

# PHYSICIAN PRACTICE OPTIONS™

August 1997

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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## Managed Care Fosters Strong Union Growth

**R**esponding to lost income and decreasing independence, physicians are doing what many consider anathema: joining labor unions.

"We've experienced strong growth in the last two years, and managed care is the reason why," says Barry Liebowitz, MD, president of the Doctors Council of New York in New York City, one the oldest and largest physicians' unions. "A steadily increasing number of private practice doctors have been calling us to find out what we can do for them," he says. "Organizing physicians is like trying to get butterflies to fly in formation. They don't like to work in packs. But practicing medicine is unfortunately becoming more an industry function than an art, and more and more doctors want to fight back."

Determining just how many physicians are members of the half dozen labor organizations representing private practice and salaried doctors is difficult because the organizations sometimes inflate enrollment figures, the AMA says. The AMA estimates the number at 14,000 to 20,000. Included in this total are 6,000 to 9,000 salaried hospital residents. Interns are not included. The unions say the total is more than 40,000 physicians, mostly salaried doctors working for hospitals, clinics, universities, or managed care organizations. Especially among salaried doctors, who make up 45% of the nation's physicians, the union movement appears to be intensifying. At its annual convention in June, the AMA House of Delegates voted to issue two reports criticizing the utility and purpose of physician unions.

"Patients inherently have to come first," says Bruce Blehart, senior counsel for the AMA. "Unions don't put patients at the highest level; they put their members first." Not true, says Liebowitz: "The AMA doesn't

like us because we do what they say they can do for their members, but we do it better."

### Variety of Services

The types of physician unions vary widely, ranging from independent locals to large national organizations. Dues generally are about \$600 a year. The Doctors Council is an independent union. "I don't want our interests to be subjugated to the interests of a larger organization," Liebowitz says. The council has 3,400 members, primarily salaried doctors employed in 14 city hospitals and five health care centers.

The Federation of Physicians and Dentists (FPD) in Tallahassee, Fla., is affiliated with the AFL-CIO, the nation's largest labor union. The American Federation of Teachers in Philadelphia primarily serves salaried health care workers, but includes some salaried physicians in its ranks. Some unions with diverse memberships are aggressively seeking private practice and salaried physicians who are dissatisfied with managed care. The Office Professional Employees' International Union (OPEIU) in New York City, which is part of the AFL-CIO, recently announced formation of the National Guild for Medical Providers, which currently includes only podiatrists but may begin organizational efforts among physicians. The Committee for Interns and Residents (CIR) in New York City recently affiliated with the independent Service Employees International Union in Washington, D.C. The SEIU has announced plans to initiate an organizational effort soon among private practice and salaried physicians in Washington, D.C.

Union services differ for private practice and salaried physicians. In general, they offer a wide range of services in areas where

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## Specialists Find New Ways to Form Sustainable Groups

Specialists are back into favor: Three states have passed laws guaranteeing access to them, some HMOs have found that offering direct access to specialists helps them sustain growth, and studies have shown that specialists are more effective than generalists at managing certain diseases, such as myocardial infarction, congestive heart failure, and asthma.

These trends are fostering managed care contracting entities exclusively for specialists. Consider these examples:

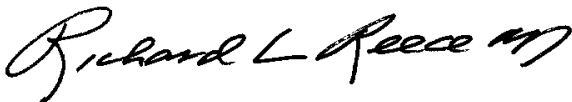
- ObGyn Management Inc., in Dayton, Ohio, was formed in 1995 by 100 obstetricians and gynecologists. The group offers capitated services and has eliminated the need for pre-authorization of surgery by reducing the number of procedures it performs by 56%.
- Several physician practice management companies (PPMCs) and hospitals have formed networks of as many as 250 cardiologists to capture managed care contracts in South Florida, Atlanta, and Baltimore, according to a recent report.
- Four orthopedic PPMCs (Integrated Orthopaedics Inc., in Houston; Specialty Care Network Inc., in Lakewood, Colo.; Orthopedic Networks of America Inc., in West Palm Beach, Fla.; and Ortholink Physician Corp. Inc., in Nashville, Tenn.) seek to capture a share of the \$100 billion musculoskeletal market, which includes the fields of orthopedics, rehabilitation, and occupational medicine, according to speakers at the Managed Orthopedic Care Conference in Washington, D.C., in May.
- Twenty specialty PPMCs have gone public, in dentistry (6), oncology (3), ophthalmology (3), orthopedics (2), occupational medicine (2), cardiology (1), urology (1), pediatric intensive care (1), and otolaryngology (1). In addition to PPMCs, specialty groups have organized independent practice associations, management service organizations, and integrated groups, all of which accept the financial risk of delivering care.

### Business Criteria

When a specialty company forms, it must meet certain business and marketing criteria for investors to consider it sustainable. A specialty company would, among other criteria, need:

- A large market with significant cash flow, such as oncology, orthopedics, ob-gyn, and cardiovascular disease, or alternatively, a niche that could be carved out easily (such as dentistry, occupational medicine, ophthalmology, pediatric intensive care, or otolaryngology);
- To deal with discrete episodes of care (such as work-related injuries on surgical procedures);
- To establish for some specialties, such as orthopedic surgery, an exclusive domain (such as muscles, tendons, ligaments, and joints), and relative control over ancillary services (such as imaging centers);
- To meet buyers' quality and cost criteria;
- A strong link to primary care physicians;
- To put clinical excellence before meeting financial goals at the expense of quality.

Blend these ingredients with package pricing and predictable expenses for purchasers, and you have the makings of a specialty group that can sustain itself and secure managed care contracts.



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# MSO Shows Why Primary Care Physicians Should Own Their Groups

Each primary care physician can and should control his or her destiny. Despite pressure by managed care plans and other economic forces to sell to larger organizations that may not be owned by PCPs, primary care doctors can form medical groups they own and operate themselves, says Michael J. Martin, MD, CEO and co-founder of Advocates for Primary Care Inc. in Santa Rosa, Calif., a consultancy that works exclusively on advising PCPs on group formation.

"We believe primary care physicians should maintain control of their own organizations, and that's what we help them do," Martin says. "We bring PCPs together and provide the expertise and consulting services they need to make that happen."

Martin, a practicing internist, says, "PCPs are understandably frustrated and angry. Their incomes have steadily decreased through discounted fees imposed by managed care organizations (MCOs). Their clinical autonomy has been taken away by MCO case managers, and the value of their practices has been reduced. At the same time, paperwork, hassles, and expenses have increased."

Martin is the former medical director of California Pacific Medical Services Organization, the management services organization (MSO) affiliated with California Pacific Medical Group, a multi-specialty group of 675 physicians, including 500 specialists, in San Francisco. Martin's experience with California Pacific MSO led him to believe PCPs cannot control the direction of their practices or protect their incomes in multi-specialty groups. In multi-specialty groups and in groups owned by hospitals, "PCPs have to ask specialists or hospitals for what they need, and often the answer is no," Martin says.

## Unusual Relationships

Martin and several other investors started Advocates in 1995 to assist PCPs in forming their own IPAs and medical groups.

"What makes us unique is that we believe PCPs can contract directly with managed care companies," Martin says.

Indeed, Daniel J. Lanahan, Advocates' chairman of the board, says that PCPs "can do better financially and clinically on their own than they can as members of large organizations like multi-specialty groups, or through shared ownership with practice management companies or MSOs. We provide a vision of where they should be headed and the information they need to get there." Lanahan is a partner with Lanahan & Reilly, a Santa Rosa law firm.

IPAs are loosely affiliated organizations of physicians or medical groups that contract with payers, such as MCOs, to deliver services, often for a set, or capitated, fee. In turn, the IPA contracts with its members to provide medical services

experienced managers, and accounting expertise to determine the competitive rates that allow physicians to make a profit. Medical groups usually contract with or develop their own MSOs to handle those services and their own administrative needs, such as credentialing, utilization review, billing, and managed care contracting. Both alternatives are expensive for medical groups. Developing an MSO usually costs more than \$1 million, of which information systems alone can take up about \$500,000. When a group purchases MSO services, the MSO frequently purchases the medical group's assets, often resulting in a loss of professional autonomy for PCPs.

Medical groups of more than a dozen or so physicians often are composed of specialists as well as PCPs. Unfortunately for

**"We formed our PCP group so that we could be first in line for the capitated dollar. The only way we could do that is to be independent, rather than be part of a group answerable to others."**

— Les Johnson, MD, Illinois Primary Care

either for a fixed monthly fee, known as a capitated fee, or on a fee-for-service basis. Medical groups are more tightly structured. They are defined by the AMA as three or more physicians who deliver patient care, make joint use of equipment and personnel, and divide income through a prearranged formula.

Under capitation, MCOs pay providers a monthly fee for each health plan member. Since reimbursement is not based on the number of services provided, physicians are at-risk for the cost of care that exceeds the monthly fee. If care for each patient costs less than the fee, the physicians keep the difference; if care costs more, the physicians pay. Capitation contracting requires information systems,

PCPs, specialists frequently dominate administration and governance in these groups because they bring in a larger portion of the group's income.

Large IPAs and groups composed solely of PCPs are comparatively uncommon, says Keith C. Borglum, executive vice president for marketing and operations and a co-founder of Advocates. "It is expensive to start a medical group, more expensive than most PCPs can afford," Borglum says. "What makes Advocates different from other options PCPs have for forming an IPA or a group and developing MSO capabilities is that our program allows them to have complete control and to maintain ownership," he says.

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### Overwhelming Response

Advocates began its marketing effort last year by mailing information about its services to thousands of PCPs nationwide. The response "was much more than we expected," says Borglum. "There's obviously real interest out there among PCPs about forming autonomous groups."

Advocates offers \$250,000 in consulting services to PCPs who are willing to organize and to promote group formation among their colleagues (see box below). Those services include legal help and organizational and marketing consultation. "We will talk with even one or two PCPs if they are willing to make an effort to organize," Martin says.

In compensation, Advocates takes 1% of the group's gross monthly revenue in per-

petuity. A group pays this 1% fee as long as it has managed care contracts, but Advocates has no ownership participation. "We begin taking a fee only when the group has contracts with managed care payers," Martin says.

Several PCPs in Peoria, Ill., responded to the mailing, and subsequently formed a 22-physician IPA named Illinois Primary Care. "Several of us were looking for some type of organization that could provide in one package the legal and practice management expertise we needed, and Advocates was the best of the consultants we contacted," says Les Johnson, MD, president of Illinois Primary Care. "We formed our PCP group so that we can be first in line for the capitated dollar. The only way we

can do that is to form an independent group rather than be controlled by hospitals or be part of a group that is answerable to the agenda of specialists."

In addition to using Advocates' organizational services, some physicians in Illinois Primary Care are purchasing services from Advocates' MSO subsidiary named Advocates Integrated Management Services Inc., in Burlingame, Calif. Those services include the use of AIMS' management information system, provider profiling, claims processing, billing, credentialing, and group purchasing—all services medical groups need to assume risk successfully under managed care contracts.

Johnson belongs to a three-member PCP medical group that is using the services provided by AIMS. "Advocates helped us to integrate our small group, and is providing the expertise we need to expand as much as we want to, hopefully to 200 PCPs or more," Johnson explains. "At the same time its MSO subsidiary is providing services as we need them."

Borglum says, "We offer them these services at a fee they can afford and with no loss of their autonomy. Later, when they have sufficient income, they can decide whether they want to form their own MSO."

In addition to the Peoria group, Advocates has development contracts with several newly formed PCP groups in New York. In addition to the New York groups, the company recently signed a contract with BayCare Medical Group, an established 220-member group in San Francisco, to provide MSO services on a fee-for-service basis.

"Our efforts have really taken off in New York because managed care is becoming stronger there and physicians are becoming increasingly aware of the need to act, and act soon," Lanahan says. "We intend to strengthen our marketing efforts in the Northeast and Southeast, two parts of the country where managed care is beginning to make its presence felt aggressively."

"Our strength is in organizing doctors," says Martin, "giving them a clear vision of what can be accomplished when they own and control their own groups, and are free to act in their own best interests." ■

## Six Steps to Success

Advocates for Primary Care assists primary care physicians in forming their own groups and IPAs in six steps:

1. *Establishing an IPA.* Advocates provides advisory services to a core group of five to 50 PCPs and assists them in forming an IPA and adopting a business plan. Advocates targets markets that have a minimum population of 300,000 and are large enough to support a group of at least 50 physicians in multiple offices.
2. *Achieving critical mass of 50 PCPs.* Advocates advises the group on how to develop the criteria needed when adding members. It outlines how the IPA should review professional qualifications, geographic considerations, and patient mix, among other issues. It provides the group with marketing letters and other solicitation materials. In order to have any clout among health plans as a preferred provider, the group must have at least 50 physicians. As physicians are added, Advocates provides agreements addressing various issues of corporate governance, fee agreements, and capital investment needed from members.
3. *Establishing strategic alliances with hospitals and specialists.* Advocates assists in forming strategic alliances with hospitals, specialists, and ancillary providers in the group's market area. This step is needed in order to build an integrated health care system.
4. *Establishing an MSO.* Advocates advises the group on forming, managing, and capitalizing an MSO. The MSO will provide management services to the group. Such services may include claims payment, utilization review, quality assurance, billing, and managing office staff. Advocates also provides many of the numerous contracts and agreements an MSO would need.
5. *Soliciting capitation contracts.* Advocates provides the group with training, marketing plans, and model contracts to solicit and complete capitated contracts with health plans, employers, governments, and individuals in their market.
6. *Raising capital and writing a business plan.* Depending on size, Advocates estimates that each group requires \$500,000 to \$1 million in working capital in its first year. Capital will be provided by the physician owners, outside investors, or a combination of the two. In this step, Advocates assists the physicians in choosing the best source of capital.

## COVER STORY

(Continued from page 1)

doctors may lack the expertise or time to do the work themselves. Unions serve both salaried doctors and physicians in private practice as advocates with managed care organizations, especially in discussions about regulations and protocols. They fight deselection from MCO provider networks, provide expertise and advice in contract negotiations, lobby state legislatures and Congress, provide advice on taxes and IRS audits, and offer life and disability insurance.

But for private practice physicians, including doctors in medical groups, unions cannot bargain collectively with payers for rates.

**“Unfortunately practicing medicine is becoming more an industry function than an art, and more doctors want to fight back.”**

— Barry Liebowitz, MD, Doctors Council of New York

That action is prohibited by Federal Trade Commission antitrust regulations. “That’s about all we can’t do,” says Gary Robinson, executive director of the Union of American Physicians and Dentists (UAPD), in San Francisco. “We’re largely a service bureau for our private practice members. But doctors are facing a situation that has changed so dramatically in the last decade that they need help with many issues related to income that don’t violate federal laws, like how to design a managed care contract or how to make sure they get fully paid in a timely fashion.” Some unions, including the UAPD, sponsor the formation of independent practice associations among members, offering expertise and sometimes capital.

### Negotiating Controversy

For salaried physicians, unions can, and often do, negotiate rates, an activity that makes the physicians’ union movement controversial. Some physicians, and some professional organizations, say they are uncomfortable with the union concept for health care professionals. These professionals are disconcerted because of the historical emphasis by unions on compensation and strikes and because they believe union agendas compromise the doctor-patient relationship.

“Physicians swear an oath to work for the good of their patients,” says Jane Orient, MD, an internist in Tucson, Ariz., who is president of the 5,000-member Association of American Physicians and Surgeons. “If the physician is working for a third party, like a union, there’s an inherent conflict in that relationship. Unions seek to promote the interests of their members, and the financial interests of a doctors’ union members may differ from the best interest of the members’ patients. A good example is a strike situation. How can patients be served if the doctors are striking for higher wages?”

The union movement is most active in California, Florida, and New York. In June, the CIR, whose 9,000 members are employed by hospitals in six states and the District of Columbia, joined the SEIU, which has 1.1 million members. The CIR has been an extremely active union for 40 years, supporting numerous strikes and collective bargaining between New York hospitals and their

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residents. Until the merger, the SEIU represented only nonphysician health care workers. The SEIU plans to spend \$1 million in the next year organizing salaried physicians.

“Since employers are consolidating and merging, you need bigger organizations to deal with them,” says John Ronches, CIR’s president. “All health care workers should be organized, and doctors should be leading the effort.”

The CIR and the Doctors Council are

composed entirely of salaried physicians. But the FPD and the UAPD have had modest success seeking private practice doctors. UAPD, which has more than 5,000 members, is the nation’s largest physician union. Virtually all of its members are in California and about half are in private practice. Founded in 1972, it has had a 70% increase in membership since 1992.

“Physicians need to understand that it’s time to stand up to corporate interests so

that they can do the job they were trained for without fear of reprisal,” says Robert L. Weinmann, MD, UAPD’s president. “No one sacrifices professionalism by joining a union. Giant corporations treat professional employees as chattel and doctors have felt for too long that professional deportment precludes fighting back in a forceful and organized way.”

Founded in 1981, the FPD has about 2,000 private practice and 1,500 salaried physician members, mostly in Florida. FPD Director Jack Sheldon says organizing efforts are under way at the Pacific Coast Medical Center in Seattle, at the Lovelace Medical Center in Albuquerque, N.M., and at the Jackson Memorial Hospital in Miami. The FPD never tells its members not to sign a contract nor threatens payers with a strike, Sheldon says. The OPEIU recently affiliated with the American Pediatric Medical Association to form the First National Guild for Providers of the Lower Extremities. The guild recently changed its name to the National Guild for Medical Providers. State chapters have formed in California, Michigan, New Hampshire, and Pennsylvania, and chapters are planned in at least three other states.

### Fighting Managed Care

Membership in unions is not the best way for physicians to fight managed care, the AMA says. “The AMA and state medical societies have a patient, not a business, orientation,” says Blehart. “Unions seek to protect their members as they would business employees, and sometimes the economic needs of physicians within a business setting can interfere with patient care—in a work action situation, for example. Unions, when they act as service bureaus, can perform significant services for doctors, but we’re already serving those functions. They can lobby for health issues. But the AMA has a great deal of experience serving as physician advocates, while also supporting the code of medical ethics.”

In June, the AMA House of Delegates voted to issue two AMA Board of Trustees reports to members on the topic of physician unions. Presented by incoming AMA President Nancy Dickey, MD, the reports, *Physicians and Unions* and *Representing Physicians Aggressively*, provide an overview of the union movement, describe the legal limitations placed on union representation

## Medical Center Physicians Fight to Form Union

In December, the 145 physicians employed by Thomas-Davis Medical Centers in Tucson, Ariz., voted 93 to 32 to join the Federation of Physicians and Dentists, a 3,500-member union in Tallahassee, Fla., and affiliated with the AFL-CIO. They had to fight hard to do so.

As soon as the vote was taken, the multi-site clinic’s new owner, FPA Medical Management, a management services organization in San Diego, filed an appeal with the National Labor Relations Board, claiming the doctors were supervisory personnel. The NLRB ruled against the clinic owners in January.

“We decided that in this case the doctors were told how many patients they had to see and what hours they had to work,” says Cornele Overstreet, a spokesman for the NLRB. “They were told many things that would take away from the normal judgment that applies to supervisory personnel.”

The Thomas-Davis unionization was unusual, but indicative of how the union concept appears to have become acceptable as managed care plans expand aggressively. At one time, the physicians who voted to join the federation had owned the clinic. In 1981, the 133 Thomas-Davis physician-owners formed their own HMO, Intergroup Health Care. By the mid-1990s, Intergroup had become Arizona’s largest HMO, insuring 379,000 members. In November 1994, the physicians sold Intergroup and Thomas-Davis to Foundation Health Corp. in San Francisco, one of the nation’s largest managed care organizations. Each of the physician-owners received Foundation stock worth \$3.2 million.

Claiming Thomas-Davis Medical Centers was losing money, Foundation announced in July 1996 that it was selling the clinic to FPA for \$195 million. The deal was to be finalized in December. In preparation for the sale, Foundation began a series of cost-saving measures in August, among them: firing 26 doctors, including many specialists; increasing the number of patients physicians needed to see; and eliminating records clerks so that doctors had to type their own notes.

Those measures, similar to the cost reductions many MCOs impose on physician employees, led to the union activities, says Keith Shelman, MD, a physician at Thomas-Davis and president of the federation’s local chapter. “Our access to specialists, internally and externally, was being constrained,” he says. “The number of patients and the amount of time we could spend with patients was to be fundamentally changed. This was a direct consequence of our being taken over by a corporate entity and a new business model that they said was necessary to maintain a profit. Our problem was that we had a conflict. Our fundamental duty was to our patients. Our owners had a fundamental obligation to their shareholders.”

Membership has publicly promised not to strike, saying a walkout would violate the Hippocratic Oath, Shelman says. But forming a union “brings the company to the bargaining table and allows us to see that the patients get the care they need.”

# Antitrust Regulations Raise Questions for Unions

Under federal antitrust law, competitors may not collectively set prices. Private practice physicians are considered competitors, and even through a third party, such as a union, they may not collectively set or bargain for rates. But a series of laws, especially the 1935 National Labor Relations Act, and court cases since then have exempted labor actions from antitrust laws, and salaried physicians are considered labor. So unions can bargain collectively for physicians who are employees of hospitals, clinics, or HMOs.

In a recent report, *Physicians and Unions*, the AMA attempts to explain the sometimes confusing difference under federal law between employed and self-employed physicians. One purpose in producing the report, according to AMA officials, is to make it clear to self-employed physicians that joining unions will not lead to collective bargaining with health plans for better rates. "It is the position of the AMA that medical associations can best serve the interests of physicians and their patients," says Bruce Blehart, AMA senior counsel. The AMA does not condemn collective bargaining opportunities

for physicians, however, and will develop a division of representation to assist state and county medical associations to help members dealing with health plans.

Although physicians who are employees fall within the labor exemption to antitrust laws and may legally engage in collective bargaining with their employers, the AMA report says, "physician employees who have attempted to form unions have not always had an easy path. Some courts have found that physicians are supervisory employees because their decisions direct other members of the health care team, such as nurses and technicians. When physicians are found to be supervisory employees...they do not qualify for the protection [from antitrust laws] of the National Labor Relations Act."

Loss of the protection of the National Labor Relations Act can be a significant handicap to physicians forming or joining unions, the AMA says. The act is designed to protect the ability of employees to engage in collective bargaining by restricting what employers are allowed to do to prevent employees from forming or joining unions. Under the act, employers must recognize

and bargain with a union. But if physicians are classified as supervisors, an employer doesn't have to recognize or bargain with their union and may even take steps, such as disciplining physicians for organizational activity, to break up the union.

The AMA report states that the recognition in January of the physician bargaining unit at Thomas-Davis Medical Centers in Tucson, Ariz., by the National Labor Relations Board was a significant victory for physicians because the NLRB ruled that the physicians were not categorized as supervisory and so were protected under the act. The AMA will support the Thomas-Davis Medical Centers physicians if their employer, FPA Medical Management, in San Diego, challenges the NLRB ruling in court, the report states.

Self-employed physicians who are in solo practice or are owner-practitioners in a medical group are considered independent contractors, entrepreneurs, or independent businesses and therefore don't qualify for the labor exemption under antitrust laws, even if they feel compelled to work on HMO provider panels.

of private practice physicians under federal antitrust regulations, and outline the assistance the AMA will provide to state and local medical associations so they can serve as alternatives to unions.

The AMA reports say the formation of the OPEIU's national podiatrists union and of the National Guild for Medical Providers, and the National Labor Relations Board's approval in January of the unionization of physicians at the Thomas-Davis Medical Centers in Tucson, Ariz., have led to discussion about union formation at several state and county medical societies.

Several problems are leading physicians, including private practice doctors, to join unions, Dickey says. These problems include the following:

- A lack of input into medical policy, incorrect determinations of medical necessity, and questionable clinical protocols;

- Abusive practices, such as late payments and gag clauses, which prohibit physicians from offering treatment recommendations a managed care organization may consider too costly;
- Declining income because health plans are driving down rates, sometimes in ways that threaten access and "which are rarely the result of true negotiation";
- Job security; and
- Inefficient utilization controls and payment requirements that necessitate extensive paperwork and raise practice costs.

As a result, some physicians are turning to unions. But unions cannot fully address the concerns of self-employed physicians in independent practices about income or job security because to do so would violate antitrust laws, Dickey says.

"We can provide the information doctors need to protect themselves within the limi-

tations of antitrust regulations," Blehart says. The AMA has formed the Division of Private Sector Representation to work with state and county medical associations.

"Traditional unions have some inherent conflicts with medical professional values, such as the use of strikes or other withdrawals of service and a focus on mandatory collective rules," Dickey says. "However, to the extent that organized collective action can be used to advance legitimate physician and patient needs, consistent with physicians' ethical values, the AMA will provide any requested assistance physicians need."

Liebowitz of the Doctors Council of New York says he has no problem with the AMA providing information or representation to physicians. "But if the AMA can do such a good job of protecting the rights of doctors, how did we get to where we are today?" he asks. ■

# Three Gastroenterology Practices Form Single-specialty Group

By Richard L. Reece, MD, editor-in-chief

As health care moves from discounted fee for service to managed care, many physicians are struggling to identify the best organizational option for their practices. Should they form a single-specialty group or a multispecialty group? Should they sell their practice to a physician practice management company (PPMC)? They also might consider joining a management service organization or adopting some other form of organization.

Until recently, managed care organizations (MCOs) have pushed primary care over specialty care, and in some markets, specialists are still particularly vulnerable to market pressure from MCOs. Specialists seeking to thrive under managed care must form groups large enough to:

1. Have negotiating clout with MCOs and other payers,
2. Offer care that is demonstrably superior to that of physician-hospital organizations or multispecialty groups, and
3. Develop a strong reputation that allows them to build demand among consumers for disease-specific services.

## Strength in Numbers

For Robert Ganz, MD, the best organizational option is a single-specialty group practice. A gastroenterologist, Ganz helped to form the Digestive Healthcare Group, a 40-member group of gastroenterologists in Minneapolis-St. Paul. Previously, Ganz had been in a relatively large single-specialty group of 20 physicians in Minneapolis that was formed in 1975. In 1995, it merged with two St. Paul groups of 20 more physicians to create the Digestive Healthcare Group.

In the nonasset merger, the physicians created a single corporation that can contract as a unit, has a profit-sharing and pension plan, and has a common board of directors and a single chief executive. The practice is one of the largest groups of gastroenterologists in the United States. One of its competitors is the Mayo Clinic, in nearby Rochester, Minn., which has a large

gastroenterology section.

Large single-specialty groups may be poised to take advantage of certain market trends, Ganz believes. One such trend rapidly gaining momentum is that primary care gatekeeper models are losing favor as consumers demand wider access to specialists. Two years ago primary care physicians in the Twin Cities were in great demand as MCOs built organizations in which PCPs controlled all patient access to specialists, Ganz says. Today, jobs for PCPs are scarce in the Twin Cities market.

Large single-specialty groups have an advantage over multispecialty groups, Ganz says. Not only do single-specialty groups have disease-specific expertise, they also can

in Dallas, dropped precipitously last year when it failed to meet its quarterly income projections after acquiring a Minneapolis oncology group, Ganz says. Since the stock dropped, the oncologists did not get the return on the sale that they had anticipated. As a result, "it was a bad experience for the Minneapolis oncologists, and word travels fast on the street among other physicians," he says, meaning many Minneapolis physicians may now be reluctant to sell to a PPMC. Moreover, PPMCs are not anxious to acquire groups in advanced managed care markets where profit margins are thin because MCOs have a monopoly.

Ganz also has strong reservations about vertically integrated systems where health

**"Single-specialty groups knitted together by information systems, by common guidelines and outcomes measures, and by procedural expertise offer the best approach to delivering optimal health care cost effectively because they can mobilize tremendous expertise."**

**—Robert Ganz, MD**

create common guidelines and outcomes measures quickly since they have many specialists speaking a common language and have none of the political conflicts inherent in groups of both specialists and primary care physicians. "Single-specialty groups knitted together by information systems, by common guidelines and outcomes measures, and by procedural expertise offer the best approach to delivering optimal health care cost effectively because they can mobilize tremendous expertise for biliary work, hepatology work, and new technology procedures," Ganz explains.

Single-specialty groups may have an advantage over PPMCs. Ganz offers the following example. The stock value of Physician Reliance Network Inc., a PPMC

plans, hospitals, and salaried physicians comprise one corporate organization, and he does not believe hospitals create efficiencies when they buy primary care practices. He cites Allina, a large vertically integrated system in Minneapolis, as an example. It has \$2 billion in annual revenue, provides care for some 1 million residents, and employs 600 physicians. The individual components of the system operate with unaligned incentives, Ganz explains. "It was simply a huge mistake to merge a hospital and a health plan and to buy all those practices," he says. "The health plan, hospital, and salaried doctors work at cross purposes, so there is constant tension." Typically, when a hospital buys a group practice, the physicians' productivity declines, in part because hospitals

employ the physicians. Since the physicians are no longer working for themselves, their incentive to work declines, experts say.

Another reason productivity declines is pressure to see more patients. "Physicians are told to increase their productivity by seeing more patients," Ganz says. "To increase the number of patients they see, they refer complex cases to specialists. In the past, they used to be slow in doing referrals because they feared losing patients to specialists. Now they don't care because it's not their practice and it's not their patients."

The Digestive Healthcare Group has been cautious in any and all of its relationships with hospitals, viewing them as friendly antagonists, Ganz says. Hospitals and gastroenterology groups can develop endoscopy units together, but other joint ventures are difficult to implement because of laws that limit physicians' investments in operations to which they would refer patients and the uncertain legal status of physician-hospital relationships.

#### A Work in Progress

The group has had more than 100,000 patient encounters in each of the last two years, either as procedures or in office visits, but merging the three groups into one functioning unit with common operating, management, and practice systems has not been easy. The merger has raised the cost of overhead, for example. But, fortunately, increases in patient volume have offset increases in costs so that the increased costs have not affected income significantly.

The group is building relationships with other health care organizations, such as large primary care groups, but it has not yet consummated a binding agreement with any of them. It is working closely but informally with a large colorectal group to investigate the genetic causes and outcomes of colonic polyps and colorectal carcinoma.

Although incomes have not risen and no new managed care contracts have been gained, Ganz notes some positives. "For the first time, we turned down a contract," Ganz says, explaining that an MCO negotiated so aggressively with the group that it would have been almost impossible for the group to profit from the contract. If the group had not been so large, it might have been forced to take the deal. "That's progress. Being in a larger group has given

us more confidence in jawboning with managed care companies," says Ganz.

Last year, the group sold its 51% interest in an ambulatory endoscopy center to AmSurg Inc., a company in Nashville, Tenn., that specializes in ambulatory surgery. AmSurg manages the unit for the group, and returns more revenue and profit than the group had experienced previously, Ganz says. The AmSurg transaction was done to give the group access to capital and to gain more market leverage, he explains.

The group is working quickly and cooperatively to establish clinical guidelines and outcomes measures, but is having difficulty deciding which information system to use,

**Gastroenterologists are working with new technologies, such as laser therapy, photodynamic therapy, and ultrasound techniques, that are helping to increase patient volume.**

how much money to invest in such a system, and exactly how to use it. Information systems require a large capital investment, and, Ganz says, the three groups have yet to agree on how fast to move and how much money to invest in such systems. "We don't want to spend so much money that we'll destroy the physician salary structure," he explains.

#### An Unusual Market

Seeking the most appropriate practice strategy in the Twin Cities involves predicting the future in this unusual market. Ganz, who has practiced there for 10 years, sees the Twin Cities market as a mature discounted fee-for-service market, but not a mature capitated market. Ganz's group deals almost exclusively with discounted fee-for-service care.

The market in Minneapolis-St. Paul is unusual partly because it has an active and innovative coalition of purchasers, the Buyers' Health Care Action Group (BHCAG), which has changed substantially how health care is delivered to the 2.5 million residents (see "Minnesota Employers Elevate Physicians' Status by Eliminating Middlemen," July). The Twin Cities is the headquarters for 30 Fortune 500 companies and 1.6 million (64%) of its citizens are employed or depend on

large corporations for their health insurance. Since BHCAG represents 28 companies, the payers and three MCOs have a monopoly over providers. Minnesota also is unusual because for-profit HMOs are illegal under state law. This law works against physicians because it creates an artificial monopoly. "Having a not-for-profit HMO monopoly is a terrible situation," Ganz explains.

The law establishes a substantial barrier to entry for profit-making HMOs that might otherwise operate there. Nonprofit HMOs do not have the capital to expand that their for-profit counterparts have. The result: Three large nonprofit MCOs have

come to dominate. "It's better to have 30 HMOs than two or three," Ganz says. A few powerful HMOs with a high concentration of market power can pay physicians what they want and easily turn physicians against one another.

Despite his concerns about the market, Ganz is optimistic about the future of gastroenterology. Since it deals with common, chronic diseases, it affords physicians an opportunity to work in a field in which specialists may be more effective than generalists at managing particular diseases. Also, gastroenterologists are working with new technologies, such as laser therapy, photodynamic therapy, and ultrasound techniques, that are helping to increase patient volume.

To be successful in a changing market, physicians need to match the services of their practices with the particular needs of their market, Ganz says. In other words, no boilerplate model exists for building a large single-specialty practice in a market dominated by managed care.

Not only does each market have its own characteristics, but each merger is different, Ganz explains. "Each physician, each group, has to go through it on their own," he says simply. "If you've seen one merger, then you've seen one merger." ■

# Oxford Builds Success by Offering Choices to Physicians and Members



**Benjamin Saferstein, MD,** is vice president of medical affairs for the New York region for Oxford Health Plans Inc., a managed care organization in Norwalk, Conn., that serves plan participants in Connecticut, New

York, New Jersey, and Pennsylvania. Oxford also has affiliated plans in Florida and Illinois. Saferstein trained in internal medicine at Mount Sinai Medical Center in New York City, in pulmonary medicine at Mount Sinai and at the Institute for Diseases of the Chest in London. Also, he worked for the National Health System for two years in Britain and has served in health systems in the United States, such as the Veterans' Administration, and in several academic medical centers. For 25 years, he was the chief of the division of pulmonary medicine at St. Michael's Medical Center at the New Jersey Medical School, in Newark. In addition, Saferstein works as an internist and as a pulmonologist with the Montclair Medical Group, in Montclair, N.J. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

## First of two parts

**Q.** Dr. Saferstein, as both a founder of Oxford Health Plans and its first medical director, what did you envision for the company 12 years ago when it was formed?

**A.** Initially, my vision focused on the problems occurring in medicine in the mid-1980s—problems related to a health system that was reimbursing physicians for procedures and tests rather than for outcomes. The system we had was not measuring outcomes, cost-effectiveness, or the value of the procedures being performed; we were also seeing primary care practices deteriorate as patients ran helter-skelter to specialists with little coordination or integration of their care. Most of all, we were seeing ill-prepared physicians whose training could have been improved.

I wanted to see more and stricter standards of quality for physicians and better initial and ongoing education, as well as an integration of medical care. Coordinating patient care was, I thought, very important.

Also, a perverse disparity existed in physician reimbursement: Some physicians had reached astronomical levels of reimbursement while the level for others was dismal. The role of the family doctor also needed to be upgraded, and I strongly believe that the destruction of the family physician led to a lot of unnecessary costs and perverse incentives.

**Q.** Do you think the model that has evolved in California would work nationwide, or do we need something palpably different?

**A.** We need something different. In fact, I would not want to practice in or to be treated under the California model. We don't want large integrated, consolidated systems with reduced patient choice and restricted provider networks, which is what the California model does. Some of the Draconian features of medical management, such as reductions in unit costs for either physicians or hospitals, have driven many physicians out of the system. As a result, many patients have sought alternative systems, and I don't see the staff-model health plan as the right alternative. Including well-trained physicians is what we envision for our model; each physician should be able to continue practicing independently in his or her environment without being tied to major salary constraints, as physicians are in a management service organization (MSO) or an HMO. What works best is physician autonomy and independence, which is what we promote in our program. We've done that by developing care teams of physicians in loosely arranged partnerships, which enable them to have access to information they traditionally would not have (for example, on utilization, member satisfaction, and outcomes). They also can share in certain performance bonuses based on exemplary management of a population of patients according to

national, regional, or Oxford standards. Through this bonus program, we reimburse at a higher rate and share with our physicians any surpluses.

**Q.** Many HMOs conduct patient satisfaction surveys, but Oxford also conducts physician satisfaction surveys. Do the results of the physician surveys show that most physicians are pleased with the innovations that have been introduced at Oxford?

**A.** The answer is yes, based on the physician satisfaction survey that we do every two years. The innovative nurse practitioner program we are doing with Columbia University and Columbia Presbyterian Hospital is one example. This program began in 1994 with funding from the Robert Wood Johnson Foundation, in Princeton, N.J. By collaborating in this pilot study, titled the Washington Heights Program, we saw an opportunity to determine what constitutes patient satisfaction and who would choose it, as well as look an opportunity to review outcomes, costs, and efficiency.

We've had many discussions with many physicians about the program because it deals with a controversial issue. In some managed care settings, other providers are being used, without supervision or observation, to provide most of the patients' care. We've not only brought this issue out into the open, we've also addressed its implications by creating this pilot program whereby nurse practitioners can work both independently and collaboratively with physicians and be paid on the same level as the physicians. Through this program, we allow members to choose their care provider. Their choice, we hope, is based on their desire for the type of care they want.

Although some physicians have been positive about the program, many have felt threatened by it. In fact, it is so controversial that I've met with the presidents of many of the regional medical societies to discuss the issue. Most of the fear physicians are feeling comes from their perception that this is a step to replace doctors.

That is not our intent. Since many nurse practitioners are already being used by physicians in chronic disease management programs for asthma, diabetes, and congestive heart failure; for case management and surgical assistance; in pediatrics and in intensive care units, our goal is to evaluate primary care given by nurse practitioners in a controlled setting and allow patients the choice. We already have nurse practitioners doing obstetrical work and midwifery. Why not primary care?

**Q:** *What is the status of the study?*

**A:** We continue to enroll nurse practitioners. But, of the initial group of 12 NPs who applied in March and April, we've enrolled only two because the criteria for entry are so discriminating. In fact, they are so stringent that only about 3% of nurse practitioners in the United States would qualify. To be considered, these nurses must hold clinical nursing degrees, be Master's level nurses, and be accredited by the National Board of Clinical Nurse Practitioners. Very few nurses meet those criteria.

**Q:** *Do you differentiate between nurse practitioners and physician assistants?*

**A:** We are looking at the nursing practitioner program as an alternative delivery system. We haven't broadened it to encompass physician assistants yet.

**Q:** *How does Oxford attempt to meet the needs of patients; in other words, how does it strive to be user-friendly?*

**A:** We use member satisfaction surveys, and we are also developing a sample physician profile and report card, which we will share later this year with focus groups of patients. The physician profile will present members with an opportunity to review what other members think about various physicians.

We also have information on our Web site ([www.oxhp.com](http://www.oxhp.com)) and in our brochures that discusses what members can expect from their relationship with an Oxford physician and how important it is to establish a member-physician relationship.

With 40,000 doctors and 175 hospitals, we believe in choice, and we don't restrict patient choice.

**Q:** *Oxford has captured attention through its alternative medicine benefit initiative. How did that evolve?*

**A:** Over the years, I saw, as a clinician, that certain medical conditions were being treated by other provider systems and that many of my patients were going to them. At Oxford, we chose to address this issue after a survey we did showed that about one third of our members were seeking that sort of care—mostly therapies involving massage, acupuncture, reflexology, and chiropractic care. In an attempt to credential a group of quality practitioners, we decided to find out which of these alternative treatments were good and which were not. So we set up a qualification and

director of our alternative medical care program is a physician affiliated with the Harvard Medical School and the head of the chiropractic program is a chiropractor.

**Q:** *Another innovation at Oxford involves paying teams of specialists for chronic or expensive diseases at a rate roughly equivalent to what a primary care physician (PCP) would be paid. It's been reported that you've assembled advisory panels and set guidelines for certain disciplines, giving each a beginning event and an ending. How well is that program working?*

**A:** We put together 13 disciplines, such as cardiology, gastroenterology, neu-

**“Some of the Draconian features of medical management, such as reductions in unit costs for physicians or hospitals, have driven many physicians out of the system.”**

standards program for the practitioners who we think best represent their field and developed a research project to determine whether certain medical conditions, such as migraine headaches, low-back pain, or stress, would best be treated by alternative delivery systems. We have since affiliated with a program at the Harvard Medical School in an effort to do an outcomes study on the issue of whether outcomes differ depending on whether traditional or alternative treatment is received.

We've also enabled patients to make a choice about the care they receive. If they want to go to a chiropractor and if they buy the rider, we will pay the freight. If they don't have the rider but still want to avail themselves of Oxford's network, they can do that as well and pay for the service. We have a fee-for-service discount rate with many of our providers and we'll provide adequate information to our members if they seek such care.

**Q:** *What has been the response from the consumer community?*

**A:** It's been overwhelmingly positive. We began the program about two years ago, and since then we have established high-quality standards and advisory panels of high-quality practitioners to monitor the care our members receive and to ensure that it is what the practitioners believe to be the highest level of care. The

rology, cancer, obstetrics, pediatrics, and created an advisory panel for each one. Each panel is run by an Oxford administrative person and chaired by an Oxford medical director, disciplined in that specialty. We also have convened these panels to address 25 of the most common subspecialty procedural or disease entities, such as breast cancer, prostate cancer, coronary bypass surgery, and hip and knee replacements. We have about 400 members being cared for by these teams.

We asked the medical community in coronary artery disease, for instance, to assemble teams of physicians and to deliver a product through which all of the services are covered for a fixed price for a period of six months or a year. An expert panel—whose members are among the best practitioners at the academic medical centers in our practicing communities—define all of the necessary procedures and follow-up standards that are considered appropriate today for the particular illness or procedure involved. That includes all of the pre- and post-operative care, radiology, anesthesia, rehabilitation—all imbedded into one global budget. We hope this strategy will eliminate an enormous amount of hassle and take us out of the business of micro-managing doctors by telling them what to do when they know full well what to do themselves. It also will enable physicians to begin

to address on their own the issues involving inliers and outliers.

In addition, we hope that these teams will develop outcome studies. We have people at Oxford who are using SF36 or some other validated tool for recording a patient's health status over time and therefore we'll have data on the outcomes of our interventions. We will compare these data with those of national outcome standards that one could expect from a patient, for example, who has had a hip replaced or has undergone heart bypass surgery. Our physicians are looking, for instance, at the number of days in the hospital, the patient's functional level, how quickly the patient returns to work, whether the patient was satisfied with the program and was treated with dignity and respect, whether the procedure was effective, and so on.

To date, we have identified some of the factors that drive member satisfaction and outcomes on 28 to 30 of the procedures that we have so far initiated. We believe this information will be a major tool for physicians to use in comparing their performance with that of their colleagues. Also, it will enlighten our members as to which procedures are done best at various institutions and what outcomes they can expect.

We plan to share the results not only with our PCPs, but also with all of our physicians in an attempt to change behavior. We believe that physicians always study for A's. No one wants to be an outlier. If they achieve a certain level of expertise, they are proud of that accomplishment and want to compare themselves with colleagues at other institutions. We may find that only a few institutions are truly good and many more are not so good. But at least we're beginning this journey of looking at both cost-effective care and outcomes.

**Q.** *Speaking of journeys, a migration seems to be occurring from methods that involve primary care gatekeepers to those that focus more on specialists. Do you sense that such a shift is happening?*

**A.** Specialists have been particularly harmed by, or perhaps left out of, the managed care equation. This whole idea of a gatekeeper, which is the dumbest term I've ever heard, represents a barrier to appropriate care. Probably 10% or 20% of care in medicine has to be given by specialists. For example, I treat many patients who are

severe asthmatics, and frankly I treat that condition much better than many PCPs because that is the all I do. There are specialists who do heart surgery and others who treat cardiac disease and end-stage renal disease. In the past, where there was free access and no barriers to referral, these physicians were readily available. The advent of the gatekeeper, however, put so many barriers and hurdles in the path of patient care that patients were not being referred. What's more, specialists were being demonized because they were spending a lot of money,

bers about what a PCP is and can do. He or she is a care coordinator, there for minor health problems, sickness prevention, health care assessment, clear record keeping, consultation on where to seek additional care, and hopefully on drugs and contraindications. In other words, the primary physician is a quarterback for care. The PCP is not there to be a barrier between a person who has a serious medical illness and one who doesn't.

**Q.** *Will PCPs welcome this concept of specialty teams?*

**“Physicians can share in performance bonuses based on exemplary management of patient populations according to national, regional, or Oxford standards. Through this program, we reimburse at a higher rate and share with our physicians any surpluses.”**

which, of course, they needed to do because they were taking care of the sickest patients. So, using the gatekeeper over a long time is not a viable alternative.

At Oxford, we are developing a non-gated PPO product, called Freedom-Select, in which patients will be able to see any physician. If they go outside of the network, they will need to pay a little more. I believe we will one day consider offering a similar feature with an indemnity product, because, if people want to go where they want, let them go, even if it costs a little more.

Clear evidence-based research has shown that a patient with congestive heart failure, with class 4 heart disease, would be better managed by a cardiologist than by a PCP. And a class 4 lung patient would be better cared for by a pulmonologist, and so on. We believe care teams might be able to provide some of this specialized care. We also have begun to re-educate our members about what they can expect from their general physicians; that they should not be asking them to do things they can't do. And we certainly don't want PCPs to do hemorrhoidectomies and incisions and surgical procedures that they're not trained to do and don't want to do.

We believe that the process we call member education begins with educating mem-

**A.** I think they will love it. In focus groups we've held with PCPs and in my own medical group in Montclair, the primary care doctors recognize the amount of information available to them through this approach. They have information regarding, for example, where to refer patients who need a hip replacement, carotid artery surgery, coronary bypass surgery, and so on. We'll be able to give them tools that will enable them to evaluate these tertiary procedures more appropriately. We know that institutions that do a high volume of cardiac surgeries do better than those that do a low volume. The more information our PCPs have the better.

That does not mean PCPs have to refer to teams doing diabetes or asthma or emphysema or chronic bronchitis—the more chronic medical illnesses. We're talking about diseases that have a beginning and an end. We recognize that no PCP does cardiac surgery. We also hope to provide PCPs with a menu of where these procedures can be obtained. If they don't want to choose from that menu, they can go anywhere they want. We're not going to restrict their access to these programs.

*Editor's note: Next month, Saferstein will discuss efforts by Oxford Health Plans to allow physicians more clinical autonomy. ■*

# Venture Capital Still Pours Into Health Care

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

Physician practice management companies (PPMCs) and health care companies in general continue to attract significant interest from venture capital firms. From 1995 to 1996, the amount of capital flowing into the sector more than doubled, and the industry ranked third in total capital raised (see Tables 1 and 2).

Analysts estimate that investment in PPMC's accounted for about \$250 million in 1995. This year, many venture capital firms plan to add to what they invested last year or to invest at least as much as they invested in 1996. Table 3 shows selected 1996 venture capital investments in PPMC's. The PPMC industry is poised for large growth, and venture capitalists are interested because only 5% of U.S. physicians were affiliated with public PPMC's at the end of last year and because enrollment into managed care plans continues unabated.

Physician groups that need capital for

infrastructure or for expansion can approach a venture capital firm for funding. Or, they could receive funding indirectly if they affiliate with a venture-capital-backed PPMC. Venture capitalists want to invest in companies that will provide them with above-average returns (usually 30% to 50% per year), and most expect to liquidate their investment within two to five years, often through initial public offerings or a sale to a third party. Of the PPMC's listed in Table 3, ProMedCo is already public, and several of the others are planning offerings in the future. Physician groups seeking venture capital funding must exhibit strength in the areas that venture capitalists evaluate before making an investment, including:

**Management team.** Experienced and qualified executives are considered the primary determining factor in a company's success.

**Financial prospects.** The company's projected revenue and earnings growth as well

as its ability to provide returns to investors of as much as 30% per year are evaluated.

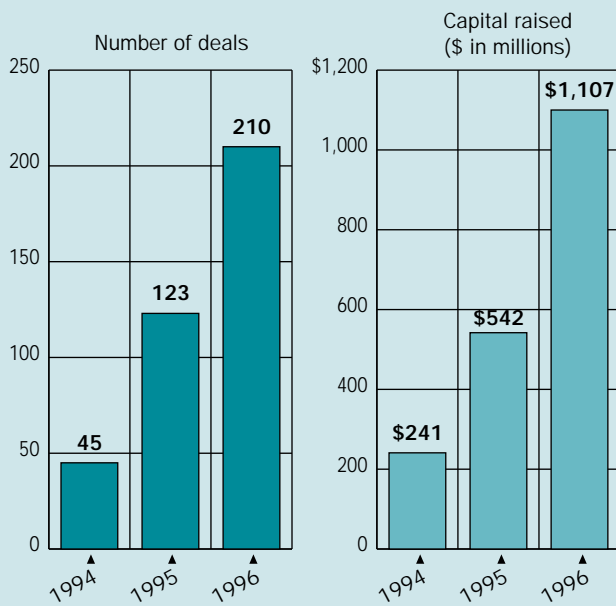
**Industry attractiveness.** Investors appraise the market's total size, its potential for growth, and the level of government regulation, as well as other factors.

**Competitive advantage.** Investors are attracted to companies with a unique operating model, expertise, product, or service that gives it a distinct competitive advantage over similar companies.

The primary reasons venture capitalists give for denying funding are a company's weak management and low market potential.

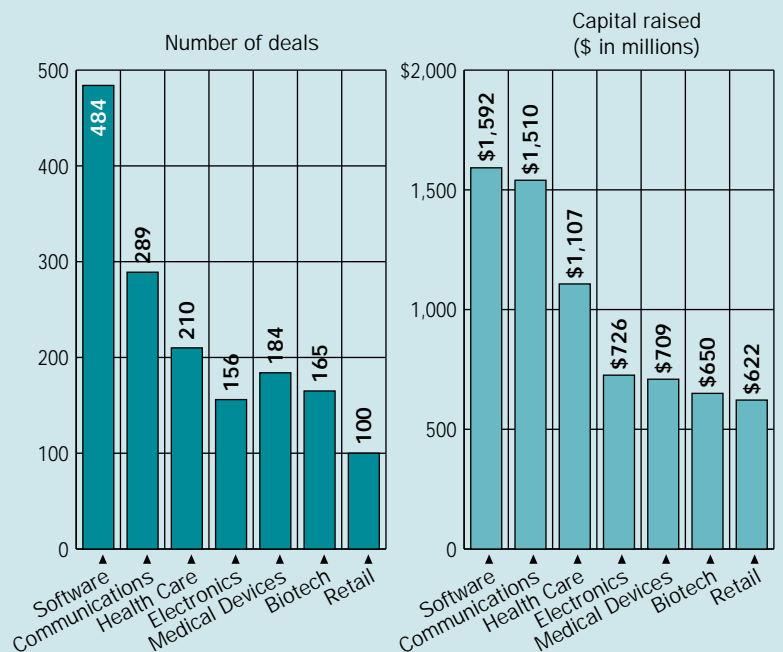
Small physician groups with plans for limited growth are unlikely candidates for venture capital, but existing PPMC's and groups of clinics forming PPMC's are attractive. Emerging and established PPMC's that are funded by venture capital will be able to continue to consolidate physician groups and to develop the infrastructure to manage these groups.

Table 1: Health Care Venture Capital Activity



Source (for tables 1 and 2): Venture One Corp., San Francisco, and Coopers & Lybrand, New York.

Table 2: Selected Venture Capital Investment—1996



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.

## CURRENT TRENDS

Table 3: Selected Venture Capital Investments in PPMCs During 1996

Venture Capital Firm	PPMC and Specialty	Investment (\$ millions)
Welsh, Carson, Anderson & Stowe, New York	• OrthoLink, Nashville, Tenn., orthopedics	30.0
	• Principal, Nashville, women's health	20.0
Sprout Group, New York	• Heritage Health Systems, Nashville, IPA management	30.0 total
	• Total Physician Services, Boca Raton, Fla., infectious diseases	
	• American Holistic Centers, Fairfax, Va., homeopathic, acupuncture, and chiropractic care	
	• GMS Dental, Anaheim Hills, Calif., dental	
Summit Partners, Boston	• American Dental Partners, Wakefield, Mass., dental	37.0 total
	• Cardiovascular Provider Resources, Dallas, cardiology	
E.M. Warburg Pincus, New York	• Meridian Occupational Healthcare, Nashville, occupational health	60.0 total
	• MediSphere Health Partners, Nashville, women's health	
	• RKS (parent of Spence Women's Health), Boston, women's health	
	• Arcon HealthCare, Nashville, outpatient surgery centers	
	• Value Oncology Sciences, Avon, Conn., oncology	
Sierra Ventures, Menlo Park, Calif.	• NovaMed EyeCare Management, Chicago, eye care	6.0
	• Orange Coast Managed Care, Orange, Calif., IPA management	5.0
Bessemer Venture Partners, Wellesley Hills, Mass.	• Princeps, Nashville, radiology	15.0 (total)*
	• Morgan Health Group, Atlanta, primary care IPA	
	• Meridian Occupational Healthcare, Nashville, occupational health	
	• ProMedCo, Fort Worth, Texas, multispecialty	
	• GMS Dental, Yorba Linda, Calif., dental	
Accel Partners, San Francisco	• Navix Radiology, radiology	4.35
	• GMS Dental, Yorba Linda, Calif., dental	10.5
	• Cornerstone Physicians, Irvine, Calif., primary care	5.2
Mayfield Fund, Menlo Park, Calif.	• MatureWell, Tucson, Ariz., geriatric care	6.0 (total)
	• Vida, Minneapolis, oncology	
	• MaterniCare, Laguna Hills, Calif., ob-gyn	

\* 1995 and 1996 investments

Source: Corporate Research Group, Inc., New Rochelle, N.Y., 1997.

### Hospitals Are Losing Money on Physician Practices

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Many hospitals are buying physician practices to keep those practices from being acquired by their competitors. Hospitals are also buying physician practices so that they can build integrated delivery systems to compete with managed care organizations (MCOs).

But the competition to buy physician practices has been stiff, forcing the price of practices to rise significantly. As such, hospitals are losing about \$97,000 per physician acquired, according a recent survey of 17 hospitals by Coopers & Lybrand, CPAs and health care consultants, in New York. Despite the losses, hospitals have spent about \$100,000 per physician and have bought about 5,000 primary care physician practices each year since 1994, according to *The Wall Street Journal*.

Frank Houser, MD, medical director for Columbia/HCA, in Nashville, Tenn., the nation's largest operator of for-profit hospitals, said Columbia may have lost as much as \$25 million on the 1,500 practices it has acquired in recent years.

In theory, hospitals should be able to recoup losses when acquired physicians refer ill patients to them, but MCOs steer patients to hospitals of their choice and the government doesn't allow mandatory referrals. Another problem occurs when hospitals put physicians on salaries or income guarantees, providing an incentive for physicians to work less than they would if they worked for themselves. Typically, hospitals see a drop in physician productivity of 4% to 15%, the Journal reported.

Some academic centers, such as Barnes Jewish Christian in St. Louis, which has acquired 230 practices, and the University of Pennsylvania, which has bought 250 primary care practices, use acquired practices as their central strategy for expansion. When purchasing a physician practice, hospitals prefer to offer about 40% of annual gross revenue, but in some markets, such as Philadelphia, hospitals have paid as much as 150% of gross revenue for such practices, The journal reported.

**Commentary:** *One way to provide an incentive to physicians is through an equity management service organization. This entity would manage the physicians' practice and would be capitalized by the hospital. Since the physicians would retain majority control, the hospital would not need to overspend capital to acquire the practice.*

### Future Uncertain for Laws Limiting HMO Liability

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Efforts in two states aimed at making it easier for patients to sue HMOs for malpractice face an uncertain future, according *The National Law Journal*. Since federal law governing health plans is evolving, it is too early to gauge the effect of these reforms.

In May, Texas became the first state to allow its residents to sue HMOs for injuries resulting from a refusal to pay for a procedure. The legislature in New York is considering a bill that would make HMOs liable for malpractice.

The effect of these initiatives, however, will be limited. Most federal courts have ruled that the Employee Retirement Income Security Act of 1974 (ERISA) preempts any state law that would regulate health benefits paid for by employer-sponsored plans. Most workers are covered by health plans governed by ERISA. HMOs have used ERISA to transfer most state malpractice lawsuits to federal court, where damages are limited under ERISA, the journal said.

But because ERISA does not apply to self-employed individuals or to those who purchase health insurance outside the workplace, there are some instances in which the ERISA defense does not apply, making state reform efforts potentially significant, the journal said.

**Commentary:** *Plaintiffs' attorneys argue that since HMOs participate in medical decision-making through coverage denials, caps on physician fees, and financial incentives to limit treatment, they should be liable for injuries that result from treatment decisions, the journal reported.*

### Academic Medical Centers Are Seeking Deals With PPMCs

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Seeking to expand their market presence, some academic health centers are negotiating with physician practice management companies (PPMCs) in an effort to grow after years of decreasing revenue from managed care companies. Beth Israel Medical Centers, in New York, and its parent, Greater Metropolitan Health Systems, for example, have signed a letter of intent with PhyMatrix, a PPMC in Miami, to form an organization to provide management services to 130 physicians, according to *Modern Healthcare*.

PhyCor, in Nashville, Tenn., and MedPartners, in Birmingham, Ala., the two largest PPMCs, are holding discussions with academic medical centers. PhyCor is considering forming an IPA for a medical faculty and a group practice. MedPartners is talking to academic centers about collaborating on outcomes research.

Shattuck Hammond Partners, investment bankers in New York, says academic medical centers and PPMCs have something to offer each other. The centers have established market bases, prestigious brand names, expertise in clinical research, and large numbers of physicians.

The PPMCs are skilled in developing primary care networks, building information systems and clinical databases, working under risk-based contracts and productivity-based compensation, and developing successful marketing strategies.

**Commentary:** *The barriers to collaboration between PPMCs and academic medical centers largely are cultural. The PPMC would need to convince the academic medical center that health care is a business requiring a surplus from clinical operations, often at the expense of research and education. Without a mission, say the academic medical centers, they have no social purpose. Without a profit margin, say the PPMCs, there can be no mission.*

### Wall Street Analysts Say Buyers Want More Value

Analysts on Wall Street who specialize in following health care trends say HMOs will soon be asked to deliver more value, according to *Managed Care Week*, a newsletter published by Atlantic Information Services, in Washington, D.C. Purchasers will demand that HMOs institute systems that limit to 15 minutes the waiting time for a scheduled office visit, speedy responses to phone calls, and direct access to specialists.

In a recent example, PacifiCare of California, an HMO in Cypress, signed a three-year agreement with the Pacific Business Group on Health (PBGH), a coalition of employers in San Francisco. Under the contract, PBGH will pay bonuses if PacifiCare exceeds certain quality targets. PacifiCare covers 32,000 members in California through its partnership with the coalition. Earlier this year, PacifiCare entered a similar agreement with CalPERS, the state agency that provides health care to state workers and retirees.

"Our goal is to improve PBGH members' health by tracking health outcomes and implementing best practices," said Jon Wampler, PacifiCare's president and CEO. A portion of rate increases that PacifiCare receives will be directed to medical groups so they may implement quality improvement programs involving health services, customer service, and data quality. In addition, PacifiCare is working with medical groups to ensure that medical outcomes data are captured for all members.

**Commentary:** *Other coming trends, the analysts said, were these: Specialists will need to raise premiums to be profitable and to satisfy investors; all providers will accept more risk (but few are prepared to do so); many provider-sponsored networks will fail, because most hospitals are unable to gain the necessary economies of scale; consolidation will accelerate, leaving only 40 to 50 large regional and national organizations as the dominant companies.*

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