

PHYSICIAN PRACTICE OPTIONS™

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A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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How Specialists Can Thrive Under Managed Care

No doubt you've read horror stories about the dismal prospects for specialists. By the year 2000, a surplus of 185,000 specialists has been projected by the Advisory Company, in Washington, D.C., an association for health care providers. Many specialists will be unemployed, observers say. Those specialists who remain will have reduced incomes.

After hearing such horror stories, medical school graduates have veered away from specialty careers in the last two years. More than 50% of these students now are going into primary care residencies, and less than 3% have selected pathology, radiology, and anesthesiology.

As managed care and other market forces restructure health care, physicians practicing solo and in small-group practices are joining integrated groups, fee-for-service plans are shifting to capitation, inpatient care is moving to outpatient settings, and specialists are becoming primary care physicians.

Yet, specialists are not helpless and should not simply roll over passively. They should not necessarily view themselves as redundant commodities in a world obsessed with costs.

A Two-curve World

What may be happening is that specialists are reconsidering the assumptions they made in recent years regarding managed care and they may be considering the fact that the velocity of change seen recently may be unsustainable. In his book, *The Second Curve: Managing The Velocity of Change*, (Ballantine Books, New York, 1996), Ian Morrison, president of the Institute for the Future, a think tank in Menlo Park, Calif., says the world is gov-

erned by two curves—the curve of the past and the curve of the future.

In health care, the curve of the past is fee-for-service medicine, dominated by autonomous specialists who derive much of their income from hospitals. Managed care enthusiasts say the curve of the future is capitated medicine, dominated by primary care physicians practicing in vast integrated corporate entities outside of hospitals, and deriving their income from salaries.

A Phantom Curve?

Morrison, however, does not subscribe to the notion that health care can solve its problems of cost, access, and quality by jumping to the second curve. In fact, he says, you can harm yourself by jumping too fast to the second curve. You can abandon your current methods of practice to jump to the second curve. But, if you're a specialist, you may jump too soon, abandon a fee-for-service revenue base, find the margins too thin in primary care, and discover the market cannot support a capitated organization—not yet anyway.

"American health care is jumping to a phantom second curve," Morrison says. "It's questionable as whether or not we're seeing a real second curve, or an unsustainable interim stage where, as much as we'd like to believe that we've solved the problem, we're really just rearranging deck chairs on the Titanic of the first curve."

'They're Going to Fight'

Morrison concludes: "It's important to recognize that these specialists who are being disintermediated—that is, cut out of the food chain—are not going to simply roll over and die. They're going to fight politically, and they are doing so through any-

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The Attraction of MSOs

Management services organizations (MSOs) recently have become an attractive practice management option for physicians seeking to consolidate into groups. Physicians recognize that they need size to compete in managed care, to expand, to acquire other practices, to build infrastructure, and to develop information systems. While affording physicians some market clout, MSOs also are being developed because health care delivery is moving away from hospitals and into physicians' offices. In addition, the rise of MSOs is driven by fear among physicians who are hearing faster music and seeing fewer chairs and by investors who see an opportunity in the \$200 billion physician industry because only \$11 billion of that amount is controlled by practice management firms.

By definition, MSOs are business entities owned by physicians, hospitals, private investors, or a combination that provide contract and practice management services to physicians and medical groups, according to a report, "Case Study Analysis of Management Services Organizations," by Thomas M. Gorey, a project consultant with Policy Planning Associates, consultants in Crystal Lake, IL. Recognizing the value of IPAs and medical groups, MSOs have incorporated IPAs and group practices into their long-term strategies, Gorey says. But unlike IPAs, which pay physicians on a fee-for-service or capitated basis, MSOs usually pay physicians a combination of salary and financial incentives, the report says.

Assuming More Risk

MSOs are moving to accept greater risk by assuming responsibility for a larger portion of premiums, the report says. They also are pursuing geographic expansion aggressively, requiring that they manage the delivery of health care from a distance, Gorey reports. In addition, they are pursuing strategic partnerships between payers and hospitals and largely are rejecting the formation of HMOs. Typically, MSOs encourage quality and utilization management activities and recognize the importance of information systems as the basis of future success, Gorey says. Physicians find MSOs attractive because they:

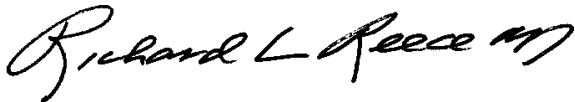
- Offer an effective way to compete in managed care
- Are often physician-driven structures
- Offer an ownership opportunity
- Attract outside capital
- Bear financial risk, freeing physicians from FTC scrutiny for price fixing and monopoly practices
- Represent a career exit strategy

These advantages notwithstanding, MSOs are not a panacea for managed care woes. Like any other business enterprise, MSOs can fail. Before you enter into an MSO, you should pick your partners well, write a business plan, do extended due diligence, assess your partners and your market, and carefully consider your strategic options.

There is no source of information on the number of MSOs in operation, and there is no easy way to compile a list of MSOs. Our best guess on the number is 1,200, compared with 2,000 IPAs and 3,000 physician-hospital organizations. But many new MSOs are being developed by PHOs, practice management firms, and hospitals and may operate under other names.

Estimates vary on how much an organization would spend to capitalize an MSO. In a concentrated local market, \$1 million may suffice, but an MSO serving a large region may require \$5 million to \$50 million. An MSO that operates nationwide may require hundreds of millions of dollars in start-up capital.

For more information about MSOs, readers may request a copy of Gorey's report from Policy Planning Associates at 815/459-4516. Commissioned by the AMA and other medical societies, the 82-page report costs \$25 for members of a sponsoring medical society, and \$95 for non-members.



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willing-provider legislation—an attempt to block HMOs from excluding physicians in their networks. They'll also fight in terms of passive-aggressive clinic behavior, where they bond with the patient against the insurers, trying to upcode their bills to creatively distort their claims and to inflate the prices and practices in order to extract as much revenue as possible from the evil managed care organizations.”

In addition to this dysfunctional specialists' behavior is the current well known backlash against managed care. After considering the litany of managed care failings, one begins to wonder if the second curve will ever arrive in force. Already we're seeing HMOs hedge their bets on the second curve by eliminating capitation, by providing open access plans with easy access to specialists, and by easing referral restrictions for gatekeepers.

Complications

Despite this dark side of managed care, the dynamics involved with shifting away from traditional fee-for-service medicine are much more complicated than managed care advocates admit. Consider, for example, these facts:

Transition is slow. The transition to capitation is slower than most observers had predicted. Purchasers glow about the prospect of having specialists and health care organizations operating on tight budgets and assuming financial risks, but HMOs are much less enthusiastic. Outside of California, where large medical groups can assume significant risks, HMOs elsewhere prefer to take the risk themselves and are making money at it. Why should HMOs turn over this profitable risk-bearing function and the accompanying 15% to 25% commission for managing risk to hospitals, physicians, and integrated systems?

Staff-model failures. The financial failure of many primary care-dominated staff-model HMOs operating in the new competitive environment is a little-noticed phenomenon. In theory, these models are supposed to be the prototypes for second-curve health organizations. Financial problems come, however, during the two- to five-year transition period between the first and second curve. In this period, the staff-model HMO needs the revenue of fee-for-service to pro-

vide the capital needed to function as a capitated organization. When the cash crunch comes, bankers and creditors have little sympathy for theoretical future potential.

The lack of primary care PPMs. Despite the cries about how primary care physicians are the engine that drives managed care, not one physician practice management (PPM) company has gone public with a primary care company. Indeed, only multispecialty and niche single-specialty companies have gone public. The most profitable and successful public companies are those with single-specialty niches, including American

cost-control and quality assurance potential of disease management programs already is providing new sources of income for some specialists. Under the theory of disease management, patients with known chronic diseases, such as depression, asthma, malignancies, cardiovascular conditions, diabetes, and hypertension, are referred directly to specialists. These specialists know how to manage care more efficiently, less expensively, with fewer complications, and better outcomes than if all such patients were sent through primary care gatekeepers. Although disease management advocates have yet to

Under disease management, patients with chronic diseases are referred directly to specialists who know how to manage care efficiently.

Oncology, Physician Reliance, Physician Resource, Orthodontic Centers, Apogee, OccuSystems, MedCath, and Response Oncology. Although the stocks of practice management companies have come more in line with market trends in recent weeks, the stocks of single-specialty niche practice management companies were trading at 46 times earnings in April. Multispecialty companies were trading at 38 times earnings, IPAs at 36 times earnings, and hospital-based companies were at 21 times earnings.

Blurring distinctions. As all forms of health care delivery become more efficient, the distinctions between tightly controlled health plans and those with open access and direct referrals to specialist are blurring. Allina Health Systems, a large managed care organization in Minneapolis, found only a 3% differential between restricted gatekeeper and open-access specialty models. In an interview in our June-July issue, futurist Russell Coile Jr. observed, “In more advanced managed care markets, some HMOs and capitated medical groups are finding that the primary care doctors may be redundant in a really efficient system....If you have patients who can be channeled directly to responsible subspecialists, and those subspecialists are capitated, then that's a more efficient model than a narrow-gated model.”

Disease management's potential. The

show this theory can work on a broad scale, they have produced convincing results that certain conditions, such as congestive heart failure and diabetes, can be managed more effectively by specialists than by generalists. In addition, pharmaceutical companies have embraced the concept.

Specialists as PCPs. The distinction between specialists and primary care physicians (PCPs) isn't always as sharp as some managed health plans would have us believe. Many specialists, especially those who are double-boarded internists, do significant amounts of primary care work. Medical subspecialists, such as allergists, non-invasive cardiologists, endocrinologists, infectious-disease specialists, and rheumatologists, are retraining themselves to be primary care physicians. For most this step isn't a giant leap because many are board-certified internists anyway.

In conclusion, the capitated, vertically integrated managed care nightmare of hundreds of thousands of redundant specialists with plunging incomes may have been overplayed. Many specialists will not—and should not—abandon their training and convert to primary care. Their days of high income and absolute autonomy may be over, but they will adjust to the new realities of managed care, and practice smarter and more cost-efficient medicine. And, most will survive. ■

Primary Concern

Group Practice Lists Six Keys to Success

By Loyd Woodward, MD



Loyd Woodward, MD, is the chief executive of the Primary Medical Clinic in Odessa, Texas. A group practice founded by Woodward in 1984, Primary Medical Clinic has 55 physicians, including

18 subspecialists in pulmonology, cardiology, neurology, gastroenterology, orthopedics, general surgery, neurosurgery, obstetrics and gynecology, and cardiovascular surgery. Although it is strongest in West Texas, the group has offices in 15 locations throughout the state.

One of the operating principles of our company is that organized, well managed primary care physicians will control more of the funds coming into health care than any other segment of medicine. We believe strongly that primary care physician groups can control specialty and hospital usage significantly. When we adopted our trade name—Primary Medical Clinic—in 1984, we also adopted these principles.

Our first clinic combined an existing family practice with a walk-in urgent care clinic that operated extended hours. The concept worked well for us, and we expanded to other locations using internally generated capital and personal capital. Through trial and error, we found that physician remuneration tied to production was necessary to maintain profitability of our centers. In addition, when we integrated our primary care physicians with subspecialists, we also needed to adjust compensation levels. As a result, we raised the revenue of primary care physicians in order to attract more of them.

Successful Expansion

One reason for our success is diversification among payers, which can be extremely important in a general medical

clinic. We prefer a balance of payers so that shifts in the market will not hurt business overnight. We maintain, for example, 15% to 25% of our total business in occupational medicine.

When we began to expand, we first increased the number of primary care physicians in a specific market area. In general, we need five to seven family physicians in the same service area, but not necessarily in the same locale. We prefer clusters of family practices with a minimum of two physicians in each practice. Obviously, the more primary care physicians we amass, the more we can dominate a market.

As more payers adopt full-risk capitation, we have begun to manage the costs of our ancillary services more carefully. Several years ago, financial projections showed that we would fare far better if we capitated ancillary services rather than continued to use a conservative fee-for-service style. Since West Texas has been identified as an area that has a shortage of doctors, the law of supply and demand dictates that patient vol-

ume will be sufficient regardless of whether we have capitation or FFS. Given the choice, we prefer capitation because our fees are pre-paid.

product for small employers in our West Texas market. Like the rest of the country, this area is populated predominantly with small employers. We will accept partial risk for managing the care of these workers. Also, we have been contracting directly with several self-insured employers. Under these direct contracts, we use FFS and capitation depending on the payer's need.

Since most physicians and insurers have trouble managing a group of primary care physicians profitably, we believe our group has a tremendous opportunity to expand. To realize this potential, we will continue to follow these six steps to success:

1. Primary Care Is primary. Each Primary Medical Clinic offers the most needed and fastest growing part of any U.S. medical practice: primary care. In Great Britain, 72% of physicians are primary care doctors. Canada has 54%; Germany and France 47% and 48%, respectively. The United States has 29%. As a result, more primary care physicians

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ume will be sufficient regardless of whether we have capitation or FFS. Given the choice, we prefer capitation because our fees are pre-paid.

Beginning this summer, Primary Medical Clinic will offer an insurance

are needed. In our group, we are a raising the number of family practitioners and ancillary personnel dedicated to delivering comprehensive primary care.

Also, we have convenient locations, which is extremely important for patients

seeking primary care, and our general medical clinics operate extended hours, treating scheduled and walk-in patients. In general, referrals are directed from this point of access to our ancillary services and specialists, beginning what we call downstream revenue.

In addition, we stress the importance of patient satisfaction, believing that our first priority should be the availability of physicians to patients. Our second priority for patients is that we believe physicians should have a positive attitude, or affability, toward patients. Our third priority for patients is the ability of our doctors. Since patients have trouble evaluating the quality of physicians, we try to ensure that all of our physicians have the skills needed to do their jobs. To ensure quality, we use a combination of patient satisfaction surveys and a committee of physicians who investigate all patient complaints and monitor the quality of care their colleagues deliver.

2. We are a physicians' organization.

Since its inception, Primary Medical Clinic has retained experienced, physician-friendly managers in key roles, believing that a patient's physical and fiscal health is best served by a physician organization. As physicians, we can evaluate physician productivity, quality, and patient satisfaction better than most management companies can. Because we are a physician organization, we also are a caring organization. Our physicians, nurses, laboratory technicians, receptionists, and clerical staff all are taught that patients don't care how much we know until they know how much we care.

3. We are cost-effective.

By operating many clinics, we offer economies of scale regarding purchasing, inventory, and management. Also, our primary care physicians are vertically integrat-

ed with specialty and ancillary medical services. After achieving market dominance in one area, we began capturing downstream revenue in ancillary and outpatient care that traditionally was referred to others. Ambulatory surgery offers a good exam-

providers, and to reduce the number of excess bed capacity in hospitals, among other initiatives.

Bound by tradition, most medical clinics are slow to react to change. Only those that are flexible will survive, much

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ple. Before we added an ambulatory surgical center, these patients were referred to other providers. Now, we retain that revenue.

4. We are competitive.

Clinics across the country tend to keep bankers' hours. Consequently, they are closed when their patients are not working. Should a patient become ill or injured on a weekend, the only option has been emergency care, where staff do not know the patient nor have access to the patient's medical history. As discussed, we offer many offices in convenient locations and extended hours. In addition we have well trained personnel for contract negotiations, especially for managed care contracts.

5. We are a flexible organization.

Payers nationwide are demanding more efficiency from all segments of medicine. In response, providers are being forced to contain costs without reducing care, to reduce the surplus of medical specialists, to increase the number of primary-care

less thrive. We are a flexible organization in that we offer strategic alliances for co-marketing and co-development with hospitals. We have promotional strategies for different physician mixes and market conditions; aggressive marketing through television, newspapers, patients, and direct mail; and we market to solo practices that need management services.

6. We will venture into new areas.

In any competitive endeavor, it is said that “He who will not risk, cannot win.” While we manage risks, we also are open to new markets and marketing ideas. One comment that has never been heard at our planning meetings is this one: “But no one else does it that way!”

Aware that success is never final, we recognize that our continued growth rests on our patients seeing us as competent, caring health care providers. That means we cannot stop proving ourselves to each patient, in each clinic, on each day. That is our commitment. ■

How Managed Care Influence Affects Market Transitions



Jacques J. Sokolov, MD, is the chief executive officer of Advanced Health Plans Inc. and AHP Development Inc., and chairman of the board of directors of Coastal Physician Group Inc. Advanced Health Plans Inc.

was formed to develop, finance, and implement advanced integrated health systems for payers and providers. Since 1992, Advanced Health Plans has developed health systems in more than 150 markets nationwide and in three foreign countries. AHP Development Corp. evaluates and identifies equity participation in strategic alliances, joint ventures, investor partnerships, and merger and acquisition activities. Coastal Physician Group is a large physician management services company, serving physicians, hospitals, managed care organizations, and other health care providers. A member of the editorial board of Physician Practice Options, Sokolov previously was vice president and medical director of Southern California Edison Co., a large electric utility.

Q: Dr. Sokolov, is it your impression that managed care is moving from West to East and that the big markets of the Northeast, the Mid-Atlantic states, and Southeast, have yet to mature?

A: In general, that's correct. The challenge here, though, is that managed care the way we experienced it in Southern California is really not reproducing itself identically across the country. In the California model, we saw large commercial employer-based health plans dominate the market to where there's only six that control about 75% of the employer-based market. In other parts of the country, we're seeing Medicare HMOs actually leading the market. In Florida, for instance, many of the markets are actually transitioning from a Medicare HMO standpoint and not from an employer-based standpoint. And in other parts of the country, such as Tennessee, Washington State, and other

areas, we're seeing Medicaid HMOs transitioning the market. So the interesting thing from a physician's standpoint is that these markets change depending upon what kind of managed care influence is happening in one of those three market segments: the employer-based segment, the Medicaid segment, or the Medicare segment. And unfortunately that makes the decisions for physicians even more complicated because one has to know really how these markets are going to change so physicians can make the right decisions.

Q: You have said that those who control the Medicare market will control the managed care market.

A: That is correct. In markets where the Medicare reimbursement is high, we see health plans, which otherwise would not have entered the market for employer-based lives, entering the market for Medicare lives. As a result of the federal rules requiring one commercial HMO life for every Medicare HMO life, the Medicare HMOs actually have drawn commercial lives into those plans just to get the Medicare enrollees that they need. So yes, that does happen. In fact, it is very prominent in Florida and I think it will be dramatic in the Northeast in New York, Philadelphia, St. Louis, all of Ohio, and even into Baton Rouge and New Orleans.

Q: And what about those markets where Medicaid is the leader?

A: To a certain extent, we've seen Medicaid be the leader early on in Arizona, in Tennessee, and we've seen it be contributory in Washington state. In general, virtually all of the federal block grants or waivers involve moving Medicaid beneficiaries into Medicaid HMOs. As a result, in areas where we haven't seen much managed care or pre-paid managed care, these Medicaid and Medicare efforts may move these markets more dramatically than even the commercial plans historically moved them. Where we've seen Medicaid be significant, it has definitely moved the Medicare and commercial segments as well.

In general, when you see one of those three market segments transition from fee-for-service to prepayment it is a harbinger that the other two segments are probably going to follow relatively quickly.

Q: The Medicare markets seem to transition more quickly in those states with mature managed care, such as Southern California, Oregon, Arizona, and Minnesota. Does that mean these states have fertile conditions?

A: Yes. As I mentioned, the reason those Medicare markets do transition quickly is because the federal reimbursement is high, and there are already mature delivery systems that can handle prepaid risk beneficiaries. If you've been handling employer-based risk patients in California, then handling Medicare-risk patients is nowhere near as difficult as if you were just doing pure fee-for-service previously. If you have mature delivery systems handling some form of risk, either for commercial/ERISA plans or Medicaid, then the Medicare risk certainly falls more quickly. In fact, in Florida, people were amazed that much of the changes that took place in 1994 and 1995, took place in only 12 to 18 months.

Q: In Connecticut, the county medical societies have moved to plan a Medicare-risk HMO product. Do you see organized medical societies as playing a role in this transition?

A: We're seeing organized medical societies playing a very active role. If you look at California, we certainly have a new large HMO called The Advantage HMO, and that's the California Medical Association. The Florida Medical Association has created both an IPA and is developing HMOs. The Virginia State Medical Association is also developing products.

In certain very mature markets, physicians and hospitals will have a tough time competing against entrenched, well funded HMOs. At the same time, the vast majority of markets don't have that oligopolistic consolidation yet. So, well organized doctors and hospitals can put together plans in a variety of markets and be successful. But it

is clearly a decision made on a region-by-region basis.

Q: *You say well-organized hospitals and doctors. Do you see them moving together in tandem?*

A: I do, and I think the evidence is there to support that. In 1990, there were approximately 200 integrated delivery systems—in other words with either contractual or structural physician-hospital linkages—that had aggregate income of physician and hospital services over \$100 million. Today, we have approximately 600 integrated delivery systems that have aggregate physician-hospital income of \$100 million or more. It is predicted by many that by the year 2000, I think we'll see about 1,200 integrated delivery systems handling \$100 million or more in aggregate physician-hospital revenue on a managed care or prepaid basis.

The ability to create these integrated delivery systems continues to accelerate. The size of these integrated delivery systems continues to grow, and the hospital-physician relationships in general are improving. Historically, as you know, some were very good, and some weren't so good. Today we're seeing much more of a need to work together as a provider system than we probably would have ever seen in the last 20 to 30 years.

Q: *What do you see as the leading edge of those integrated systems, the hospital or the physician group? Do you see any possibility that practice management companies will be the contracting entity?*

A: We're seeing every flavor of ice cream. We have markets where there's a dominant hospital system that's well run. They've pulled their physicians together in a positive way and they're taking the lead. They're becoming their own HMO and their own integrated delivery system on a number of levels. That's certainly one model.

In other markets, we see physician organizations that are well run—like the Geisinger Clinic, for instance. These physician organizations are pulling the hospitals together and building their own health plan and being very successful.

In still other markets, publicly traded physician management companies are the primary integrators. PhyCor, Coastal, or MedPartners, which are all physician man-

agement companies, are pulling together contractually or structurally in terms of owning doctors and their practices. They are pulling the physicians together and contracting with hospitals or hospital systems to create integrated delivery systems.

Also, we'll see for-profit hospital systems

Just as there are a variety of different successful managed care organizations across the country, there'll be some successful not-for-profit hospitals that are managed effectively and efficiently. And, quite frankly, there will be some that don't make that transition for whatever reason.

“Hospital and physician relationships are improving. We're seeing much more of a need to work together as a provider system than we have seen in the last 20 to 30 years.”

pulling their physicians together. Columbia/HCA is doing that in Kansas City and a number of places.

There is every wrinkle imaginable, and one cannot ignore the fact that the fiduciaries, which are the insurance companies and the HMOs, are actively attempting to be primary integrators themselves and have established dedicated delivery networks that are successful.

In general, the integrated delivery system strategy is one that is being approached, not only from an insurance and an HMO standpoint, but from a doctor and hospital standpoint. In many ways the end structure is remarkably similar. The question is where you're starting from in order to get there.

Q: *But since the focus of care is moving outside of the hospital, what do you see is the future of the classic voluntary not-for-profit American hospital?*

A: Many of us believed that the enormous oversupply of hospital beds in the voluntary not-for-profit environment and in the for-profit market would mean significant consolidation among hospitals, and we have seen that.

But more important, I've seen a number of hospitals remain open at 30%, 40%, and 50% occupancy. In these situations, the hospitals are consciously moving many services to out-patient environments and trying to reduce fixed cost so that they don't carry the over-supply of beds at the same cost structure that they have had historically. But, we will see aggressive for-profit hospital chains, such as Columbia/HCA, try to out-compete voluntary not-for-profit hospitals.

In the cases of extreme over-supply of hospital beds, we will see a significant number of those hospitals close. Whether they are for-profit or not-for-profit will be relatively immaterial in relation to how well they're managed, which is the most important component.

Q: *What do you see happening in rural America?*

A: That's going to transition dramatically. We are currently involved in evaluating delivery systems for the State of North Dakota. In North Dakota, there are something like 48 hospitals of which more than 30 are rural, and, in many instances, these hospitals are the only sites for care for 100 miles. Many times, those rural hospitals are intermediate care locations where people receive a certain level of care before they're moved to more advanced acute-care settings. We will see a significant reduction in rural hospitals and an improvement in efficiency in moving people from what I will call super-ambulatory care centers to different advanced and tertiary care centers. Either rural hospitals will transition into what I would call super-ambulatory care centers or become more triage-oriented or effective pre-transport sites before patients are moved to more advanced acute-care-oriented centers farther away.

If you're going to enter the hospital market niche for rural hospitals, you really have to be in the 50- to 150-bed range, not in the under-50-bed range. The under-50-bed hospitals will transition predominantly to super-ambulatory care centers.

Q: *What is the future for the 250-bed rural hospitals?*

A: The key questions for these hospitals are, What role do they play? What geographic service territory do they serve? And are there direct competitors in those markets?

Take, for example, Rockford, Ill., which is only about 90 miles from Chicago. It has three relatively large hospitals in the 300- to 400-bed range, and clearly that environment could use two hospitals and not three. It's almost inevitable in that situation that there will be some consolidation or closure of beds to create two hospitals or two systems. If two hospitals are there already and two hospitals are needed, then probably little would happen in that community besides healthy competition.

What happens depends largely on the over-supply of beds, the geographic service territory, and how the different market segments are transitioning. If you have predominantly a fee-for-service reimbursement structure in the different market segments, then those hospitals will sustain themselves longer than if they are thrust into rural managed care networks. When hospitals are asked to handle pre-payment and other managed care systems that require substantially more infrastructure than most rural hospitals and physicians really can deal with, then they struggle.

Q: And, what about those crown jewels of American medicine, the academic medical centers?

A: There are a continuum of strategies for academic medical centers. The strategies range from the progressive, far-reaching approaches to those that are narrow approaches that involve fighting managed care. These narrow academic medical centers just don't understand that the entire structure for reimbursement is changing. They're not looking at Medicare HMOs or Medicare-risk plans. The more expansive approaches involve becoming an HMO, developing physician practice management companies, integrating community physician networks with their own academic tertiary centers, buying additional hospitals that provide them with different kinds of feeder systems or geographic coverage. This latter group of aggressive, well run, financially viable academic medical centers will do well.

In the middle between those academic medical centers that are doing exemplary things and those that are doing little is a

continuum of different incremental strategies. These academic medical centers either will have to be much smaller, much more focused on tertiary care, or they're going to have to be much larger and much more focused on comprehensive management of the medical loss ratio for a population of patients. What governs that bifurcation of strategy is the geographic area that the academic medical center covers and the supply of academic medical centers and sophisticated tertiary care community hospitals. In addition, the maturity of the market seg-

information systems and infrastructure and so forth. Do you see that as a continuing dramatic consolidation?

A: Yes, I see it as a continuing dramatic evolution in terms of physician roles within a variety of these different systems. Let me articulate what I mean by that. As I look across the physician services industry, I see enormous growth and ongoing consolidation. Those two factors are the two drivers in terms of physicians looking at their roles over time in relation to capital or organizational structures. In terms of physician

“There are a continuum of strategies for academic medical centers that range from the progressive, far-reaching approaches to those that are narrow and that involve fighting managed care. These narrow academic medical centers don't understand that the entire structure for reimbursement is changing.”

ments that those medical centers serve will have a significant effect on strategy. If they're in an aggressive managed care environment, they're going to have to make decisions about how to handle the medical loss ratio, which is very different from what they have done historically with fee-for-service medicine.

Q: What about those major eastern cities that have five to seven medical schools, such as Boston, New York, and Philadelphia?

A: There's going to be consolidation in those cities. In fact, we're already seeing consolidation from a facility standpoint, in Boston at least. We are seeing the facilities consolidation, and the teaching program consolidation is only a matter of time. The University of California at San Francisco and Stanford, for instance, are discussing consolidating their programs. If we have 126 academic medical centers today in 1996, by the end of the decade we may have consolidations of 20 academic medical centers.

Q: You mentioned consolidation in the physician services industry. Physicians seem to have awakened to the fact that they are, after all, at the core of the health care delivery system. As such, they're looking for capital for

management services companies, certainly the consolidation of Mullikin with MedPartners and with Caremark making a \$4 billion entity is dramatic. PhyCor has about \$800 million in physician revenue and Coastal has around \$700 million in physician revenue. Those three PPMs alone put you way over the \$5 billion to \$6 billion revenue range. There are another 15 to 20 companies that are publicly traded that involve both specialty physician services, such as oncology, ophthalmology, and others, and then there are a number of PPMs that are in the incubator phase. They've had a first round of financing and they're ready to go public sometime in the next two to four years.

Having said that, I see more PPMs coming onto the scene and I see more of those companies being consolidated into larger companies. But physicians clearly have a number of options related to the PPM options that I think will be very exciting. I view that as a very positive situation, not a negative one, because for the first time physicians really have much more control over their destiny than perhaps historically they had when they were in much more of a cottage industry perspective. ■

1996 Physician Practice Acquisitions

(Selected transactions through July 2, 1996)

Acquirer (Announcement date)	Target and Location (Number of MDs)	Purchase Price (Millions)	Notes
PhyCor (07/02/96)	Clark Holder Clinic, La Grange, Ga. (47)	ND	Founded in 1936. PhyCor's third Georgia acquisition.
PhyCor (07/01/96)	Focus Health Services, Denver (58)	ND	Clinic affiliated with a 240-MD IPA. PhyCor's fifth Colorado acquisition.
MedPartners/Mullikin (07/01/96)	Summit Medical Group, Summit, N.J. (75)	ND	Consideration 100% stock. Accounted for using pooling-of-interests method.
FPA Medical Management (07/01/96)	Foundation Medical Centers Thomas-Davis Centers, 2 IPAs, in California, Arizona, Florida (245)	\$220	Consideration in cash, common stock, and notes. Twelve centers in Southern California, 18 in Arizona, IPAs in Florida and Arizona.
PhyCor (05/24/96)	Harbin Clinic, Rome, Ga. (62)	ND	Founded in 1948. Has more than 20 specialties.
FPA Medical Management (05/20/96)	Sterling Healthcare Group, Coral Gables, Fla. (1,000)	\$208	Consideration of up to \$186.4 million in stock, \$12 million in cash, and \$10 million in assumed debt.
PhyCor (05/16/96)	Carolina Primary Care, Columbia, S.C. (29)	ND	Formed in 1995 by three groups that merged to create one multispecialty group.
MedPartners/Mullikin (05/14/96)	Caremark International, Northbrook, Ill. (7,250)	\$2,340	100% stock pooling. Combined company to have over \$4.4 billion in revenue.
FPA Medical Management (05/06/96)	Physicians First, Inc. Miami (125)	\$25	Target was subsidiary of Physician Corp. of America.
MedPartners/Mullikin (04/30/96)	Cardinal Healthcare Raleigh, N.C. (75)	ND	100% stock pooling.
PHP Healthcare (04/25/96)	10 BCBS Primary Care Clinics, New Jersey (NA)	\$33	Consideration 100% cash.
PhyCor (03/12/96)	Clinics of North Texas, Wichita Falls, Texas (75)	ND	Formed in 1995. PhyCor's seventh Texas clinic acquisition.
OrNda HealthCorp. (02/28/96)	Fallon Clinic, Worcester, Mass. (280)	ND	Acquired minority interest in clinic and health systems.
PhyCor (01/19/96)	Arizona Physicians Center, Phoenix (35)	ND	Founded in 1987. 77% primary care.
PhyCor (01/19/96)	South Bend Clinic, South Bend, Ind. (46)	ND	Founded in 1986. Interim management agreement since Nov. 1, 1995.
MedPartners/Mullikin (01/17/96)	Eaton Medical Group, San Joaquin, Calif. (23)	ND	Provides care for 12,000 pre-paid enrollees. Began operations in 1947.

NA = Not available ND = Not disclosed

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

Success Factors for Physician Companies

By Brooks G. O'Neil

Health care is at the dawn of a new age, a dawn of changes in the physician services market and other health care sectors. Smart investors and forward-thinking doctors have shown in the last 15 months that they are beginning to appreciate the opportunities that exist for physicians. Indeed, Piper Jaffray is excited about what is happening in health care today, and we believe the changes in physician services represent a tremendous opportunity. The best opportunity exists in physician practice management (PPM) companies, but before discussing the nine factors critical to PPM companies' success, one needs to understand the current environment on Wall Street and how physician practice is changing nationwide.

To view my comments in the proper perspective, one first must appreciate a common shortcoming among stock market investors: They are extremely nearsighted. The stock market text books discuss what is called efficient-market theory. Under this theory, Wall Street accurately reflects all available information instantaneously. While this theory is true in the long term, it is not true in the short term. In the short term, there are extreme periods of over- and under-valuation. Investors in pension funds and mutual funds have an extremely short-term, immediate-performance focus because their results are published every day in newspapers nationwide.

Besides focusing too much on the short term, stock market investors are preoccupied with earnings growth, as evidenced by many stocks. We don't believe, however,

that the current valuation in stocks is sustainable. Investors are putting a huge premium on the basis that these companies are growing at a rate of 30%, 40%, 50% or more on a quarterly or annual basis. These growth rates will not continue. Having said that, we believe PPM companies will continue to be a significant investment opportunity in the future.

The \$1 Trillion Oxymoron
Second, to understand my perspective, one must also understand the current health care environment. In health care, there's a concept called not-for-profit medicine, which, in truth, is a \$1 trillion oxymoron. There is a huge health care infrastructure in this country that we need to adjust, and not-for-profit systems are not the answer. The answer is brass-knuckles, free-market competition. We encourage physicians to get in the ring and compete. The goal is to find ways to improve the quality of care while reducing the cost of care, and if you don't believe that brass-knuckles free-market competition is the way to do that, you probably shouldn't invest in this business.

Over the last 30 years, four important changes have altered health care. They are significant growth, changes in who buys health care, the increased influence of managed care, and the role of hospitals.

The business of health care has been experiencing explosive growth. It is now a \$1 trillion system with 6% annual growth for the last 10 years. It represents 15% of gross domestic product. The growth of

health care has tremendous implications for how it is organized and how it's delivered and what impact it has in our communities.

In 1960, individuals were the largest buyers of health care. Today employers and large groups are the biggest buyers of health care. When individuals were the biggest buyers, health care was a local business—and it largely remains a local business. But having large buyers that have operations in many markets will force health care to move to a regional system and eventually—likely in the not-too-distant future—to a national delivery system. As it moves to a regional and national system, it will create enormous opportunities.

The growth of managed care is another major change. While not everyone is excited about managed care, its influence clearly has spread rapidly. We expect enrollment in HMOs to continue to grow.

In fact, the twin forces of managed care growth and the movement to regional and national care delivery networks are linked. The recent acquisition of FHP, a large HMO in Fountain Valley, Calif., by PacifiCare Health Systems of Cypress, Calif., is just one example. The acquisition by United HealthCare of Minneapolis of Metra Healthcare of Hartford, Conn., is another. Aetna has bought U.S. Healthcare. Each of these deals is driving the nationalization of health care delivery, and, over the next five years, we will see continued consolidation among HMO companies.

Another factor of significant importance is the role of hospitals. Clearly that role is shrinking rapidly. There's gross excess capacity of hospital beds nationwide. Since hospitals are not the most efficient place to practice medicine, the role of hospitals will continue to shrink.

Unchanged amid this turmoil is the role of physicians, the focal point of health care. Physicians deliver care and they control costs. As a result, the \$200 billion physician practice management market is extremely attractive. Since physicians



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control 85% of health care spending, one can measure the size of the market at \$200 billion or \$850 billion. In either case, the market capitalization of all publicly traded companies in this business is about \$10 billion. The enormous opportunity for growth over time is obvious.

Getting Organized

Despite the trend toward group formation over the last 30 years, only about one-third of all physicians are in groups of three or more. That fact alone has profound implications for physicians. One fundamental assumption one can make about health care is that the delivery of care in small units is simply inefficient. Many physicians may disagree with that opinion, but the changes that have occurred in health care make this point difficult to argue. Even though physicians are practicing with limited business organizations today, the model of practicing in small units is being replaced rapidly. This situation creates another oxymoron: that of the well run physician organization. With all due respect toward physicians, there remains tremendous opportunities to improve the business aspects of most practices.

For physicians to remain viable in their communities and to make a profit in the future, they need to be well organized and they need to be well financed. Practice administrators need basic business management expertise because the complexity of the system and the concentration of buyers demand significantly more business expertise than most physicians have today.

Under managed care, physicians need expertise in three major areas: One is contracting expertise. Although some may do so reluctantly, many physicians simply sign all contracts that come across the table. In order to thrive in the future, physicians will need to be under contract, and so they should have expertise in how to negotiate and structure contract terms.

The second area of expertise that physicians need—and may be much more significant—is providing care in a managed

care environment. Physicians can learn managed care expertise, but the vast majority of physicians are not prepared to do so. Managed Medicare is an example. Medicare-risk plans are growing quickly, yet few physicians understand how to provide senior care in an HMO environment.

tunity is to save money on overhead and administration. The average practice spends between 45% and 65% of gross billings on overhead and administration. If you have a \$200 billion industry and can save just 5% on administration and overhead, you create \$10 billion in savings.

“We encourage physicians to find ways to improve the quality of care while reducing the cost of care. And if you don’t believe that brass-knuckles free-market competition is the way to do that, you shouldn’t invest in this business.”

The third area of expertise is capital. Capital is critically important because those practicing in a managed care environment need to invest significantly more dollars in information technology than they have invested in the past.

Seeking Partners

Recognizing that they need to form larger groups to be competitive in the future, many physicians are thinking about which partners will help them meet these critical areas of need. While the traditional group practice remains viable, many have not done a good job historically of addressing the key areas of need. Also, hospitals are not good partners. The objectives of hospitals are inherently different and in conflict with those of physicians. Structures that attempt to combine the two objectives are fundamentally flawed. Among health plans, the staff-model HMOs are struggling nationwide.

The most attractive alternative in the future will be companies that actively partner with physicians, PPM companies. Three levels of opportunity exist for PPM companies. The first is the opportunity to consolidate existing practices on an accretive basis, meaning making a positive contribution to profit. Most PPMs still focus only on consolidation. The second oppor-

tunity exists in changing physician practice patterns. This opportunity has the most potential and is the most time consuming to realize.

Nine Critical Success Factors

Now that we have discussed Wall Street and the current health care environment, it becomes easier to understand the nine significant areas that investors look at when they are considering the value of a PPM company. The nine factors are as follows:

1. Management expertise. Investors are not hoping to find a management team that’s going to work out in the future. They expect a management team that’s seasoned, including a CEO, a CFO, and other executives, in a team that’s ready to execute a business plan for a long time. The two areas of expertise we look for most are business management and physician leadership. Occasionally we find a successful company without one or the other component, but the winners in this business generally have both.

2. The right model. When one gets to know the PPMs operating today, one sees a range of focus and a range of business models. We believe a single business model has the greatest chance for success. PhyCor is an example of a company that

has such a focused strategy. It has focused on multispecialty physician groups, and this tactic has enabled the company to build a track record of consistent growth and profitability.

3. History. Track record is the best indicator of future success. It's not the only indicator, but companies with a strong track record are likely to be successful in the future. Physicians have come to us with companies that did not have a past. We will look seriously at them, but it's difficult to gauge whether they're going to work.

On the topic of history, physicians should keep in mind that the market for

5. Managed care expertise. This factor is critical for the long term success of any physician company. The biggest opportunities today are in markets that are under-penetrated by managed care. PhyCor, for example, focuses on markets where managed care penetration is low. There are enormous opportunities in these markets, and PhyCor will expand its managed care expertise as HMO penetration grows in these areas.

MedPartners is another good example. MedPartners has spent a lot of time accumulating and consolidating physician groups in the Southeast. There's little managed care in the Southeast, and conse-

what you can do in the future, but the public market cares only about how quickly and how much you'll grow. The public markets want to know how, where, and, most important, when. In addition, you had better grow when you say you're going to grow. At our firm, we look for aggressive but controlled growth and we think there are plenty of opportunities to invest in companies that follow that strategy.

8. Returns. There's a lot of focus today on the return on equity that publicly traded PPMs deliver. Yet some venture capitalists have focused on unit level economics. They don't look at the reported numbers for a consolidated entity. They try to understand if the unit level economics are favorable and if a dollar invested at the unit level can generate an attractive return. Every one of the PPMs today is generating attractive returns at the unit level.

9. Valuation. Some physicians ask, "How can I have a strong rating on a stock that's trading at 50 times earnings today?" We have an open-ended opportunity in the market today to create extraordinary valuations, and there is little institutional ownership of these companies. Therefore I am comfortable continuing to recommend many physician companies. But keep in mind that the valuations are very high and if you miss your projections by a penny, as American Oncology did recently, you could lose a significant amount of valuation in a short time. American Oncology lost \$400 million of market capitalization in its stock in one day. As a result, management was very upset and the physician owners were very upset as well.

Any PPM company that has all of these factors is almost certain to be successful in the long term because it has shown that it understands the stock market, the current health care environment, and most important, it understands the opportunities inherent in physician services today. ■

[Next month, in part two of "Success Factors for Physician Companies," Brooks O'Neil will discuss examples of successful PPM companies.]

"Hospitals are not good partners. The objectives of hospitals are inherently different and in conflict with those of physicians. Structures that attempt to combine the two objectives are fundamentally flawed."

physician companies is a long-term opportunity. The window is not going to slam shut in the next year or two. There are ideal times when one would want to enter the stock market, of course, but there's plenty of opportunity for well structured, highly focused, physician companies in the long term. Physicians need not feel as if they should race to go public next week to take advantage of lofty valuations.

4. Geography. The public market is pre-occupied with companies that operate in multiple markets. It is difficult to get a high valuation if you don't operate in multiple states. In fact, the more states in which you have a presence, the better. The economic reality of managing your business is that it's difficult to operate in multiple markets. Piper Jaffray is interested in companies that are building local market dominance and are considering how they can replicate a strong local market position in other markets.

quently much excess cost. MedPartners made a smart move: It went to Southern California and bought significant experience in managed care. As a result, the company will teach physicians in other parts of the country what those physicians in Southern California have learned the hard way over the last 10 years about managed care.

6. Physician mix. Many observers, particularly in the medical press, talk about how important it is to own or control primary care physicians. While that concept is important, we haven't seen one successful primary care company in the public market. We believe that those companies that acquire great physician assets—primary care or otherwise—will be well positioned over time.

7. Growth strategy. The public market is intensely and inherently focused on growth. Therefore, what you've done in the past is significant as an indicator of

A Health Plan Manages A Medicare-risk Contract

By Kathy Zaharias, RN, M.B.A.

A health plan opened a new medical center to serve a predominantly senior population and to expand the geographical coverage of its medical group. Initially, the health plan hired two full-time primary care physicians—one in family practice and one in internal medicine—to manage a senior membership of 1,500 persons. Additional primary care physicians would be hired as membership increased. Functioning as its own business unit, the medical center was financially at risk for 100% of the Medicare funding of approximately \$395 per member per month (PMPM) and responsible for the center's operating expenses and all medical services members required. Contracts were executed to provide specialty, ancillary, and in-patient services to members.

The health plan learned quickly that efficiency is needed if a medical group is to be successful under a capitated contract. Success requires that providers change how they think about delivering health care and how they structure financial management and information systems. It also requires changes in the mix of nurses and other providers, and new utilization management, member services, and paneling systems.

Once information became available, the first nine months of activity reflected poor financial performance, high inpatient and outpatient utilization, and dissatisfaction

among members. (See Table 1: Actual Performance Versus Targeted Performance.) Additionally, the two physicians resigned.

about the financial implications of contracts;

- Lack of physician awareness about formulary use and the financial implica-

Table 1: Actual Versus Targeted Performance

	Actual	First-year target	Second-year target
Bed days per 1,000 members	2,000 to 2,400	1,650	1,200
Specialty costs PMPM	\$160	\$120	\$100
Health care costs as a percentage of revenue	118%	96%	80%
Compliance with drug formulary	56%	85%	85%
Disenrollment per 1,000 members	3.6%	2.1%	2.1%

High Cost Problems

It became clear from viewing the actual versus targeted performance, that the plan had higher than expected in-patient utilization, high outside specialty costs, and high utilization of non-formulary pharmaceuticals. Management concluded that the following conditions were barriers to resolving these problems:

- Insufficient resources for case, utilization, and quality management;
- Lack of physician awareness about contracted services that were available and

tions of using non-formulary pharmaceuticals;

- Insufficient, inaccurate, and late management information;
- A per-diem hospital contract that reflected not only high daily rates, but also numerous exclusions for imaging and respiratory services.

To address these problems, the plan hired five medical professionals, including two internal medicine physicians and one family practice physician to manage members in the outpatient setting and in the local community hospital. The size of each physician's panel was 2,000 members (adjusted for age and severity of illness). The plan also hired a nurse practitioner at \$60,000 annually to manage visits for health screens and urgent care, to identify high-risk members, and to conduct rounds on members in a skilled nursing facility. Hiring a nurse practitioner saved the plan \$60,000 annually after paying the salary and other associated costs. The savings came because the nurse practitioner freed up physicians to manage more acutely ill patients. As a result, access to primary care physicians improved.



Kathy Zaharias, RN, M.B.A., is a health care management consultant with Milliman & Robertson, actuaries and consultants, in Irvine, Calif. A registered nurse since 1973, Zaharias has worked with a wide variety of managed care delivery systems and health care providers, including physician groups and staff-model HMOs. A specialist in assessing, developing, implementing, and managing operational systems in medical groups and clinics, Zaharias has developed, evaluated, and negotiated capitation contracts, including those that contain quality and service-performance criteria. She has consulted on utilization, case, and quality management; patient access; nursing triage and consultation; prior authorization for specialty referral; and physician scheduling. Zaharias has a bachelor of science degree in nursing from the California State University of Long Beach and master of science degree in Business Administration from the University of Phoenix. This article is the second of two parts. Part one, "What You'll Need for Capitation," was published in August.

STRATEGIES

In addition, an RN case manager was hired at \$45,000. Charged with supporting the primary care team in the inpatient and outpatient setting, the RN case manager implemented daily concurrent review for every hospitalized patient. The savings from this review alone were estimated at more than \$200,000 during the RN's first three months of employment.

A telephone nursing triage or consultation system also was developed. To implement this system, the role of an existing clinic RN was expanded, thereby incurring no additional expense. Also, an after-hours on-call triage or consultation system was developed as a test in four medical centers. The monthly expense was \$325 per medical center. This after-hours system saved \$5,000 in its first month of operation by eliminating inappropriate visits to the emergency room. In addition, the medical staff shifted many ER visits to urgent care or primary care, when appropriate.

Making Changes

To address the problem of high specialty costs, management reviewed the specialty network from a financial and service perspective and moved some specialty services to providers who were more conservative and more friendly toward managed care. Moreover, management renegotiated contracts for high-cost specialties and implemented a program to identify and treat high-risk patients.

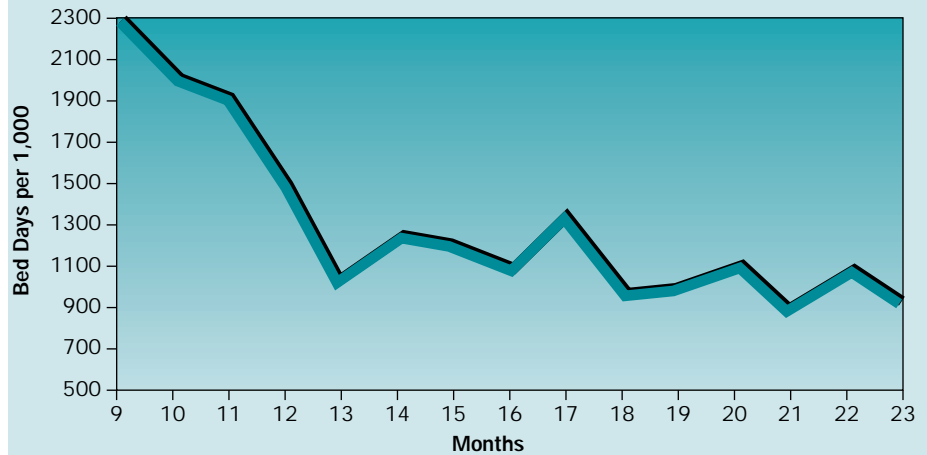
Management also developed operational systems to handle prior authorization, document and track inpatient and outpatient utilization, and provide the physician-administrator team with accurate management reports.

To address utilization and quality management issues, weekly meetings were established. At each of these meetings, a clinical pharmacist reported on formulary utilization.

Among the reasons the plan had a high number of complaints from members and a higher than expected disenrollment rate were a lack of access to physicians over the phone, a lack of availability of appointments, and a lack of systems to support primary care paneling, member access, member services, and provider scheduling.

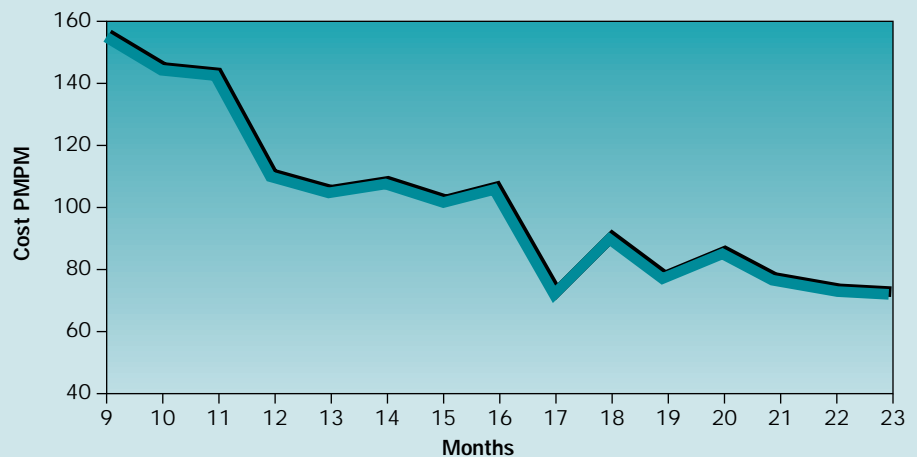
To address these problems, management installed operational systems to support primary care paneling and to improve access

Table 2: Bed Days per 1,000 Members



Note: The plan was implemented in month 9.

Table 3: Specialty Costs



Note: The plan was implemented in month 9.

and service to members by adjusting provider scheduling strategies and the mix of personnel. In addition, management established mechanisms to document and track member access and paneling activity.

The process of assessing the problems at the medical center and developing a corresponding plan of action began in the center's seventh month of operation. Once the action plan was developed, the health plan set priorities for each corrective measure and began implementing each one within two months. The first priority was to manage quality and utilization by holding meetings of the Utilization/Quality Management team.

Among other results, the health plan documented decreases in bed days, admis-

sions, average length of hospital stay, specialty costs, and pharmacy costs. Profitability and member satisfaction rose. (Tables 2 and 3 summarize the results over 15 months for bed days per 1,000 members and for specialty costs.)

The increased awareness of managed care and capitation as a reality for reimbursement challenges medical groups to manage health care costs efficiently. Efficiency means that all services delivered must be medically necessary, care must be delivered by the provider with the appropriate level of expertise, care must be provided in the appropriate and least intensive setting, the cost of the resource must be matched to the appropriate setting, and, finally, administrative costs must be minimized. ■

Do HMOs Provide Adequate Care for Seriously Ill Patients?

Health experts say young and rapidly expanding managed-care plans in New York City have not adequately developed the physician networks or treatment programs to handle patients with complicated needs, according to *The New York Times* (July 15).

"Patients with serious illnesses say that getting appropriate treatment within an HMO has a frustrating hit-or-miss quality, depending on whether the HMO happens to have made arrangements with a doctor knowledgeable about the particular ailment," the *Times* reported. Patients reported that if they persisted in appealing HMO denials, they would get the requested treatment, but only after long and potentially dangerous delays. One 54-year-old woman was diagnosed with colon cancer with liver metastases after she switched to an HMO, the *Times* reported. Her general doctors and a cancer specialist recommended surgery by an out-of-network surgeon, but the HMO refused to pay. The patient died before she could receive treatment.

The newly formed HMOs in New York have small rosters of specialists, convoluted rules for difficult cases, few solutions for the chronically ill, and a resistance to innovative new procedures, the *Times* said.

Comment: As managed care enrollment rises, doubts grow about its motivations for caring for the sick. In some immature markets, such as New York and Philadelphia, HMOs may not yet have enlisted the proper specialists to care for patients with rare diseases or complications.

Cornell, Columbia Form Alliance

Columbia and Cornell universities have formed the University Physician Alliance among 2,800 physicians with appointments at Presbyterian Hospital and New York Hospital to negotiate jointly with managed care companies and insurers. Eventually the arrangement may include 8,000 Columbia and Cornell physicians at more than 20 affiliated hospitals.

It is the first time two medical school faculties have formed a clinical alliance while the medical schools maintain separate identities. In an effort to take physicians to the patients, the alliance will develop joint practice sites in neighborhoods throughout the metropolitan region. The alliance also will reduce overhead by eliminating duplicate support services.

The faculty practice plans at Columbia and Cornell produce about \$413 million annually in total operating revenue.

Comment: In six weeks, six major New York City area hospitals merged. In mid-June, Mount Sinai and New York University joined hands; two weeks later, Beth Israel and Long Island Jewish Medical Center came together. On July 25, New York Hospital and Presbyterian united. In addition, the medical staffs of Cornell and Columbia formed University Physician Alliance. The new alliances may soon discover that simply being bigger is not enough. The market wants lower prices and cares little about world-class reputations.

Eye Care Practices Sold for Cash, Stock

Physicians Resource Group Inc., a practice management company in Dallas that specializes in managing eye care centers, has acquired the assets of five eye care practices and has reached agreement to acquire a sixth practice. The five practices are in Lakewood, Fla.; Houston; Paducah, Ky.; Kingman, Ariz.; and Rockford, Ill. It has an agreement to acquire the assets of an eye care practice in Corpus Christi, Texas.

Altogether, Physicians Resource Group is estimated to be paying about \$17 million for the six practices, including \$700,000 in cash and \$16.3 million in 552,812 shares of company common stock. Of the shares, some 147,193 cannot be resold for two years. Combined, the six practices have 14 ophthalmologists, 10 optometrists, 18 locations and one ambulatory surgery center.

Comment: Increasingly, practice management companies are offering company stock in lieu of cash when purchasing physician practices. Accepting stock can be risky because the stock of practice management companies can be highly volatile.

Managed Care Continues Expansion into Hospitals

Managed care arrangements with U.S. hospitals are continuing to expand significantly. An average of 95% of urban and suburban hospitals report having HMO contracts, according to a new national survey of hospital CEOs by Deloitte & Touche, CPAs. Some 69% of rural hospitals reported having HMO arrangements, up 24% in two years, according to the survey.

Titled U.S. Hospitals and the Future of Health Care, the survey shows that despite the great number of managed care arrangements, some 99% of respondents reported that hospital patients have little understanding of managed care. In addition, physicians are only marginally better informed, the survey showed. Some 15% of respondents report that physicians have a full understanding of managed care, even though 67% of respondents report physicians serve on their boards of directors.

The survey represents the opinions of 1,020 CEOs of acute care hospitals and executive directors of multi-hospital systems nationwide.

Only 21% of respondents expect their hospitals to be independent within five years. In the last two years, 16% of responding hospitals had joined larger organizations.

Comment: As managed care continues to reshape health care, providers begin to focus on outcomes and care management systems to ensure quality. The survey found, for example, that 57% of respondents have implemented outcomes measurement programs in the last two years, and 76% expect to initiate or continue such programs in the next five years. In addition, 70% have redesigned clinical processes and 68% have implemented critical paths and care management programs.

NEWS AND COMMENTARY

Massachusetts to Publish Malpractice Data

Gov. William F. Weld has signed a bill to give consumers easy access to data on physicians. The data will include physicians' malpractice awards, disciplinary actions by hospitals and medical boards, settlements in lawsuits, and convictions for felonies or serious misdemeanors. Massachusetts is the first state to offer such extensive data on physicians' performance.

The Massachusetts action is unusual because the state will consolidate data from a variety of sources and make available performance data that are not normally made available to the public. Consumers will be able to get the data this year by calling a toll-free phone number. The program will be administered by the state Board of Registration in Medicine, which licenses physicians. Next year, the board plans to publish the data on the Internet and on CD-ROM for distribution to public libraries.

Comment: The Massachusetts Medical Society proposed the idea after a series of newspaper articles showed how a few doctors had repeated malpractice claims.

Vermont Hospital Invites Chiropractors to Practice

Vermont's largest hospital, Fletcher Allen Health Care, in Burlington, will allow chiropractors to provide limited care to patients. Chiropractors will be allowed to do spinal manipulation for acute lower back pain related to a recent strain and not related to a herniated disk or neurological problem. A study funded by the federal Agency for Health Care Policy and Research, in Rockville, Md., has found that spinal manipulation by chiropractors is effective in relieving such pain.

Comment: Physicians have long been suspicious of the practices and claims of chiropractors. Yet patients say they prefer the care of chiropractors over that of other providers.

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

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

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

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

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

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