

PHYSICIAN PRACTICE OPTIONS™

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A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Caution Required When Considering PPMCs Strategy Offers Advantages, But Advisers Say Beware of Pitfalls

A rising number of physicians are turning to physician practice management companies (PPMCs) to provide the capital and management expertise needed to contract effectively with managed care organizations. About 40,000 of the nation's 530,000 practicing physicians are affiliated with a PPMC, up from about 25,000 in 1996, according to the American Medical Association in Chicago, and some analysts predict as many as 100,000 physicians will become so affiliated within the next five years.

But this practice strategy is not without risk. Some physicians say that affiliation with one of the nation's approximately 200 PPMCs has been a boon to their income and enhanced their ability to provide quality service, but others complain that after joining a PPMC they suffered a loss of autonomy and their incomes fell.

"PPMCs are not for everyone," says Albert Barnett, MD, a health care consultant in La Habra Heights, Calif., and former CEO of the Friendly Hills HealthCare Network, an integrated health system in La Habra, Calif. "Physicians have to be very careful about what they're getting into. A lot of times they don't understand the impact a PPMC can have on the way they practice medicine."

Some health care industry analysts say a quality PPMC can provide the expertise needed in health care today. "Physicians need resources to compete and to manage expenses effectively, and these resources must be managed in a sophisticated fashion," says Brooks O'Neil, a managing direc-

tor and research analyst with Piper Jaffray Inc., investment bankers in Minneapolis. "They also need expertise in managing operations efficiently so that they can maximize productivity. Three forms of skills are essential: professional management, managed care expertise, and information technology management. These skills are available through affiliation with a good PPMC."

Jon Dula, MD, is a 53-year-old family practitioner with King's Daughter Clinic in Temple, Texas, whose 45-member group has been affiliated with a PPMC for the past two years. "It has been a big economic advantage to us, allowing us to do things we couldn't have afforded to do on our own," says Dula. "It has allowed us to expand our operations through marketing, and deal more successfully with managed care by providing the expertise we lacked in contract negotiations."

For these and other reasons, O'Neil says, physicians should examine a PPMC closely before deciding whether to form a relationship. "Not all PPMCs will be successful, and many will fail," he says. "Therefore, it is important to evaluate a PPMC, and quality of management is critical. Management must have a focused market strategy. PPMCs need market power to succeed. And since health care is a local business and since every market is different, PPMCs need individualized strategies to succeed. The question that physicians need to be asking about PPMCs is whether the PPMCs are creating value in the practices they acquire."

Russell Foulk, MD, a reproductive

(Continued on page 7)

Quality Commission's Recommendations Raise a Question

The recent report of the president's Advisory Commission on Consumer Protection and Quality in the Health Care Industry makes suggestions that may have a significant effect on how medicine is practiced in the future. The commission makes more than 50 recommendations designed to improve efforts to collect data on the quality of care delivered and to improve the health care system for all. While stating that the U.S. health care system delivers some of the finest care in the world, the report also shows that some 41 million Americans remain without health insurance coverage. This serious flaw in the system may be the most significant, and it is often overlooked, the report says.

The report says other serious flaws include:

- *Avoidable errors.* One study found that from 1983 to 1993, deaths due to medication errors rose more than twofold.
- *Underutilization of services.* Millions of Americans do not receive necessary care and suffer needless complications that add to health care costs and reduce productivity.
- *Overuse of services.* Millions of Americans receive services that are unnecessary, increase costs, and often endanger their health.
- *Variation in services.* A pattern of wide variation exists, a clear indicator that the practice has not caught up with the science of health care.

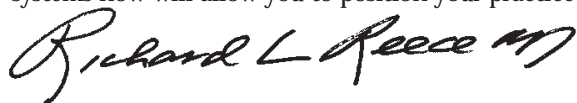
The report calls for developing comprehensive quality measures to reflect the full continuum of health care, including care delivered to patients with chronic conditions and disabilities. Also needed are broader health care outcomes measures. To manage this information, the commission says, health care providers should invest substantial sums in new information systems.

The problem for physicians in clinical practice, however, is much more fundamental because medical information systems are in their infancy. No system exists that effectively links hospitals with office practices in real-time. Despite its best efforts, PhyCor Inc., a physician practice management company in Nashville, cannot find one system to accommodate the 56 clinics and 170 IPAs in its network, says Paul Keckley, a member of our editorial Advisory Board and PhyCor's vice president for strategic development.

The day is coming when physicians will need information systems to manage all aspects of their practices. Last fall David M. Wesley, vice president of strategic product planning for Object Products Inc., a company in San Francisco that makes clinical decision support software for physicians, predicted that within three years, physicians will begin implementing such systems at the point of care.

While the message from the president's commission is aimed at the entire health care system, physicians believe the priority ought to be on practice management and clinical support systems that help them provide quality, cost-effective care. After all, what's more important: providing quality care or the ability to report on it after the fact?

For physicians interested in providing the best care, now is the time to begin getting a system in place that will allow you to report on the quality of care you deliver. Those who begin adding the necessary hardware and software now will be in the best position when the government or health care purchasers begin demanding such data. What's more, adding effective information systems now will allow you to position your practice ahead of others that fail to do so.



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HMOs Make Physicians Wait for Payments

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

Many physicians know that some HMOs did not do as well in 1997 as they had done in previous years. The physicians know it because they weren't paid by health plans as quickly as they had been. In fact, reports show payments to physicians have slowed considerably in the past year. In April, doctors and hospitals in Massachusetts reported their frustration in waiting for payments from Harvard Pilgrim Health Care, in Brookline, Mass., the largest health plan in the state. Several physician groups reported trying to collect on outstanding bills dating back two years, *The Boston Globe* reported. Some Harvard Pilgrim physicians threatened to drop patients if they were not paid by June 1. One physician, who asked not to be named, said Harvard Pilgrim owed him more than \$200,000. "I can't afford to make interest-free loans to an HMO," he said. Attempting to explain the problem, Harvard Pilgrim officials met with many physicians and said that the worst was over. The health plan has been combining computer systems as a result of a merger four years ago with Pilgrim Health Care, in Norwell, Mass., the HMO officials said.

Oxford Health Plans, in Norwalk, Conn., has had trouble paying physicians on time since 1996. As part of an agreement with New York Attorney General Dennis Vacco, Oxford agreed last fall to pay at least \$1 million in interest on claims from New York physicians and hospitals that had not been paid within 30 days. In February 1997, the New York State Medical Society and the New York State Society of Medical Oncologists and Hematologists complained to Vacco about late payments from managed care organizations. Payments to some physician practices were late by an average of four months, and several hospitals reported being owed tens of millions of dollars. At the time, Oxford said it paid slowly because it was upgrading its computers and that it was taking steps to improve claims payment systems. Since then, however, physicians have learned that Oxford was having serious financial trouble. In the fourth quarter of last year, the HMO reported a loss of

\$285 million, wiping out all of the earnings it had reported in seven years as a public company, *The Wall Street Journal* said. Losses have been reported by other health plans, as well. Kaiser Permanente, a large managed care organization in Oakland, Calif., reported a loss of \$270 million for 1997. PacifiCare Health Systems Inc., an MCO in Santa Ana, Calif., reported a loss of \$114 million for the fourth quarter.

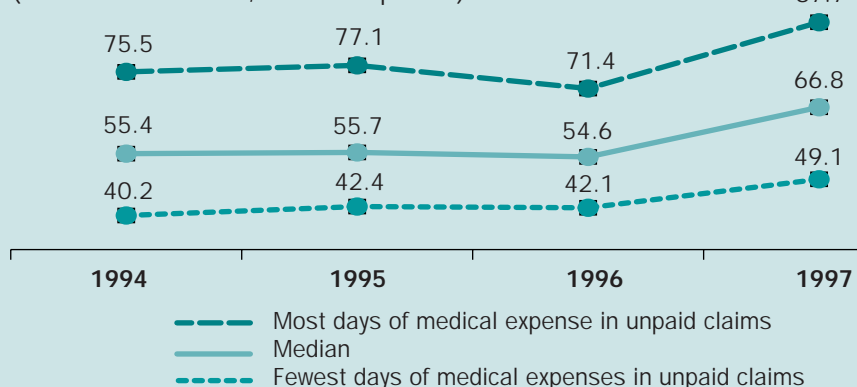
Profitability Declines

InterStudy, an organization in Minneapolis that collects data on HMO trends, has reported that health plan liquidity has been falling for three years. Lower financial liquidity means the assets of a health plan, such as cash available to pay current liabilities, have been diminished. Despite the drop in liquidity, HMOs had paid providers within a fairly predictable time frame until last year, InterStudy said, when the number of days of medical expenses in estimated unpaid claims had begun to lengthen. The decline in financial health has lowered the capacity of many plans to reimburse providers as quickly as they once did. In 1994, the median number of days of health plans' medical expenses in unpaid claims was 55.4. By the third quarter of last year, that number had risen to 66.8, InterStudy said (see table). Without question, the most dramatic HMO financial trend through last year was the

decline in profitability, InterStudy said. In 1994, almost all HMOs reported being profitable, and the average profit margin was 2.4%. Since then, industry profitability has steadily declined through the third quarter of last year. Only 49% of plans reported being profitable at that time, and the average profit margin was -1.2%, InterStudy reported. According to InterStudy, the reason profit declined was the success of public and private health care purchasers to negotiate low premium increases. In 1994, the typical HMO had premium increases of 5%. In 1996, premiums rose by only 0.5%, InterStudy said. Now, for the first time since 1992, many HMOs are pushing up health care premiums by double-digit rates, according to *The New York Times*. Employers in California, Illinois, Minnesota, New Jersey, and New York are facing demands from HMOs for increases of 10% or higher, the *Times* said. Benefits consultants estimate that health insurance premiums may rise by 9% to 14% this year. If so, HMOs are likely to see increases in revenue and profitability. But the worst may not be over for a while. In April, the federal Health Care Financing Administration said it was seeking to save money in the Medicare program and urged claims-processing companies to slow payments to hospitals and physicians. The slower payments are aimed at keeping the program within budget through Sept. 30. ■

HMO Days of Medical Expenses in Unpaid Claims

(Actual and incurred, but not reported)



Source: InterStudy, Minneapolis, 1998.

Specialty Consult MDs Learn to Become Team Players

When leaders of the only two hospitals in Great Falls, Mont., merged last year, physician staffs saddled with long-simmering feuds and caught in turf wars brought their hostilities to the newly formed company. After lots of hand-wringing among directors eager to secure the financial future of the newly formed Benefis Healthcare Inc., they called in organizational psychologist Jack Singer, PhD, of Las Vegas. Singer, whose expertise is in health care, was able to help the physicians let go of their anger and learn to trust each other.

“Dr. Singer brought to the surface the fact that a merger causes stress and stress can be harmful,” says Cascade County Medical Society president M. L. Margaris, MD., “You have to recognize and deal with stress, rather than let it boil under the surface.”

U.S. manufacturers discovered organizational psychologists (OPs) in the 1940s. Known at the time as efficiency experts, OPs visited manufacturing plants to observe, listen, assess problems objectively, and make suggestions to improve productivity. Their suggestions worked and their popularity grew. Today, OPs are commonplace in corporations, and as medicine becomes more businesslike, health care providers are also recognizing the value of these specialists. Leaders of physician groups and other health care provider organizations are coming to understand that when staff members fail to cooperate, productivity suffers. Kaiser Permanente, Group Health Inc., PacifiCare, hospitals that are part of Columbia/HCA, and many other such organizations have used OPs with success.

By dropping the veils of secrecy to reveal deep-rooted problems of resistance, denial, and reluctance to accept health care change, many provider organizations have created streamlined, competitive organizations that operate more efficiently.

“We’re finding enormous demand for our kind of help,” says Samuel Davis, senior director of health care for Delta Consulting Group, a company in New York that

employs OPs. Singer says that his business has “picked up exponentially. In 1994, I worked with five medical groups. Last year, I worked with 35.”

One measure of OP popularity is in membership figures for the Society of Industrial and Organizational Psychologists, a trade organization in Bowling Green, Ohio. From 1990 to 1997, SIOP’s roster rose nearly 40%. And, in an organizational psychology PhD program at the California School of Professional Psychology, in Alhambra, most graduates receive job offers before they have even completed their dissertations, according to professor Michael Jospe, PhD, a consultant to health care groups.

OPs believe that the single greatest threat to any group is internal variables. Groups that function well weather changes in external variables, such as government intervention, financial difficulties, and market turmoil caused by increased enrollment in managed care. But when people within an organization cannot work together toward common goals, the group can’t succeed and may eventually fail.

increased health insurance costs for stress-related illnesses.

Most often, OPs are hired before or after mergers and acquisitions. The goal is to help disparate physicians used to working solo learn to work as part of a team, to calm fears, and to boost morale.

“Getting along is something doctors were never taught,” Jospe says. “They’re thrown together in a group practice and tensions crop up.”

Blending Cultures

Tension causes morale problems, says Cynthia Scott, PhD, of Changeworks Inc., San Francisco, who consults with medical groups and has written 13 books on OP. “And when groups have problems, they make more mistakes,” she says.

When a merger or acquisition is pending, Scott advises managers to plan to address issues of identity, loss, and fear. “Hospitals that merge don’t realize that signing the papers is not all they have to do. They also have to blend cultures with different histories and rationales,” she says. She suggests

“Getting along is something physicians were never taught. They’re thrown together and then tensions crop up.”

—Michael Jospe, PhD, California School of Professional Psychology

“Where the individual’s sense of larger purpose coincides with the organization’s, there are higher morale and success,” says Mary Lynn Pulley, PhD, author of *Losing Your Job, Reclaiming Your Soul* (Jossey-Bass: 1997). Pulley is also an OP who has consulted with Vanderbilt University Medical Center, in Nashville, Tenn.

Singer says sick organizations unable to foster cooperation produce sick employees who experience increased stress levels, low morale, high turnover, burnout, absenteeism, violent behavior, substance abuse, and hypertension. The price tag is

that managers involve physicians in decisions and conduct meetings to let them vent their feelings. “If you involve people in the process of change that requires them to alter their behavior, they are less resistant to change,” she adds.

OPs are most effective when administrators who call them in have clear goals. “Instead of saying, ‘I want people to feel better about working here,’ they say, ‘I want communication between physicians and nurses to improve,’” says Dorothy Largay, PhD, an OP in Los Gatos, Calif.

OPs and physicians share a similar *modus*

operandi. They both take a patient through interviews or surveys, determine a diagnosis, and prepare a treatment plan. OPs aim to: foster two-way communication, teach how to set priorities, train for new responsibilities, give feedback, eliminate double standards, hold brainstorming sessions that lead to constructive solutions, determine strengths and weaknesses, and enhance customer service so that patient satisfaction surveys improve enough to win contracts.

"If the situation within the organization is unpleasant long enough, doctors become willing to talk."

—John Fennig, PhD, DRI Consulting

OPs rarely introduce themselves to physicians as psychologists, preferring the word "consultant" so as not to alienate. Surprisingly, reticence is rare. "If the situation within the organization is unpleasant long enough, doctors become willing to talk," says John Fennig, PhD, of DRI Consulting, Minneapolis, who works with health care groups. "Where we're not welcomed by physicians, we probably can't help. That's when people disband."

OP fees can run a hefty \$350 hourly and \$3,500 daily, and success is not guaranteed. "In 20% of cases, the organization is not willing or able to make changes," Fennig says, "because the changes are unpleasant, scary, or too onerous."

Fennig offers the example of a case in which a partner was gender insensitive, and changing that behavior "wasn't in his tool box." Fennig's services were cut short. "I lament those situations because we did exploratory surgery and had to sew the patient up before correcting his problem," he says.

Preventive Medicine

Then there are the organizations that seek a quick fix to their problems. One or two visits with an OP may not work if the treatment plan requires a longer duration. The symptoms may be ameliorated but the underlying systemic problems may remain unfixed.

Forward-thinking organizations call in consultants before problems arise. Such was the case with ProHealth, now a 150-physician primary care group in Farmington, Conn. In 1994, 38 doctors were considering forming a management services organization. They held a retreat and asked William Roberts, a Connecticut organizational consultant, to guide them. Roberts, formerly a theologian, was not an OP but had extensive experience in mergers and acquisitions, having worked with Prudential Residential Services when it purchased Merrill Lynch Realty in 1989.

"It was the most satisfying part of what we did," reflects ProHealth chief medical officer and founder James Cox-Chapman, MD. Roberts administered the Myers Briggs, a standard personality test. "We found we were all different types but we had no risk takers," explains Cox-Chapman. "So we had to compensate. We learned that people had different strengths and skills. Roberts made us think about ourselves as a group rather than as soloists, and he made it clear we needed to

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confront change head on.”

But OPs can't resolve all problems. Fennig worked with a 200-physician multispecialty group in the Midwest that had among its members a respected and gifted primary care physician. “He was saving a lot of lives, but the testing he was ordering was costing the practice a fortune,” Fennig says of the PCP. “I was referred by one of the group's psychiatrists who wanted someone outside the organization to handle the problem.” Fennig assessed personalities, administered psychological tests, and conducted interviews. “Eventually, the physician's spending was curbed, which pulled him outside his comfort zone because he was having to use more clinical judgment and less lab-driven testing. Again, his spending increased and he could not meet goals. Eventually, he negotiated a severance,” Fennig says.

Unfortunately, some organizations don't realize their problems are serious enough to ask for help. “What is the cost of frustration?” asks Largay. Adds author Scott, “What is the cost of workers' comp claims, a strike, or angry people making mistakes?”

To avoid the maelstrom of problems that plague medical groups, physicians must learn to cooperate and collaborate, both of which are relatively new concepts for physicians. Under fee-for-service medicine, many physicians worked in solo or small-group practices. Under managed care, physicians are finding they need to work in larger groups. In other words, they need to work closely and collaboratively with many other physicians. Unfortunately, collaboration is not a simple concept to teach.

“The difficulty is that physicians self-select because they have high needs for autonomy,” says Deborah Crown, PhD, an OP who teaches in the business school at the University of Alabama at Tuscaloosa. “The profession requires a high degree of autonomy—those who can make choices on their own. But now there are other variables. It's very hard for physicians to decide where they can give up control and where they can maintain control. That's a difficult balance.”

Ostensibly, physicians complain about money, space, hours, scheduling, and reimbursement. Behind those issues are concerns related to turf, ego, status, reputation, and deference to seniority, according to Leonard J. Marcus and others at the Harvard School of

Public Health and authors of *Renegotiating Health Care: Resolving Conflict to Build Collaboration*, (Jossey-Bass, 1995). The trick is to get doctors to focus on the bigger picture.

“I ask doctors what are the individual strengths of each team member,” says Jospe. “This is a simple concept but it alters their perception about being empowered. I make sure everyone's skills are used to best advantage. If doctors think they're better or more qualified than their colleagues, it's hard to get teamwork.”

Fortified for Competition

Some health care organizations find it's more cost effective to hire a staff OP than to call one continually for consultation. Three years ago, Lisa Collings, PhD, was brought in to serve Harris Methodist Health System, an eight-hospital group in Dallas. Collings worked with physician groups to help them meet new goals established when Harris merged last year with Presbyterian Health Care System, a six-hospital group in Fort Worth, and with St. Paul Medical Center, a Catholic hospital nearby.

Harris had a managed care plan coveted by Presbyterian. Presbyterian offered access to a larger physician network to attract larger employers, such as American Airlines, Lockheed Martin, and Bell Helicopter. Harris, and other nonprofit hospitals, were being threatened by for-profit competitors, and at least one hospital was having financial problems.

Collings was invited on staff retreats or ini-

tiated talks with groups to understand problems. Her mission: delineate business gaps and offer tools, such as training, to close the gaps. “Some staffs were very progressive,” Collings says, “and were willing to discuss trust and distrust issues. But there were a significant number of holdouts who thought they could continue their careers as soloists.”

One clinic she worked with had three physicians and 80% turnover. Each physician preferred to schedule patients differently. One wanted emergency patients scheduled through lunch, another didn't. Each time the staff changed, preferences had to be explained again.

Collings and her staff called a meeting of the physicians to air complaints. “It sounds so simple but it was the first time these doctors scheduled time to talk together,” she says, “Even when issues can't be resolved immediately, merely acknowledging their presence can be significant.”

Although she was frequently frustrated, Collings says, “I look back to a year ago and realize we've come pretty far. I suspect it's an evolution. Now physicians are asking for my services.”

OPs agree that not every physician group needs help. “What happens if organizations don't hire us? Sometimes they're lucky. They have natural managers of change. Increasingly, though, consolidations fail because the strategy or the implementation is wrong,” Davis says.

—Reported and written by Maureen Glabman, in Miami.

Before Hiring an OP, Check This List

No organizational psychologist can make all your group's problems disappear. But a good one can play an important role in furthering your organization's mission. Before you hire an OP, ask yourself:

- What major problems need to be addressed?
- How are these problems manifested?
- How are patients, staff, and others affected?
- How do you want your organization to be different after the OP leaves?
- How will you know when your goal has been achieved?
- Are there nonnegotiable issues with which the OP must work?
- How much authority will you give to the OP?
- How fast do you want results?
- What resources are you willing to commit to this project?

“As it is in every business, there are good operators and bad operators among PPMCs. Physicians should remember that they are making a major career decision, usually a 40-year relationship. It’s like entering a marriage.”

— Michael Blau, McDermott, Will & Emery

(Continued from page 1)

endocrinologist in Reno, Nev., says he is disappointed with the relationship his group has had with a PPMC over the past two years. “Many of our physicians feel they are working harder for less money,” Foulk says. “They feel that the PPMC has not added any value whatsoever. The PPMC made promises about increasing patient volume and collecting a higher percentage of accounts receivable. That hasn’t happened.”

A Growth Industry

The PPMC industry is growing quickly. At the end of 1996 there were about 30 publicly traded PPMCs, generating annual revenue of about \$12 billion, according to Peter S. Stamos, director of Stanford University’s Comparative Health Research Center in San Francisco. As of April 1998, there were 45 publicly traded and about 150 privately owned PPMCs. About two dozen PPMCs are planning to go public by the end of the year, according to Michael Blau, an attorney and chairman of the Physician Practice Management Company Group of McDermott, Will & Emery, a law firm in Boston. Stamos predicts that by 2002, the PPMC industry could capture one-third to one-half of the nation’s \$200 billion physician-services market, or \$70 billion to \$100 billion in annual revenues.

This growth is coming amid a wave of physician practice consolidations, largely motivated by the increasing cost of doing business and the growing dominance of managed care. The number of physicians in solo practice is falling, from 38% in 1983 to 27.4% in 1997, according to the AMA. And the number of physicians employed by a hospital, by a health plan, or by other physicians is increasing, from 24% in 1983 to 50% in 1997. The number of medical groups has risen by about 50% between 1990 and 1996, to 5,000 multispecialty and about 14,000 single-specialty groups, the AMA says.

“Changes in technology and payer

arrangements are driving a trend toward consolidation in the health care industry,” says O’Neil. “This trend has enormous implications for all providers. The need for physicians to organize has never been greater.”

PPMCs are responding to this need, says Paul H. Keckley, vice president of strategic development for PhyCor Inc., in Nashville, Tenn., one of the nation’s largest PPMCs. “The market for PPMCs is huge and growing. Success in that market requires long-term, successful market relationships between physicians and their capital partners, based on aligned incentives. PPMCs meet this need for alignment, perhaps better and more efficiently than arrangements with hospitals or health plans,” he says.

The most significant contribution PPMCs make to affiliated physician practices is increasing a practice’s value by helping it to gain market share, Keckley says. “Operating performance at the market level will determine which of today’s 45 or so publicly traded PPMCs will be in business 10 years from now,” Keckley says. “It will not simply be a matter of the ability to sign a contract and do a deal. It will be the ability to perform in the local market. The single greatest question that ought to be on the minds of physicians in looking at a partner should be the ability of that partner to provide long-term value.”

Questions to Ask

Affiliation discussions between PPMCs and physicians usually begin with PPMCs promising they will enhance the revenue, or value, of the practices they acquire. “That’s how PPMCs make money,” says Nathan Kaufman, senior vice president of Superior Consultants Corp., health care management and information systems consultants in San Diego. “They promise they will increase patient volume and accounts receivable, and then increase their own worth through expanding the number of practices under their umbrella. That

enhances their stock value.”

PPMCs offer two incentives to physicians during affiliation discussions. The first incentive involves purchasing a group’s assets and accounts receivable, usually with a combination of cash and stock in the PPMC. The second incentive involves offering professional management. In exchange for up-front cash and stock, the PPMC is paid from 15% to 20% of a practice’s income, after expenses, for an extended period, usually 30 to 40 years.

In determining how much stock and cash to offer a medical group, a PPMC assesses the group’s current market value, including patient volume, existing payer contracts, and annual revenue. “How this initial payment is structured is a crucial issue,” says Kaufman. “Many privately owned PPMCs promise that physicians will make a fortune on their stock options when they go public, and then some go bankrupt. What combination of stock or cash a group accepts should depend on the track record of the PPMC involved.”

Evaluating the financial strength and effectiveness of a PPMC requires diligent appraisal, says Blau. “As it is in every business, there are good operators and bad operators among PPMCs,” he says. “Physicians should remember that they are making a major career decision. It’s like entering a marriage.”

Due Diligence

Therefore, before affiliating with a PPMC, physicians should get advice from an attorney, accountant, or consultant, and conduct three types of due diligence: corporate, operational, and clinical, Blau says. Corporate due diligence requires a thorough examination of a PPMC’s financial statements, stockholder agreements, management structure, by laws, and articles of incorporation.

“Real due diligence begins with an examination of operational structure,” Blau con-

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tinues. A physician group should examine a PPMC's history carefully, reviewing how well the PPMC has managed other physicians and its record of increasing market share.

When evaluating the operational structure of a PPMC, physicians should review the effectiveness and capabilities of its information system; the expertise, experience and number of staff; its billings and collections capabilities; and its ability to train personnel. "In my opinion, quality professional management is the most important benefit a PPMC can offer a group," Kaufman says. "It is the biggest asset a PPMC can provide."

Blau says, "Physicians need to get deeply into a PPMC's operations. They should conduct site visits, both at the PPMC's corporate offices and at the offices of medical groups already associated with the PPMC. It's one thing to get promises on paper, but it's critical to actually check to see if what one is being told is true."

The third element of review involves a clinical evaluation, also called a cultural review. Blau says, "Physicians should carefully examine the capabilities, goals, and treatment philosophies of a PPMC's medical director and senior staff, including a scrutiny of clinical protocols." When a physician group is paying 15% to 20% of revenue over 30 or more years, hostility can develop if the PPMCs and its affiliated physicians differ in their approach to clinical protocols and treatment philosophies.

Barnett agrees, saying a lack of cultural compatibility is a significant reason that affiliations between PPMCs and medical groups fail. "The most important relationship in health care is the patient-physician relationship," Barnett says. "If a PPMC adversely affects that relationship, its initial investment is worthless."

Look for Value

When considering the issue of what value a PPMC can offer a physician organization, O'Neil says there are four key elements physicians should look for: a focused market strategy, managed care expertise, strong management skills, and what he calls "execution."

Focused Strategy. This element involves understanding what will make a long-term affiliation successful. Successful PPMCs

Top 10 Physician Practice Management Companies (by 1997 revenue)

Company	Specialty	Net Revenue (in millions)	Revenue after earnings retained by physicians
MedPartners Inc., Birmingham, Ala.	Multispecialty	\$6,331	NA
PhyCor Inc., Nashville	Multispecialty	2,171	1,120
FPA Medical Management Inc., San Diego	Primary care	1,166	NA
Physicians Resource Group Inc., Dallas	Ophthalmology	474	412
Coastal Physicians Group Inc., Durham, N.C.*	Emergency departments	448	NA
American Oncology Resources Inc., Houston	Oncology	424	322
Physician Reliance Network Inc., Dallas	Oncology	414	317
PhyMatrix Corp., Fort Walton Beach, Fla.**	Multispecialty	347	NA
MedCath Inc., Charlotte***	Cardiology	129	NA
Pediatrix Medical Group Inc., Fort Lauderdale, Fla.	Neonatology	129	NA

* Coastal's revenue is for nine months ending Sept. 30, annualized. As of April 30, 1998, the company had not reported 1997 earnings.

** PhyMatrix' revenue is for its fiscal year ending Jan. 1, 1998. Figure is from earnings reported on March 26, 1998.

*** MedCath's fiscal year ends on Sept. 30. Revenue for MedCath is for the last 12 months as of Dec. 31, 1997, to make it comparable to that of other companies. For the fiscal year ending Sept. 30, 1997, revenue was \$110.9 million.

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

understand the dynamics of their business and focus on dominating each market in which they have a presence. These PPMCs understand referral patterns among physicians and recognize the need for primary care and specialty physicians to deliver care effectively. Also, they encourage physicians to control ancillary services that help drive up profit.

Managed Care Expertise. Successful PPMCs can sign and implement contracts with large national and regional managed care organizations, and they can manage the financial risk of delivering care.

Strong Management. There is an extreme shortage of management talent in health care and the evolution of the physician services market has just begun, meaning this shortage will become acute in time. The consolidation of physician services will go through phases in coming years, and the PPMCs themselves will merge with each other, especially when smaller ones struggle.

Good management is critical to survival.

Execution. PPMCs need to deliver on three crucial levels, O'Neil says. "First and foremost is patient care," he explains. "Every patient must receive superior quality care. Second is at the physician level. Physicians are very difficult to organize and to manage. They will become frustrated if a company does not execute its business plan quickly and effectively. And third, at the corporate level, the level most visible to investors, companies must make a profit to survive," O'Neil says. "One way to determine if PPMCs are creating value in the physician organizations they create is to review their return on capital invested in individual practices, not the overall return on capital invested by the PPMC at corporate level," O'Neil says. "Physicians need to be very careful when they make decisions about PPMC affiliations," says Barnett. "The advantages can be considerable for some physicians, and the problems disastrous." ■

As the System Changes, Health Policy Expert Sees Positives and Negatives



Paul B. Ginsburg, Ph.D., is an economist and health policy expert and president of the Center for Studying Health System Change, an independent research organization in Washington, D.C., that is funded by the

Robert Wood Johnson Foundation, a health care philanthropy in Princeton, N.J. The center analyzes how the health system is changing, assesses the implications of those changes on consumers, and communicates its findings to policy makers and the public at large. Previously, Ginsburg was the founding executive director of the Physician Payment Review Commission (PPRC), created by Congress to provide nonpartisan advice about Medicare and Medicaid. Under Ginsburg's leadership, the PPRC developed the Medicare physician payment reform proposal that was enacted by Congress in 1989. Ginsburg previously worked for the RAND Corp., in Santa Monica, Calif., and for the Congressional Budget Office. Ginsburg earned his Ph.D. in economics from Harvard University. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q. *Dr. Ginsburg, you've been president of the Center for Studying Health System Change for three years now. Please tell us about the center and what you're trying to accomplish there.*

A. *The center's mission is to inform private and public-sector decision makers about changes in the health care system and about what those changes mean to people. We have an extensive range of activities, which include a longitudinal study to track the health care in 60 randomly selected communities. To do that, we conduct surveys of households, physicians, and employers and we visit sites to interview health system leaders. We also run conferences at which we present our research or bring in other experts to present theirs.*

Q. *Is it challenging to track changes in a system driven by private forces?*

A. *Yes, it is. We've seen this effort pre-dominantly as a focus on private, or market, forces, and we've gone through ups and downs as to whether public policy plays a significant role. One thing that's clear is that the health care policies of the 1970s have been jettisoned. Now, the important policies being discussed concern the shaping of the market and the provision of safeguards for patients in terms of market outcomes. In fact, recent changes in Medicare's role as a purchaser are likely to have an important effect on these health care markets.*

Q. *There's been a tremendous shift in the last year toward regulation in managed care. Isn't that correct?*

A. *Yes. Regulation of managed care is at the top of the policy agenda.*

Q. *I'd like to address three segments of this market: consumers, physicians, and trends. First, about the consumers. You were recently quoted as having said that the so-called pro-consumer laws are more favorable to physicians than to consumers. Would you elaborate on that point?*

A. *Consumer protection and physician protection often are hard to separate. In some areas, they coincide and in other areas physicians seem to be helped more than consumers. Let me give you some examples. Having a strong appeals mechanism for patients, who can be assisted by their physician in appealing a decision by a health plan, is a consumer protection. But having a law that prohibits capitation contracting between health plans and physicians is not in the consumer's interest. Given consumers' priorities both on broad choice of provider and on containing cost, capitation contracts are positive from the consumers' perspective. Costs will have to be contained in order for consumers to be able to afford health insurance.*

Q. *Do you believe, then, that capitation brings a kind of budgetary discipline to the way physicians practice?*

A. *I do not believe that individual physicians should face large capitation incentives. What I would like to see is*

capitation contracts with organizations—whether it's a hospital, a medical group practice, or an independent practice association—so that the organizations have incentives to contain cost. The organizations in turn would influence physicians in a different manner, such as using information systems to put medical knowledge that the physicians need at their fingertips. That is a healthy response to organizational capitation incentives.

Q. *Capitation seems to be spreading more slowly than was predicted by its advocates. Is that because this growth is uneven nationwide or just in certain parts of the country?*

A. *The growth rate of capitation varies throughout the country because much of that growth is determined by the presence of organizations equipped to accept the capitation payment and to manage within that context. In California, for example, capitation is much more feasible because of the large medical groups that are organized to deal with it. Another example is areas in which the system is organizing around hospitals, like Indianapolis, one of our study sites. Most of the physicians in that community are aligned with a particular hospital and those hospitals have capitation contracts with HMOs. But there are also markets, such as Washington, D.C., that lack the large organizations equipped to manage under capitation. Even so, the motivation to use capitation has increased because of the pressure on health plans to expand by having more physicians and more hospitals in their networks. That means the health plans' ability to manage care is reduced and capitation becomes more attractive to them.*

Q. *Some observers have predicted that consumers will dominate in the health care revolution. Regina Herzlinger, a professor at the Harvard Business School, maintains that in the end consumers will dictate the rules of the market. Do you believe she's right?*

A. *At any one point in time, the market will strive to serve consumers and to*

(Continued on page 10)

“Individual physicians should not face large capitation incentives. What I would like to see is capitation contracts with organizations so that they have incentives to contain cost.”

(Continued from page 9)

meet their needs. I'm not sure what consumers are expressing today, but I know it's very different from what they were expressing three years ago, and it may be very different from what they will express three years from now. I am concerned that today's consumer expression seems to be in the area of wanting broad choice of providers. In a sense, plans that are responding to that are probably making it harder for themselves and the delivery system as a whole as far as incorporating information technology, managing quality, and the like. In fact, I'm not sure whether it's choice or control that consumers really want. Consumers want to have the ability to go elsewhere for treatment if their physician disagrees with them as to what should be done, and plans ought to guarantee them that ability. But in reacting to consumers' interest in having the ability to make that choice, some plans may

between a managed care plan and a traditional plan, and many chose the managed care plan. Back then, they were in a much more positive state of mind than consumers are today because, increasingly, they do not have the option of choosing a traditional plan. What's more, many consumers who were the most reluctant about choosing managed care are now, through lack of other options, forced into managed care.

Q. *Recently, the woes of the HMOs have dominated the news. Are these signs that the HMO industry has peaked or that managed care is transforming into something else?*

A. Certainly the profitability of managed care has declined substantially. Part of the reason for that is that purchasers are much more aggressive and employers are much more willing to switch plans. There has also been a lot of pricing pressure on health plans, and health plans until very

that it grew too fast and didn't develop the infrastructure it needed to keep up with its growth. That's why it stumbled. Like Oxford, other plans have lost money because of difficulties in digesting a merger or in dealing with rapid growth. So, these news stories are not indicative of trends for the industry, but rather they offer a sobering realization that the health care financing business has more difficulty performing some functions that might be much easier, or are simply taken more for granted, in other industries.

Q. *So, what is happening is a kind of awkward financial adolescence for the HMO industry as its systems mature?*

A. Yes. It's a time of turmoil with an emphasis on being quick to get into new markets and grow fast. But as the number of HMOs that have either pushed further than they should have or have gone through this adolescent period increases, we can expect that future health plans might be a lot more cautious about making changes quickly, realizing how easy it is to lose money if their systems aren't up to what they're trying to do.

Q. *Has the federal investigation of Columbia/HCA dealt a severe blow to the for-profit hospital industry?*

A. No. It's had an important effect in that local hospitals, once so fearful of Columbia, will no longer jump into preemptive mergers or affiliations to keep Columbia out of their communities. Also, to the extent that Columbia gets smaller, other for-profit hospital companies will buy its hospitals, which will probably limit the degree to which any single for-profit chain gets very large. There will also be a lot more caution exercised by hospitals in how they work with home care businesses and the like.

Q. *Let's talk now about physicians. Is the reaction of physicians against managed care having an effect on the HMO industry or on pro-consumer legislation?*

A. Yes. The political activities of physicians have been very effective in rais-

“The motivation to use capitation has increased because of the pressure on health plans to expand by having more physicians and more hospitals in their networks.”

actually be going further than they need to in order to satisfy consumers.

Q. *So, you're saying that consumers want the ability to override their physician?*

A. Yes, the physician or the health plan. And they don't want to be locked in to a physician they didn't choose.

Q. *Last year, managed care enrollment grew so that it now involves 85% of Americans employed by corporations, and that's up from just 54% four years ago. Is the significance of this radical, rapid transformation from fee for service to managed care just beginning to dawn on Americans, and is that what's triggering this backlash?*

A. Yes, that's an important part of it. Previously, consumers who enrolled in managed care plans had a choice

recently tried to get into new markets to establish themselves, which often meant coming in with a lower premium. So, there are understandable market forces, particularly on the revenue side, that have squeezed managed care plans.

As for recent news articles about the stumbling of Oxford Health Plans and other HMOs, it seems to me that they haven't stumbled in doing the cutting-edge things but rather in doing some basic things, like paying bills. Oxford couldn't get the bills out to employers, which meant the doctors couldn't get paid; in the process of not getting the doctors paid, Oxford lost track of what its costs of care were. In effect, Oxford had provided such an attractive product to consumers and to physicians

“Oxford had provided such an attractive product to consumers and to physicians that it grew too fast and didn’t develop the infrastructure it needed to keep up with its growth. That’s why it stumbled.”

ing the issues of HMO regulation in both the states and in Congress. That so many physicians are unhappy about their interactions with the system of managed care is something public officials should notice and be working to address.

Q. *Do you regard the physician practice management trend as significant or as just a passing fancy?*

A. This is a movement that started out doing fairly mundane things—helping physicians to run their offices more efficiently and to bill more effectively. Now, however, the physician practice management companies (PPMCs) are attempting to provide a new role, basically as an intermediary between physicians and health plans. There’s a potential contribution in that role because the communities that do not have large, well-developed group practices need an infrastructure to organize the physician side of the delivery system. PPMC’s are attempting to do that either by forming independent practice associations or by providing capital and technical assistance to somewhat smaller group practices. There’s a real need there, but I’m not sure whether PPMC’s will be successful in filling that need by providing enough value to outweigh the costs they incur.

Is it a passing fad? If it is, it’s much too early to tell because they’re just getting started in trying to go beyond the role of simply helping physicians run their offices to being an intermediary that helps physicians function as part of a more integrated delivery system.

Q. *Some would argue that hospitals, physician-hospital organizations, and other integrated hospital-based systems are in a heated contest with PPMC’s for the loyalty of American physicians, who represent the core of any delivery system but are locally short on capital. If so, then the question becomes: How are hospitals going to control the system when the care is migrating outside of the hospital?*

A. My guess is that they’re trying to get into the delivery system by having outpatient clinics, by purchasing physician

practices, and by increasing the care of patients outside of the hospital outpatient department. The weakness in this strategy is that hospital relations with physicians have often been quite mixed. What’s more, there’s not much history of hospitals working with physicians on either cost or population-based quality issues. So, as I see it, a PPMC tends to be more of a physician-centered model that competes with the hospital-centered model. But, as you say, the key factor in all of this is the physicians. Hospital-based systems tend to be more oriented toward specialty physicians, who have often been the more prominent physicians in hospitals, whereas PPMC’s and other physician-centered models tend to be more primary-care oriented.

Q. *The Balanced Budget Act of 1997 pushes provider service organizations*

“In reacting to consumers’ interest . . . some plans may actually be going further than they need to in order to satisfy consumers.”

(PSOs), which are another mechanism for caring for Medicare recipients. Some argue that these organizations will fundamentally change the landscape of the American health care system by having provider-owned hospitals and doctor-owned organizations taking care of Medicare populations through capitation and by risk assumption. How rapidly will PSOs become a factor?

A. Not very rapidly because what’s needed for a provider organization to succeed is what provider organizations tend not to have. They need to know how to market, and they need to organize themselves to manage care on a risk basis. We’ll see a lot of partnerships forming between provider organizations and insurers to compete in this market where the provider organization is playing a more favorable role than might have been the case in the past.

Q. *So, PSOs don’t portend a mass movement in the Medicare population toward Medicare-risk plans?*

A. No. The Medicare population has always been cautious about enrolling in managed care plans, and that will continue. To some extent, a local organization, with a significant brand name recognized for quality and good service, may accelerate the movement into risk contracting by the Medicare population. The constraint is going to be the readiness of provider organizations to attract and serve large numbers of risk-based Medicare beneficiaries.

Q. *A recent study in Minneapolis involved extensive surveys of Minnesota doctors and patients. One of the study’s conclusions dealt with the satisfaction with managed care of healthy and sick populations and of doctors. The study concluded that there was a real prob-*

lem with managed care in terms of anxiety among the sick about access to care and concern among physicians about providing for an aging, sicker population. Do you have any thoughts on this problem?

A. The core of health care has to be how well the system serves sick people. Managed care is starting to do more for sick people in terms of its involvement in disease management for the chronically ill. But any system that leads the sick and their physicians to be unhappy or worried about the care that is being given (or not given) is not a system that is serving us well.

Q. *But the managed care system, as you point out, is beginning to address the issue of disease management.*

A. That’s right. And as more people move into managed care, the urgency increases for sick and healthy people to be satisfied with the experience. ■

New Terms, Definitions Issued for PSOs

By Edward B. Hirshfeld, JD

In April, the Health Care Financing Administration (HCFA), the federal agency that administers Medicare, issued a new rule for provider-sponsored organizations (PSOs). A PSO is a type of health plan owned and operated by providers that may be offered to Medicare beneficiaries as part of the new Medicare+Choice program created by the Balanced Budget Act of 1997. The act defines the term "PSO" and states how a PSO must be structured. The new rule explains the meaning of the terms used in the definition and the structural requirements in detail.

The terms and definitions relate to the following:

- Definition of PSO
- Public or private entity
- Provider
- Substantial proportion
- Affiliation
- Substantial financial risk
- Majority financial interest

Definition of PSO. A PSO must be (a) a public or private entity, (b) that is organized and operated by a single health care provider or a group of affiliated health care providers, (c) that provides a substantial proportion of the benefits package required by the Medicare program directly through the provider or the affiliated providers, (d) the affiliated providers must share, directly or indirectly, substantial financial risk with respect to the provision of the Medicare benefits package, and (e) the affiliated providers must have a majority financial interest in the PSO entity.

Public or private entity. A PSO may be a for-profit or nonprofit entity, and may use the full range of business forms for both kinds of entities.

Provider. A provider is defined as "any individual who is engaged in the delivery of health care services in a state and who is required by state law or regulation to be licensed or certified by the state...and any

entity that is engaged in the delivery of health care services in a state and that, if it is required by state law or regulation to be licensed or certified by the state, ...is so licensed." All PSO providers will be required to meet the conditions of participation and certification that applied to providers in Medicare HMOs before the act was passed.

The new rule clarifies that an individual provider must furnish health care services directly. This provision ensures that PSOs are composed of providers that are in fact actively delivering care. An important issue is whether entities composed of providers fit the definition, especially provider intermediaries, such as independent practice associations (IPAs) and physician practice management companies (PPMCs). HCFA wants to ensure that PSOs consist of providers that are actually delivering care

HCFA recognizes that the 70% threshold could chill market opportunities for physician groups by, in effect, precluding them from establishing PSOs without affiliating with a hospital. But HCFA staff members believe sufficient competition exists among hospitals in most service areas to ensure that hospitals will want to affiliate with physician-owned PSOs, and therefore physician groups should not be at a disadvantage.

Nonrural providers may participate in a rural PSO. However, to ensure that a PSO is primarily rural, it must demonstrate that the use of providers outside of the rural area is consistent with area referral patterns, that a majority of the enrollees reside within the rural area it serves, and that it has the same level of accessibility and availability of care through local providers as nonenrollees living in the same area, including such routine

The new rule clarifies that an individual provider must furnish health care services directly. This provision ensures that PSOs are composed of providers that are in fact actively delivering care.

without arbitrarily excluding participation of entities that combine direct patient care with nonclinical health-related services. Therefore, the new rule specifies that an entity is a provider if it is "organized and operated primarily for the purpose of furnishing health care services directly or through its provider members or entities." HCFA will consider the entity's organizational structure, lines of business, mission, bylaws, and the controlling interests to determine its predominant nature.

Substantial proportion. The new rule sets the substantial proportion requirement at 70% of the Medicare items and services, and 60% for PSOs in rural areas. PSOs may decide what service mix to use to meet this requirement, since no prescribed mix of services is required. HCFA will use Medicare expenditure data—not Medicare encounter data—to determine whether the test is met.

services as primary care, specialty care, and emergency services.

Affiliation. The purpose of the affiliation requirement is to distinguish the PSO as an entity composed of separate providers that have combined to contract with Medicare. The act requires affiliation through one of the following relationships: (a) one provider must, directly or indirectly, control, be controlled by, or be under common control with the other provider; (b) both providers must be part of a controlled group of corporations under Section 1563 of the Internal Revenue Code; (c) each provider is a participant in a lawful combination in which each provider shares substantial financial risk in connection with the organization's operations; and (d) both providers are part of an affiliated service group under Section 414 of the Internal Revenue Code.

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

Providers may affiliate individually with a PSO or as a group through organizations such as IPAs or PPMCs. HCFA staff members believed that requiring individual affiliation could restrict PSO development unnecessarily. The affiliation requirement is not intended to constrain the internal organizational structure of a provider entity that is affiliated with a PSO. The rules do not limit the organizational flexibility of an IPA or its payment arrangements with physicians.

The third method of affiliation, “a lawful combination where each provider shares substantial financial risk,” is probably the best way for independent physicians to affiliate. HCFA will interpret the “lawful combination” part of this test as compliance with federal antitrust guidelines and other federal and state laws. Given that the substantial proportion requirement effectively requires that a physician organization be affiliated with a hospital to form a PSO, this method offers the most flexibility. It does not require the physician organization to control, be controlled by, or be under common control with a hospital.

Substantial financial risk. The purpose of the substantial financial risk requirement is to differentiate PSOs from other health plans by giving providers in PSOs an economic incentive to improve the PSO’s delivery of health care. HCFA wants affiliated providers to be at financial risk for more than the services delivered by the provider, and to have a stake in the PSO itself. The rule does not define a specific level or category of risk that must be met. Instead, HCFA will rely on a case-by-case review of risk-sharing arrangements. The intent of the rule is to allow PSOs to use a wide range of methods to achieve substantial financial risk. To provide some guidance, the rule sets forth certain arrangements that may qualify. It cautions that they might have to be used in combination, meaning that use of just one of them might not give the affiliated providers an adequate stake in the financial risk the PSO must assume to constitute substantial financial risk.

These arrangements include capitation, percentage of premium, and significant fee withhold or bonus-penalty arrangements. Withholds may be used to cover the losses of the PSO or the losses of other affiliated providers, or may be returned to the affiliat-

PSO or a significant capital investment in the PSO by the IPA.

It should be noted that the rule defines substantial financial risk in a way that allows providers to affiliate without being under common corporate control, without

The rule allows a physician group that forms a PSO to affiliate with a hospital without offering the hospital an equity or ownership interest in the PSO, and vice versa.

ed provider or distributed among the affiliated providers if the PSO meets its utilization management or cost-containment goals. HCFA also will consider other financial commitments, such as significant ownership by the affiliated providers in a for-profit PSO, significant investments from an affiliated provider, or a guarantee by an affiliated provider to cover the debt or operating expenses of the PSO. Finally, the amount or level of financial risk borne by any given affiliated provider does not have to be uniform. The risk can vary according to factors such as the size or capacity of the provider, the financial strength of the provider, and the nature of the services rendered.

HCFA emphasizes that the sharing of substantial financial risk must be between the PSO and the affiliated providers. The financial arrangements between a provider entity and the providers that are part of that entity do not count toward the test; it is the arrangement between the provider entity and the PSO that is critical. The risk shared must be in the PSO enterprise itself. Ordinary risk-sharing arrangements in which providers take risk only for a limited number of the services that they provide are not adequate. An arrangement in which an IPA takes risk for primary and specialty care physician services is not sufficient, for example. There must be another arrangement that links the IPA with the overall financial risk of the PSO. Such a link could be a withhold used to cover the losses of the

acquiring an equity financial interest if the PSO is for-profit, and without acquiring governance rights if the PSO is nonprofit. In other words, the rule allows a physician group that forms a PSO to affiliate with a hospital without offering the hospital an equity or ownership interest in the PSO, and vice versa. The affiliation technique that can be used is the one that allows providers to affiliate “in a lawful combination under which each of the providers shares substantial financial risk.” As explained above, this method of affiliation can be through managed care financial risk-sharing arrangements, such as capitation.

Majority financial interest. This provision does not require each of the affiliated providers to have an ownership interest in the PSO. It may be owned and controlled by one of the providers or any combination of the affiliated providers. Therefore, a PSO may be owned by a subset of the affiliated providers. This provision is important given that a physician organization must be affiliated with a hospital to satisfy the requirement that the affiliated providers must deliver a substantial proportion of the items and services included in the Medicare benefits package. Therefore, this provision will allow physicians to affiliate with a hospital without including the hospital as a PSO owner, and vice versa.

Finally, nonproviders may have a financial interest in a PSO, but may not acquire a majority ownership interest. ■

Why Physicians Give Up the Status Quo

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

Over the past several years, we have helped numerous physician groups nationwide assess their strategic options. Generally, these groups have decided to affiliate with a partner rather than stay independent. This trend toward affiliation is being driven by the growing internal and external challenges physicians face as a result of managed care and by the dynamics of the markets in which the physicians operate (see Table 1).

To illustrate the factors that lead physicians to make the decisions they make regarding partnering, we offer the following overview of the issues several of our clients have con-

fronted. To protect our clients' confidentiality, we call them Clinic A, and Clinic B, etc. The issues and how each clinic resolved them are outlined in Table 3.

Each clinic faced challenges primarily in three areas:

1. Competition
2. Managed care penetration
3. Need for capital

Most of the clinics that decided to affiliate with a partner did so because they were facing increasing competition, had rising enrollment in managed care in their markets, and needed capital to expand by consolidating with other physician groups or to

purchase information systems. Clinic B, the only clinic that chose not to affiliate with a partner, is located in a market where there is currently no immediate push for capitation. Even so, the physicians in Clinic B are continuing to consider their options, knowing that the situation could change dramatically in the next few years.

Making the Decision

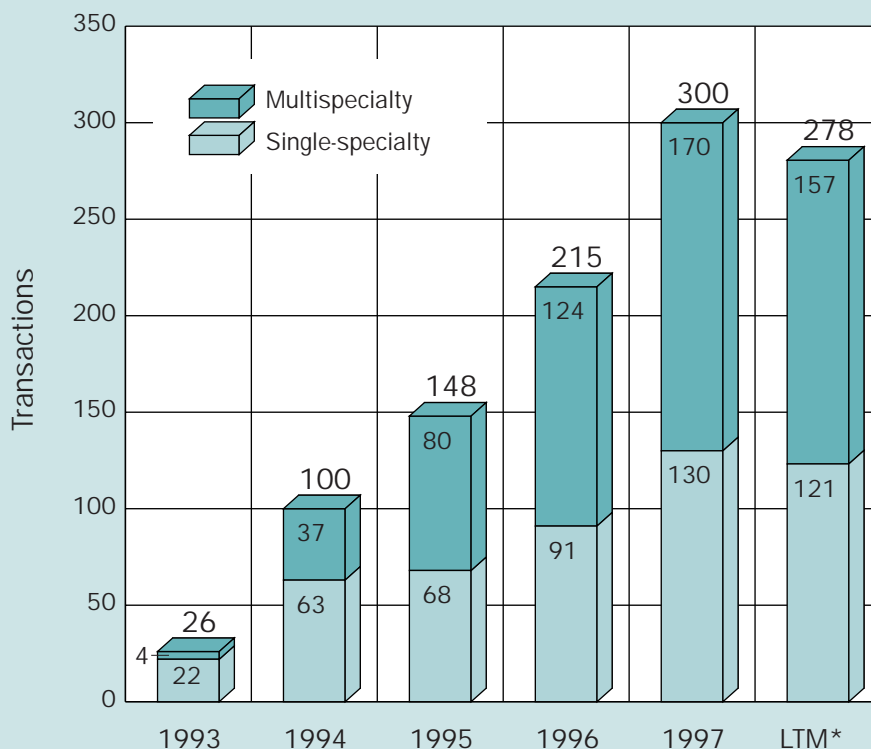
To help physician groups evaluate the implications of a partnering decision, such as selling their practice to a physician practice management company versus continuing to remain independent, we have organized the key economic components into a formula (see Table 2).

To the extent that the value of the purchase price proposed by the strategic partner is at least equal to the estimated value of the management fee (adjusted for the time value of money) paid to the partner, the transaction will typically make sense from an economic perspective. If the physician group determines—after due diligence on the prospective partner—that the resources the partner brings (such as low-cost capital, managed care expertise, and best practice procedures) will enhance the physicians' compensation, then the value of the transaction may significantly exceed the value of remaining independent.

A thorough economic and strategic analysis of the clinic's partnering and financial options using a process designed to build consensus among the physician group members, particularly its leadership, is paramount for any group considering these types of alternatives. Many factors must be taken into account in reaching a decision about what direction is in the best long-term interests of the physician group.

In Table 3, we have explained the competition, managed care environment, capital needs, result, and rationale each clinic used in evaluating its strategic options. ■

Table 1: Number of Announced Physician Practice Acquisitions



* LTM is last 12 months as of March 31, 1998.
Source: Townsend Frew & Co., Durham, N.C.

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Table 2: Evaluating an Affiliation

$$\text{Total Value of Affiliation} = \text{Purchase Price (in stock, cash, notes)} + \text{Value of Future Physician Compensation (net of fees paid to partner, including synergies)} + \text{Intangible Value of Affiliation (quality of life, governance structure)}$$

Table 3: Five Clinics Review the Options

Issue	Clinic A	Clinic B	Clinic C	Clinic D	Clinic E
Competition	Smaller players are organizing, threatening market share.	Competing clinic has affiliated with a national PPMC and a local hospital is pressuring the clinic to affiliate.	Local physicians are organizing competing networks.	Physicians in nearby markets are backed by national PPMCs and plan to enter Clinic D's market.	Rapidly growing group in same market has partnered with a PPMC.
Managed Care	Heavy managed care penetration and premium reductions are pressuring physician income.	Predominantly discounted fee for service and currently no push toward capitation.	Market rapidly moving toward capitation.	Currently only primary care capitation.	Little capitation currently but capitated programs are expected within three years.
Capital Needs	Wants to grow market share aggressively and expand into and develop new markets.	Capital needed to improve information systems infrastructure, and for acquisitions.	Capital needed to invest in physician network development, information systems infrastructure, and ancillary care.	Capital needed to pay debt and for information systems and acquisitions.	Capital needed to expand PCP network, increase market share, and develop management infrastructure.
Result	Affiliated with a local hospital	Remained independent	Sold to a publicly traded PPMC	Sold to a privately held PPMC	Sold to a publicly traded PPMC
Rationale	Benefits of a PPMC were not enough to offset the total value that the clinic could realize through the hospital affiliation and the clinic structured a PPMC-like deal with hospital.	Clinic received proposals from five partners and determined it was in its best economic and strategic interests to remain independent.	Partnership viewed the low-cost capital and management resources a PPMC provides as a way to accelerate the implementation of its strategic plan.	Physicians decided gaining access to capital and management resources increased likelihood of long-term strategic success and affiliation relieved the clinic and its shareholders of personal liability for financing.	Clinic viewed low-cost capital and management resources of a PPMC as a way to accelerate implementation of its strategic plan.

Will Direct Contracting With Employers Increase?

The future of employers' efforts to contract directly with physicians remains uncertain, according to the authors of an article in the April 9 issue of *The New England Journal of Medicine*. The authors reported that the Buyers' Health Care Action Group (BHCAG), a coalition of employers in Minneapolis, is an example of direct contracting between employers and physicians. The coalition has been successful in using its significant buying power to help reshape the market and to foster competition, said the authors, Thomas Bodenheimer, MD, of the Department of Family and Community Medicine at the University of California at San Francisco's School of Medicine; and Kip Sullivan, a lawyer with Minnesota Citizens Organized Acting Together, based in St. Paul.

BHCAG has 28 self-insured employer members and a total of about 125,000 employees. Last year, it eliminated insurers and began contracting directly with care systems, which are groups of physicians and other provider organizations, such as hospitals.

HMOs have retained their edge over the coalition, however, because the coalition is so small, representing only 4% of health care spending in the Twin Cities. To date, the hope among physicians that eliminating HMOs would increase the money allotted for actual medical services has not come to fruition, the authors said. They predicted that three factors would affect how rapidly direct contracting spreads nationwide: the strength of the employer-coalition movement, the emergence of physician-led or hospital-led provider networks, and the willingness of employers to allocate the additional resources needed to switch from contracting with health plans to contracting with providers.

Comment: *Since large employers have succeeded in moving employees into managed care, physicians must deal with them if they want to influence managed care.*

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