120
McDonough District Hospital, Macomb	41
McFarland Clinic, Ames, Iowa	114
Total	887

Source: Stratum Med, Urbana, Ill., 1997.

Medical Groups Seek to Limit Liability Over Surgical Device

Four medical associations are trying to protect themselves from lawsuits over a device known as the pedicle screw, according to *Modern Healthcare* magazine. The North American Spine Society, the Scoliosis Research Society, the American Academy of Orthopaedic Surgeons, and the American Association of Neurological Surgeons have been named in suits brought by patients who had suffered postsurgical complications, including spinal fractures and spinal fluid leakage, allegedly related to the pedicle screw.

The lawsuits number more than 1,000. Until 1993, patients had been suing surgeons and the manufacturers of the device. But in 1995, plaintiffs named medical societies that had conducted programs explaining how the screw can be used in back surgery. Also named were magazine staff members who wrote articles praising its use, and hospitals that sponsored programs to educate physicians. The suits contend that these organizations and persons are liable because they helped to promote a high-risk device. The suits charge that the four medical associations received money from manufacturers in which presentations were given on the screw.

Comment: *The associations claim that sponsoring meetings in which the device was discussed is a matter of free speech and that the payments were fees for exhibit space and other meeting costs.* ■

More Questions Asked About Columbia/HCA Referrals

Federal officials are investigating physician referral practices at Columbia/HCA Healthcare Corp.'s home health agencies in Miami, according to *The Wall Street Journal*. Officials from the federal Department of Health and Human Services also are investigating Columbia's acquisition of nonprofit hospitals, its physician investments, and its relationships with doctors in partnerships and joint ventures in several locations in Texas and Florida, *The Journal* reported. Home health referrals are being reviewed because Columbia's home care division has an aggressive internal target of capturing 85% of referrals from Columbia facilities, *The Journal* said.

In March, federal officials investigating Medicare billing practices raided Columbia facilities in El Paso, Texas (*Physician Practice Options*, May). After the raid, the value of Columbia's stock dropped sharply. Thomas Frist Jr., MD, vice chairman of the board of Columbia/HCA, said company officials had begun meeting with employees nationwide to restate the company's principles.

Comment: *Columbia may be most vulnerable to a finding of wrongdoing in Florida, where it controls 25% of the hospital market, because the federal probe focuses on Medicare abuse, and Florida has the largest managed Medicare population and the highest costs per Medicare patient in the country.* ■

(Continued on page 16)

Vertically Integrated System Struggles in Twin Cities

The Allina Health System, in Minneapolis, is struggling financially, according to *Modern Healthcare* magazine. Ironically, the integrated delivery system took its name because it supposedly aligns the incentives of its affiliated hospitals, physicians, and health plans. Vertically integrated systems, which include hospitals, physicians, and at least one health plan, cannot thrive because the financial incentives of the various parties are diametrically opposed, says Jeff Goldsmith, president of Health Futures, a consulting firm in Charlottesville, Va.

In 1995, Allina made \$2.3 million, but this year it will barely make profit, the magazine reported. The company has \$2.3 billion in annual revenue, operates 19 hospitals, and provides care for more than 25% of the population of Minneapolis through its HMO and PPO plans. Despite its size, it has had difficulty aligning the incentives of its hospitals, physicians, and health plan. Its health plan was forced to contract with a rival hospital to satisfy members' demands for a wide choice of hospitals. By offering other hospitals, Allina thus had to rob its own hospitals of much needed patients.

Physicians also have been voicing dissatisfaction. Reportedly, Allina is losing more than \$30 million on the 450 physician practices it owns. In an attempt to improve its relations with doctors, Allina has offered to give physicians more financial incentives and has asked them to become associates or partners by sharing the financial risk of the cost of delivering care. Physicians would then have an opportunity to earn more if they manage care appropriately.

Comment: *The problem with vertically integrated systems is that many parties with conflicting financial interests are asked to work for just one larger entity, says Goldsmith. "You end up not achieving optimal performance, and I don't see the synergy."* ■

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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:

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- Where should I go to get capital?

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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:

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